

## Average Regional APG rates for Out of State Providers - July 2009

Rate Cd	Rate Cd Desc	Visit Type	Upstate			Downstate <sup>[1]</sup>		
			Base Rate	Blend	Capital	Base Rate	Blend	Capital
1441	CLINIC	Episode <sup>[2]</sup>	\$ 199.00	\$ 85.66	\$ 10.91	\$ 258.90	\$ 121.07	\$ 17.72
1413	CLINIC	Visit <sup>[2]</sup>	\$ 199.00	\$ 85.66	\$ 10.91	\$ 258.90	\$ 121.07	\$ 17.72
1416	AMBULATORY SURGERY	NA	\$ 122.55	NA	\$ 108.48	\$ 156.91	NA	\$ 115.70
1419	EMERGENCY DEPARTMENT	NA	\$ 135.27	NA	\$ 13.84	\$ 175.11	NA	\$ 22.61

[1] Out of state providers located in counties contiguous to the NYS downstate rate region will receive the downstate base rates. Counties contiguous to the NYS downstate rate region include: Sussex, Passaic, Bergen, Hudson, Essex, Middlesex, Union and Monmouth Counties in New Jersey; Pike County in Pennsylvania; and Litchfield and Fairfield Counties in Connecticut. All other out of state providers will receive the NYS upstate rate.

[2] Under the new ancillary policy NYS Medicaid intends to pay for stand alone ancillaries as part of the APG reimbursement. This means that all ancillaries associated with hospital clinic and emergency department visits billed under the Ambulatory Patient Group (APG) payment methodology must be included on the APG claim. In cases where the ancillary is performed by a vendor, rather than by the APG biller, the outside vendor may not bill NYS Medicaid directly, but rather must receive payment from the APG biller. Certain ancillaries are exempt from this policy and may be billed directly to NYS Medicaid by ancillary vendors (see the APG section of the DOH website for details). Additionally, an ancillary vendor may, when applicable and appropriate, bill Medicaid for the professional component of radiology services. Ancillary services associated with ambulatory surgery services billed under rate code 1416 are exempt from this policy.

To facilitate this process, DOH has instituted a new billing option for out of state providers effective October 1, 2009. This option is known as "episode payment." To obtain payment for "stand alone" ancillaries APG billers (e.g., hospital clinics) must do one of two things:

- a. If the recipient is dually eligible for Medicare and Medicaid, use rate code 1413 (non-episode payment) and "reassign" the actual date of service for the ancillary to the same date of service of the medical visit or procedure (so the ancillary will not be viewed by the payment system as a "stand alone"), or
- b. If the recipient is NOT dually eligible for Medicare and Medicaid, use rate code 1441 (episode payment) and code all ancillaries using their actual dates of service. Under episode payment all procedures coded on a claim, regardless of the coded dates of service, are viewed by the payment system logic as being part of the same visit. Therefore the concept of "stand alone" ancillaries does not apply so long as at least one medical visit or procedure is coded on the claim. The advantage of episode payment is that all procedures on the episode claim can be coded with their actual dates of service, rather than requiring reassigned dates of service as is necessary under non-episode payment.