Policy and Billing Guidance Ambulatory Patient Groups (APGs)

PROVIDER MANUAL

REVISION 2.1
August 2012

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Please Note: Red text indicates new policy clarifications and additions to the manual since the issuance of the July 1, 2009 revision. Although every effort has been made to keep this policy manual updated, the charts and lists are subject to change. The actual payment amounts and whether or not a service will be reimbursed through the APG payment methodology is based on the current version of the grouper/pricer and the APG data dictionary.

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Policy and Billing Guidance

Ambulatory Patient Groups (APGs)

CHAPTER 1: BACKGROUND AND INTRODUCTION TO AMBULATORY PATIENT GROUPS (APGS)

1.1 PURPOSE:

The purpose of this document is to provide Medicaid policy and billing guidance to Article 28 providers billing under the Ambulatory Patient Groups Payment methodology to the extent this methodology is applicable to hospital-based outpatient, ambulatory surgery, and emergency departments, and to free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers.

1.2 STATUTORY AUTHORITY FOR NEW PAYMENT METHODOLOGY:

Chapter 53 of the Laws of 2008 amended Article 2807 of the Public Health Law by adding a new Section (2-a). Public Health Law 2807 (2-a) required a new Medicaid payment methodology based on Ambulatory Patient Groups that would apply to most ambulatory care services provided by hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers. The law specified that the new payment methodology be fully phased-in over a four year period, starting the later of December 1, 2008, or upon approval of federal financial participation by the Centers for Medicare and Medicaid Services. The law specifically exempted from the new APG payment methodology payments for services made on behalf of persons enrolled in Medicaid managed care or Family Health Plus, and payments for services certified under the Mental Hygiene Law (i.e. OMH, OMRDD, OASAS).

In 2009, Article 2807 (2-a) was further amended to permit the application of the APG payment methodology to services provided by facilities licensed under the Mental Hygiene Law. The law also authorized the Department of Health to adopt and amend rules and regulations to establish an Ambulatory Patient Group (APG) methodology.

The latest version of the Department's regulations are available online at:
www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_regulations.pdf.

1.3 OVERVIEW OF NEW PAYMENT METHODOLOGY:

The Ambulatory Patient Groups or APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc. APGs categorize the amount and type of resources used in various ambulatory visits. Patients within each APG have similar resource use and cost. APGs group together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. APGs are designed to predict the average pattern of resource use of a group of patients in a given APG. The APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each patient visit.

The APG payment methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services. This new payment methodology also allows for greater payment homogeneity for comparable services across all ambulatory care settings (i.e., outpatient department, ambulatory surgery, emergency department, and diagnostic and treatment centers). By linking payments to the specific array of services rendered, APGs make Medicaid reimbursement more transparent and rational.

The APG reimbursement methodology replaces a reimbursement system for ambulatory care services which is a mix of outdated methodologies that has been frozen or not updated to realistically reflect the cost of providing care. These methodologies were often based on fixed dollar payments that do not vary by severity of illness or complexity of procedure. These antiquated reimbursement methodologies have thwarted the appropriate migration of services from costly acute care settings to less costly primary and preventive care settings.

The APG methodology covers most medical outpatient services. It reimburses based on patients' conditions and severity, and packages the cost of certain ancillary lab and radiology services into the overall payment. It addresses the inadequacies of the previous system by paying varying amounts per visit, based on service intensity.

Coupled with new investments in primary care and primary care enhancements described in Chapter 6 of this document, the goal of the APG reimbursement methodology is to incentivize providers to improve the quality of and access to preventive and primary health care services for Medicaid enrollees.

1.4 SCOPE OF SERVICES:

The APG payment methodology is applicable to outpatient, ambulatory surgery and emergency department services provided by general hospitals and to ambulatory care services provided by diagnostic and treatment centers and free-standing ambulatory surgery centers.

The APG payment methodology is not applicable to:

- ~~services provided outside of a facility's licensure under Article 28 of the Public Health Law (e.g. APGs are not currently applicable to services certified under the Mental Hygiene Law)~~
- capitated payments made on behalf of Medicaid managed care or Family Health Plus enrollees;
- payment for Ordered Ambulatory services
- payment for physicians' services in hospital settings billed using the Physician Fee Schedule;
- payment to Federally Qualified Health Centers (FQHCs), except when the FQHC has voluntarily agreed to participate in the APG reimbursement system, or;
- payment for long term care, home care, personal care.

1.5 IMPLEMENTATION SCHEDULE:

Approval of federal financial participation by the Centers for Medicare and Medicaid Services (CMS) is required prior to implementing the APG payment methodology in different settings.

- APGs were implemented in hospital outpatient departments and ambulatory surgery centers on December 1, 2008.
- APGs were implemented in hospital emergency departments on January 1, 2009.
- APGs will be implemented in freestanding diagnostic and treatment centers and freestanding ambulatory surgery centers upon CMS approval, retroactive to September 1, 2009.

APGs will be implemented in facilities licensed under the Mental Hygiene Law in SFY 10/11, upon CMS approval. For additional information on implementation, please contact the following NYS agencies which govern mental hygiene:

Office of Mental Health (517) 474-6911
http://www.omh.state.ny.us/omhweb/clinic_restructuring/.
e-mail: clinicrestructuring@omh.state.ny.us

Office of Alcohol and Substance Abuse Services (518) 485-2207
e-mail: APG@oasas.state.ny.us

Office of Mental Retardation and Developmental Disabilities
(518) 474-3558 Policy Issues – Bureau of Behavioral and Clinical Solutions
(518) 474-1745 Rate Setting Issues – Bureau of Cost and Revenue Solutions
(518) 402-4333 Provider Enrollment and Claiming Assistance – Bureau of Central Operations

For the full implementation schedule, please visit:
www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm#training_schedule.

1.6 BLENDING OF APG PAYMENT:

Both hospital-based ambulatory surgery and emergency department services received 100% APG payment with the implementation of the APG reimbursement methodology. However, APG reimbursement for hospital outpatient departments, diagnostic and treatment centers and free-standing ambulatory surgery centers is phased-in as required by law. In the initial phase of blending, reimbursement for each individual visit is based on 25% of the full amount that the APG methodology would calculate for the visit (based on coded procedures and diagnoses) and 75% of a provider-specific existing payment for the blend amount. The existing payment used for blending purposes is based on a provider's average per visit reimbursement for services moving to APGs for calendar year 2007.

The APG portion of the blend increases on December 1, 2009, January 1, 2011,and January 1, 2012 according to the following schedule:

Setting	*Effective Date of Implementation*	*Blend Percentages With Dates of Change*
Hospital Outpatient Department	December 1, 2008	Starting Dec 1, 2008, 25% of payment will be based on APGs. The percentage will increase to 50% on December 1, 2009; to 75% on Jan 1, 2011; and to 100% on Jan 1, 2012.
Hospital Emergency Room	January 1, 2009	100% of payment will be based on APGs starting Jan 1, 2009.
Hospital-Based Ambulatory Surgery	December 1, 2008	100% of payment will be based on APGs starting Dec 1, 2008.
Free-standing Diagnostic and Treatment Center	September 1, 2009	Starting on September 1, 2009, 25% of payment will be based on APGs. The percentage will increase to 50% on December 1, 2009; to 75% on Jan 1, 2011; and to 100% on Jan 1, 2012.
Free-standing Ambulatory Surgery	September 1, 2009	Starting on September 1, 2009, 25% of payment will be based on APGs. The percentage will increase to 50% on December 1, 2009; to 75% on Jan 1, 2011; and to 100% on Jan 1, 2012.

When APGs are implemented in facilities licensed under the Mental Hygiene Law, free standing mental hygiene providers (not hospital based providers) will have an APG phase-in period that is distinct from the phase-in schedule for D&TC clinic services listed above. The variable blend percentages will be linked to the APG rate code.

There are certain APGs and individual procedures that are not subject to the blend. The complete list of "no blend" APGs are available online at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_blend.pdf.

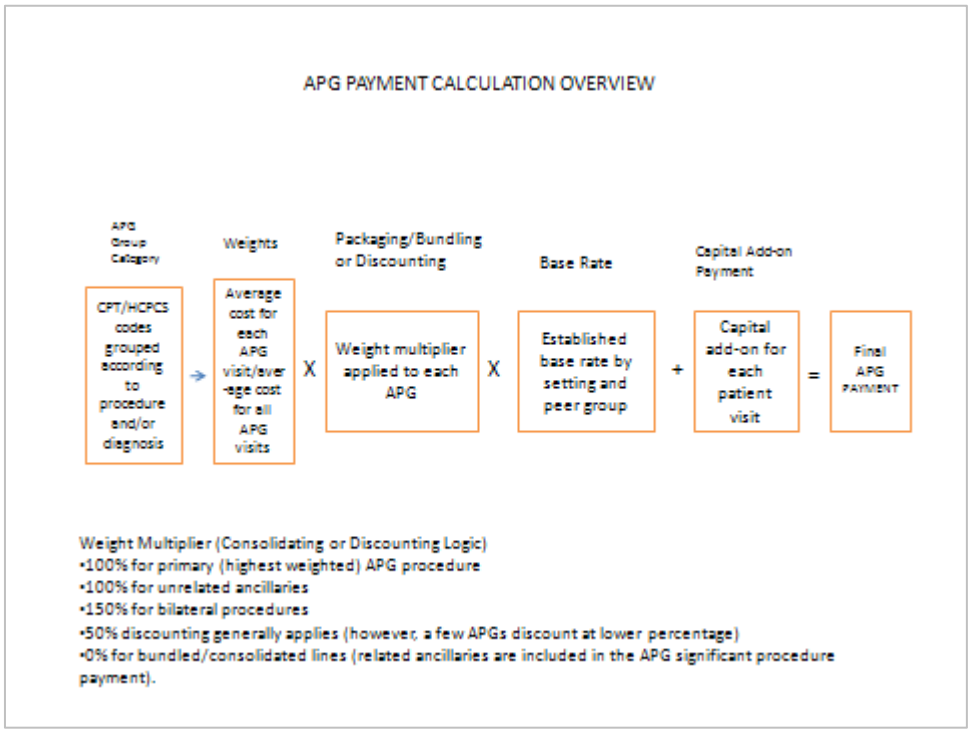
The complete list of "no blend" procedures are available online at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_blend_procedures.pdf

CHAPTER 2: APG GROUPING LOGIC AND USE OF MODIFIERS

2.1 MORE ON THE APG PAYMENT METHODOLOGY:

As previously discussed, APGs are a patient classification system designed to pay providers based on the amount and type of resources used during a patient encounter. Patients in a given APG have similar clinical characteristics as well as similar resource use and cost. APGs require facilities to report all services provided during the patient encounter. Provider payments are directly related to the actual services provided based on patient diagnosis and the CPT/HCPCS codes reported on the Medicaid claim. Medical services requiring a higher level of professional and ancillary care are paid a higher rate than those of a lower intensity.

APG processing uses software that examines the procedure codes and any associated modifiers reported in each of a claim's service lines and assigns each line an APG code, along with other relevant values (e.g. APG weights, packaging flags, discounting percentages, etc.). Each APG code carries a "weight" based on the group's average cost, from which appropriate payment levels are established. The APG "weight" can be multiplied by a percentage to reduce or increase the weight, depending on the APG grouper's evaluation of the service line, resulting in the service line's final "weight." For medical visits, the assignment of an APG is dependent on the ICD-9 Primary Diagnosis Code recorded on the claim.



There are a number of procedures (primarily pertaining to eyeglasses, mental hygiene services, rehabilitation therapies and hearing aids) which are assigned a procedure-based weight that is different from the APG weight. In the APG payment methodology, the procedure based weight overrides the APG weight. Additionally, if a procedure is assigned a procedure-based weight it will pay even if it groups to a Never Pay APG. However, if the procedure groups to an "If Stand Alone Do Not Pay APG", it will not pay if it is the only procedure on the claim or is accompanied by non-paying procedures. Discounting and consolidating logic will still occur where applicable.

Some of the procedure-based weights also recognize units. For example, the physical therapy APG includes units based and non-units based procedures. The units based physical therapy procedures are assigned a procedure based weight that is different from the physical therapy APG weight. When coding a unit- based procedure, the number of units should also be reported on the claim. The procedure-based weight and the number of units are both used in the APG payment calculation for the units based procedure.

The "final weight" for a given visit is multiplied by a provider-associated base rate as part of the APG payment calculation. For hospital outpatient departments and diagnostic and treatment centers, the APG payment is "blended" with a historical weighted average payment of the provider's pre-APG rates to arrive at the final payment amount. A single claim can be assigned one or more APG values, each of which carries its own "weight," depending on the service line procedure codes, modifiers, and in some cases, diagnosis codes. The eMedNY system will use the EAPG Grouper/Pricer for processing institutional outpatient claims upon the effective dates of APG implementation as identified in section 1.5 of this document. Affected providers are required to use new rate codes on and after those effective dates. Use of the new rate codes results in payments for services based on the APG classification and payment rules.

When a visit consists entirely of "no capital add-on APGs" or "no capital add on procedures" a capital add-on payment is not included in the final APG payment for the visit.

For a complete list of "no capital add-on APGs and procedures" please visit:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_capital_add.pdf.
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_capital_procedures.pdf.

2.2 APG TYPES:

The EAPG Grouper/Pricer maps CPT and HCPCS procedure codes and ICD-9 diagnosis codes reported on a claim to APGs to define the ambulatory visit. Multiple APGs may be assigned to a visit. The four primary types of APGs are described below.

Significant Procedures: A procedure/service which constitutes the reason for the visit and dominates the time and resources expended during the visit. (Examples: excision of skin lesion, stress test, insertion of a central venous catheter, treating fractured limb)

Medical Visits: A visit during which a patient receives medical treatment but does not have a significant procedure performed. Evaluation and management codes are assigned to one of the medical visit APGs based on the primary diagnosis reported on the claim. (Examples: follow-up visit for patient with congestive heart failure, chronic obstructive pulmonary disease, hypertension)

Ancillary Tests and Procedures: A test or procedure ordered by the primary physician to assist in patient diagnosis or treatment. (Examples: immunizations, plain film x-rays, laboratory tests)

Incidental Procedures: An integral part of a medical visit usually associated with professional services being given to the recipient. (Example: range of motion measurements)

For a full list of APG types, please visit:
www.health.state.ny.us./health_care/medicaid/rates/apg/docs/apg_types_categories.pdf

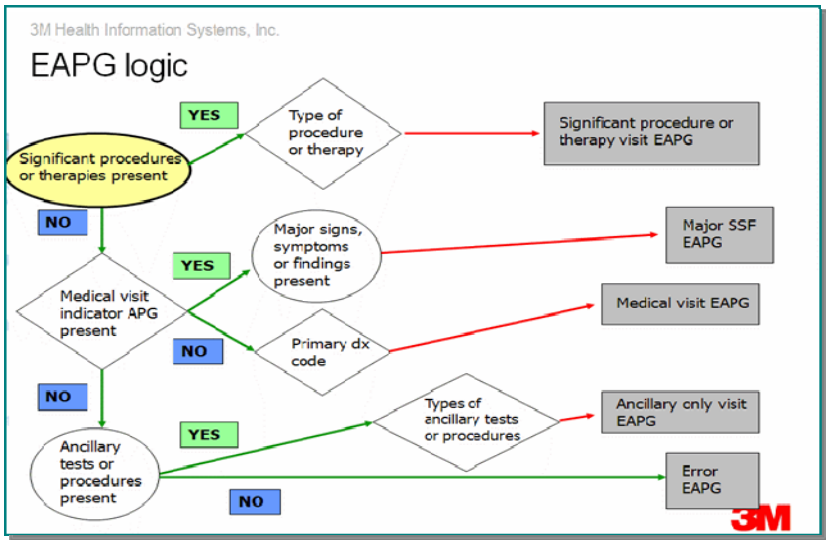
2.3 APG CLASSIFICATION LOGIC:

In the APG classification system, the patient is described by a list of APGs that corresponds to services provided to the patient. The significant procedure (rather than diagnosis) is the initial classification variable. Procedures that could be performed on an ambulatory basis are categorized as either significant procedures or ancillary services.

Patients who undergo a significant procedure are assigned to a significant procedure APG on the basis of the CPT code that describes the precise significant procedure. Patients receiving medical treatment that does not involve a significant procedure are assigned to a medical APG based on the ICD-9 diagnosis code. In some instances, a patient may receive a significant procedure and a medical visit, in which case the visit would be assigned to a significant procedure APG. Under the default APG logic, the procedure would be paid at the line level and the medical visit payment would be included (packaged) in the payment for the significant procedure. A patient who neither received medical treatment nor underwent a significant procedure but had an ancillary service performed would be assigned an ancillary service APG.

Patients with any significant procedures or therapies are assigned to one or more significant procedure APGs. If there are no significant procedures present and there is a medical visit (Evaluation and Management CPT code reported), the patient is assigned to a medical visit APG. If there is neither a significant procedure nor a medical visit code, but there are ancillary test(s) or procedure(s) present, then the patient is assigned one or more ancillary APGs. If there is no significant procedure CPT code, medical visit (evaluation and management CPT) code or ancillary code, the claim is considered an error.

The figure below provides an overview of the APG assignment logic as discussed above.



The complete APG logic is included in the 3M Health Information Systems Definitions manual which is available through 3M's Definitions Manual Website at:

http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/Definition_Manuals/.

Effective January 1, 2010, the EAPG grouper logic was revised to recognize a list of significant procedures with which medical visits will no longer package. Medical visits will no longer package with: the more significant ancillaries; dental procedures; physical, speech and occupational therapy; and counseling services. When certain significant procedures are performed on the same day as a medical visit, no packaging would occur and payments would be received by the provider for both the medical visit and significant procedure at the line level.

For a complete list of "significant procedures with which medical visits do not package," please visit: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_not_package.pdf.

2.4 GROUPING ELEMENTS OF THE APG PAYMENT SYSTEM:

The APG System uses three methods for grouping different services provided into a single payment unit: ancillary packaging, significant procedure consolidation or bundling; and multiple significant procedure and ancillary discounting.

Ancillary Packaging: Ancillary packaging refers to the inclusion of certain ancillary services in the APG payment rate for a significant procedure or a medical visit. When ancillaries are packaged, the costs of the ancillaries are included in the payment amount for the significant procedure or medical visit. Under APGs, ancillary lab and radiology services that are inexpensive or frequently provided are generally packaged into the payment for the significant procedure or medical visit. Other ancillary services, particularly those that are expensive or infrequently ordered such as MRIs are paid as separate ancillary APGs.

Uniform packaging of ancillaries is used in the APG payment system. Ancillaries that are uniformly packaged include ancillaries that are performed for a wide range of different visits and which are relatively low cost in comparison with the average cost of the significant procedure and medical visit APGs.

To view the list of ancillaries which are always packaged, called the Uniform Packaged Ancillary List, please visit: www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_uniform_packaging.pdf.

Significant Procedure Consolidation: Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment. The APG system relies on a significant procedure consolidation list developed on the basis of clinical judgment which identifies for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure and which can be performed with relatively little additional effort. The APG grouping logic consolidates related significant procedures. (Example: a Level I (primarily diagnostic) lower gastrointestinal endoscopy is consolidated into the Level II (primarily therapeutic) gastrointestinal endoscopy.) Unrelated significant procedures are not consolidated. Multiple unrelated significant procedures on the same date of service also are not consolidated in the APG classification system, but payment for additional unrelated significant procedures will be discounted.

Discounting: Discounting refers to a reduction in the standard payment rate for an APG. The APG payment system applies discounting when multiple unrelated significant procedures are performed or the same ancillary service is performed multiple times during a visit. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure itself (e.g. the cost of doing two procedures at the same time is less than the cost of doing those same procedures at two different times).

In summary, the APG payment system is a visit-based prospective payment system with uniform ancillary packaging, significant procedure consolidation and multiple unrelated procedure discounting. Packaged ancillaries, incidental procedures, and lower cost drugs, biologicals and supplies are included in the payment amount for a significant procedure and medical visit. Exceptions are identified in Chapter 4.

Effective January 1, 2010, medical visits will no longer package with higher intensity significant ancillary procedures (e.g., mammograms, MRIs, CAT scans, etc.) and will pay separately at the line level. Similarly, medical visits will no longer package with dental procedures; physical, speech and occupational therapy; and counseling services. When provided on the same date as an E&M visit, these services will pay at the line level.

Effective January 1, 2010, multiple same APG discounting (rather than consolidation) which currently applies to most dental services (e.g., APG 352 Periodontics) will be expanded to include occupational therapy (APG 270), physical therapy (APG 271), speech therapy (APG 272) and most mental hygiene APGs (APG 323). For a complete list of APGs that will discount rather than consolidate when combined with other same or similar APGs, visit: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_multiple_discounting.pdf

Also, effective April 1, 2010, some APGs will discount at rates other than 50%.

For a complete list of "variable discounting' APGs, please visit:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_discounting_percentage.pdf

2.5 USE OF MODIFIERS IN APGS:

Use of modifiers provides the means by which providers can indicate that a service or procedure has been altered by some specific circumstances while not changing the definition or the code for the service. The APG system recognizes the following seven billing modifiers.

CPT Modifier 25 (Distinct Service): This modifier is used when there is a significant, separately identifiable evaluation and management service by the same physician on the same date of service as a significant procedure.

The CPT Modifier 25 should be used on an E&M code only when the patient's condition requires a significant, separately identifiable E&M service above and beyond the significant procedure performed on the same date of service. This modifier should not be used to report an E&M service that resulted in a decision to perform the significant procedure.

▸ ***Note:*** During the initial phase of APGs, Modifier 25 will be disabled and the use of Modifier 25 will have no effect on payment. The EAPG Grouper/Pricer will package the cost of the medical visit flagged with a Modifier 25 in the payment for the significant procedure APG (i.e., the initial APG weights were developed taking into account the disabling of Modifier 25 logic). In the future, Modifier 25 may be activated and the APG weights will be modified accordingly.

CPT Modifier 27 (Multiple E&M visit): This modifier is used when there are multiple outpatient E&M encounters on the same date of service. The CPT Modifier 27 should be used when a patient receives multiple E&M services performed by different physicians in multiple outpatient settings (e.g. hospital emergency department and clinic) on the same date of service. Modifier 27 should be appended to the second E&M code when reporting more than one E&M service to indicate that the E&M service is a "separate and distinct" encounter provided the same day.

▸ ***Note:*** This Modifier should not be used for reporting of multiple E&M services performed by the same physician on the same date of service.

▸ ***Note:*** Normally, the second E&M will group into APG 449, "additional undifferentiated medical visit," when Modifier 27 is used. However, during the initial phase of APGs, the weight for APG 449 will be set to zero, which will disable Modifier 27. The initial APG weights for medical visits were developed taking into account the disabling of Modifier 27 (i.e., payment for additional medical visits on the same date of service was packaged in the payment for the primary medical visit). In the future, Modifier 27 may be activated by re-weighting APG 449, with the other medical visit APG weights revised accordingly.

CPT Modifier 50 (Bilateral Procedure): CPT Modifier 50 should be used to report bilateral procedures that are performed during the same operative session.

▸ ***Note:*** This modifier should not be used to report surgical procedures that are identified in code terminology as "bilateral" or to report procedures identified in code terminology as "unilateral or bilateral." When Modifier 50 is used, both procedures will be reimbursed, but the APG Grouper/Pricer calculates the payment at 100% rate for the first procedure and at 50% of the rate for the second procedure.

CPT Modifier 52 (Reduced Services): CPT Modifier 52 should be used when a service or procedure is partially reduced or eliminated at the physician's discretion or when an initial bilateral procedure cannot be performed as such. As with CMS, NYSDOH does not allow the use of Modifier 52 when the endoscopic procedure is incomplete and there is a CPT or HCPCS/level II code to describe the actual service performed. If a code is available that fully describes the outpatient procedure performed, this code choice supersedes the reporting of a code describing the intended, albeit not performed, procedure. When Modifier 52 is used, the payment for the procedure will be discounted by 50%.

CPT Modifier 59 (Separate Procedures or Distinct Procedural Service): CPT Modifier 59 should be used to designate instances when distinct and separate multiple services with the same APG are provided to the patient on a single date of service (eg. separate encounters, different surgeries, different sites or organ systems, separate incisions). Modifier 59 may also be used to report those procedures/services considered a component of another procedure, when the service is carried out independently or considered unrelated or distinct from the other procedures/services provided at the same time. Normally when multiple procedures map to the same APG, the additional occurrences (beyond the first) will consolidate (i.e., no payment at the line level). However, when Modifier 59 is used, the additional same APG procedures will pay at 50% of the amount paid for the first procedure.

CPT Modifier 73 (Terminated Procedure): CPT Modifier 73 should be used when a surgical procedure is cancelled subsequent to the patient's surgical preparation (but prior to the administration of anesthesia) due to extenuating circumstances or those that threaten the well-being of the patient. ▸ **Note**: Modifier 73 should not be used for elective cancellation of a procedure before administration of anesthesia. If Modifier 73 is reported and the procedure is an approved Ambulatory Surgery Center service, the payment will be discounted by 50%.

CPT Modifier UD (340B Drugs): Drugs obtained at the 340B price are identified by the UD modifier and it is not required that an NDC code be provided when submitting a claim. However, the actual acquisition cost of the drug should be listed on the claim. See the Medicaid Update (December 2007 and April 2008) articles entitled *'National Drug Code Required on Medicaid Claims'* and *'Coming Soon: Easy Identification of 340B Priced Claims'* for details at the following links:

http://nyhealth.gov/health_care/medicaid/program/update/2007/index.htm.

http://nyhealth.gov/health_care/medicaid/program/update/2008/index.htm.

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CHAPTER 3: PROVIDER BILLING GUIDANCE

This chapter outlines the changes in provider billing resulting from APG implementation and provides guidance on how to bill and submit claims using the new APG reimbursement methodology.

3.1 USE OF APG RATE CODES:

Essentially, the minimum change required to bill and get paid under APGs is to code claims using one of the APG rate codes assigned to your facility upon APG implementation. The following table shows the new APG grouper access rate codes.

Setting	Service	APG Visit Rate Code	APG Episode Rate Code	Effective Date (Visit)	Effective Date (Episode)
Hospital	**OPD/Clinic**	**1400**	**1432**	**12/01/08**	**07/01/09**
Hospital	**OPD – MR/DD/TBI**	**1501** [1]	**1489** [1]	**07/01/10**	**07/01/10**
Hospital	**School Based Health Center**	**1444**	**1450**	**04/01/09**	**10/01/09**
Hospital	**Ambulatory Surgery**	**1401**	**NA**	**12/01/08**	**NA**
Hospital	**Emergency Department**	**NA**	**1402**	**NA**	**01/01/09**
Free-Standing DTC	**Clinic**	**1407**	**1422**	**09/01/09**	**09/01/09**
Free-Standing DTC	**Clinic - MR/DD/TBI**	**1435** [2]	**1425** [2]	**09/01/09**	**09/01/09**
Free-Standing DTC	**School Based Health Center**	**1447**	**1453**	**09/01/09**	**10/01/09**
Free-Standing DTC	**Dental School**	**1428** [3]	**1459** [3]	**09/01/09**	**10/01/09**
Free-Standing DTC	**Renal Clinic**	**1438**	**1456**	**09/01/09**	**10/01/09**
Free-Standing DTC	**Ambulatory Surgery**	**1408**	**NA**	**09/01/09**	**NA**
All DTC Codes are pending CMS approval.					

Reminder: Only services listed on your facility's Operating Certificate may be billed, except for ancillary laboratory and radiology services related to clinic visits subject to APGs provided by outside lab and

[1] These codes may only be used after 07/01/10 for beneficiaries with recipient restriction codes 81 or 95.
[2] These rate codes are to be used for beneficiaries with recipient restriction codes 81 or 95.
[3] Rate codes 1428 and 1459 are assigned to academic dental center providers.

For a full list of hospital rate codes subsumed with APG implementation, please see:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/outpatient_rate_codes.pdf

For a full list of DTC rate codes subsumed with APG implementation, please see:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_dtc_rate_codes.pdf

3.2 SERVICES NOT PAID UNDER APGS:

Certain rate codes and claims remain outside of APGs and will continue to be paid under existing Medicaid payment mechanisms. These include:

- ~~Services provided outside of a facility's licensure under Article 28 of the Public Health Law (e.g. Mental Hygiene and OMRDD specialty services);~~
- Child rehabilitation;
- Payments made to Medicaid Obstetrical & Maternal Services (MOMS) Programs and Health Supportive Services providers;
- Payments for HIV Counseling/Testing;
- Payments for Tuberculosis/Directly Observed Therapy;
- Payments for Ordered Ambulatory Services;
- Monthly billings of Medicare co-pays and deductibles for dual eligible enrollees;
- Payments for Screening for Orthodontic Treatment;
- Payments for Comprehensive Medicaid Case Management/Targeted Case Management.

Rate codes which have not been subsumed by APG rate codes are referred to as carved out rate codes.
A complete list of hospital outpatient department carved-out rate codes and rate codes subsumed by APGs are available online at: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/outpatient_rate_codes.pdf.

A complete listing of diagnostic and treatment center clinic carved-out rate codes and rate codes to be subsumed by APGs are available online at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_dtc_rate_codes.pdf.

Additional services which are not reimbursed using the APG methodology are discussed in section 4.20 and 4.21 of this manual.

3.3 IMPORTANCE OF ACCURATE MEDICAL CODING:

To ensure appropriate reimbursement under the new APG payment methodology, all claims **must** include:

- **one of the new APG grouper access rate codes (listed in Section 3.1);**
- **a valid, accurate ICD-9-CM primary diagnosis code*; and**
- **valid CPT and/or HCPCS procedure codes.**

* The **primary diagnosis code** is the ICD-9 code describing the diagnosis , condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

APG reimbursement for an Evaluation and Management (E & M) visit will be determined by the primary ICD-9-CM diagnosis code and the level of the E & M visit CPT code. Diagnosis and procedure coding and billing must be supported by the documentation in the medical record. ▶ ***Note**:* Secondary diagnoses or additional codes that describe any coexisting conditions should also be coded, since if any of these codes group to APG 510, "major signs, symptoms and findings," then that diagnosis will be used in place of the primary diagnosis to group the medical visit.

3.4 VISIT PAYMENT POLICIES AND THE TRANSITION OF EPISODE CLAIMING:

A "visit" is defined as a unit of service consisting of all the APG services preformed for a patient that are coded on the same claim and share a common date of service. There may be multiple APGs associated with a visit, depending on the services provided. Upon initial APG implementation (Dec. 2008), the "visit" was the basic unit for payment.

As of July 1, 2009, for hospitals, most ancillary laboratory or radiology services associated with a medical visit and/or a significant procedure billed under the APG payment methodology became the fiscal responsibility of the APG provider and had to be included on the APG claim, even if the ancillary services were provided by outside vendors or on different dates of service. This ancillary policy will also apply to D&TCs prospectively effective January 1, 2011. Consistent with this change, new rate codes were issued for hospital OPDs and will be issued for DT&C clinics which enable the APG Grouper/Pricer to recognize an "episode" of care.

An "episode" is defined as a unit of service consisting of all services on a claim, regardless of the coded dates of service. Under episode billing an episode shall consist of all medical visits and or procedures that are provided by a clinic to a patient on a single date of service plus any associated non-carved out ancillary laboratory or radiology services, regardless of the date of service of those ancillaries. Under episode claiming, multiple episodes should not be coded on the same claim or the payment could be subject to excessive packaging, consolidating, and/or discounting.

For emergency departments, the significant procedures and/or medical visits comprising the non-carved out ancillary services portion of an episode need not be on a single date of service and may instead be on consecutive dates of service.

3.5 USE OF VISIT AND EPISODE RATE CODES:

The EAPG Grouper/Pricer is programmed to use two grouping mechanisms for billing purposes. The "visit" grouping mechanism applies APG packaging, consolidation, and discounting to all services on a claim with the same date of service. With visit billing there can be more than one visit on the claim and each visit will process separately through the grouper/pricer based on the coded dates of service. The "episode" grouping mechanism applies APG packaging, consolidation, and discounting to all services on a claim regardless of the date of service. Therefore, on an episode claim there can be only one visit/episode on the claim and date of service is ignored by the grouper/pricer.

Visit Rate Codes and Ancillaries: When using visit rate codes to claim for a visit, all associated ancillary or radiology services must be reported on the same claim as the medical visit or significant procedure that generated the ancillary service. For claiming purposes, providers must reassign the dates of ancillary lab or radiology services to correspond with the date of the medical visit or significant procedure that generated the ancillary service. If the dates of the ancillaries are not reassigned, it is likely that they will be viewed by the grouper/pricer as "if stand alone, do not pay procedures" and no payment will be made. To avoid the reassignment of dates that can be necessary under visit claiming, NYS DOH implemented the episode claiming option, whereunder correct dates of service can be coded for the ancillaries and they will still group with, and be paid with, the relevant/associated medical visit or significant procedure. While multiple visits may be reported on the same claim when using visit rate codes, the Grouper/ Pricer will apply the APG grouping logic to all services and procedures with the same date of service.

All services and procedures provided to a patient with the same date of service and rate code (based on servicing provider type – i.e. OPD, Ambulatory Surgery Center, ED, and D&TC) must be billed together on one claim. If two claims are submitted for the same patient with the same rate code, same date of service, and same provider (hospital or D&TC), only the first claim submitted will result in payment. The second claim will be denied.

If a patient returns to the clinic for multiple visits on the same date of service, all the procedures must be billed on one claim with the appropriate APG rate code (1400 for hospital OPDs or 1407 for DTCs). If the provider attempts to submit multiple APG claims for that rate code for the same recipient/same date of service, only one claim will be paid. All others will be denied as duplicative claims. If a patient is initially seen in the hospital emergency room and the visit ultimately results in the provision of a same-day ambulatory surgery service outside of the emergency room, the hospital should bill the visit only under the ambulatory surgery rate code.

Episode Rate Codes: As described above, for purposes of APG reimbursement an "episode of care consists of a medical visit and/or significant procedure that occurred on a single date of service and all the associated ancillary laboratory or radiology services that occurred on or after the date of the medical visit or significant procedure. When using an episode rate code to claim for an episode of care, providers must include a "from" and "to" date in the claim header to reflect the episode of care as well as specific dates at the line level for each service provided as part of the "episode of care.

All procedure codes related to an episode of care should be reported on a **single claim with their actual dates of service.** This includes the medical visit and or procedures that occurred on a single date of service and all associated ancillary laboratory or radiology services on or after the medical visit or significant procedure, regardless of the provider or date of service. When using an episode rate code, the Grouper/Pricer will apply the APG grouping logic to all services and procedures on the claim, regardless of the dates of service. If procedures from two different episodes of care are coded on the same claim, unwarranted discounting or consolidation may occur, resulting in underpayment to the APG biller.

As with use of the visit rate code, if two claims are submitted by the same APG provider for the same patient, using the same episode rate code and the same "from" date for the episode of care, only the first claim submitted will result in payment. The second claim will be denied.

Note: Implementation of the ancillary billing policy described above will be delayed for DTCs until January 1, 2011. Therefore, upon implementation of APGs in DTCs through December 31, 2010, ancillary laboratory and radiology services which have historically been referred by DTCs to outside providers or vendors may continue to be billed directly to EMedNY by the ancillary service provider using the appropriate Medicaid fee schedule. During this time period, these ancillary services are not the financial responsibility of the DTC and should not be reported on the APG claim. However, any ancillary laboratory or radiology service provided directly by the DTC clinic or historically included in the clinic's former threshold or specialty (e.g. as with former PCAP rate codes) payment should be reported on the APG claim, even those that map to "a never pay APG" or an "if stand alone do not pay APG.".

The ancillary billing policy will be implemented prospectively in DTCs, effective January 1, 2011. Additional guidance on the ancillary billing policy will be issued at that time. In the interim, see Section 4.4 for more information on the APG ancillary billing policy.

The primary differences between visit and episode rate codes are summarized in the chart below:

Visit Rate Codes	*Episode Rate Codes*
• Multiple visits (i.e., medical visits and/or significant procedures with different dates of services, plus associated ancillaries) may be reported on a claim. • Providers must reassign dates of ancillary lab and radiology services at the line level to correspond to date of the medical visit or significant procedure visit that generated the order for the ancillary service. • Grouper/Pricer applies APG logic to all services and procedures with the same date of service.	• Only one episode of care may be reported on a claim. • Providers must include a "from" and "to" date in the claim header to reflect the episode of care. • Providers report the actual dates of service for all procedures which are part of the episode of care at the line level (any medical visit/significant procedures on the same date of service and associated lab and radiology services on or after that date service). • Grouper/Pricer applies APG logic to all services and procedures included on the claim, irrespective of the dates of service.

APG billers assigned episode rate codes (hospital OPDs, D&TCs, and SBHCs) are expected to use episode rate codes for all claims effective January 1, 2011, except when billing for Medicare/Medicaid dual eligibles or for services routinely billed on a monthly basis. In the interim, APG billers may use either the appropriate visit based rate codes (1400, 1407,1435) or the appropriate new episode of care rate codes(1432, 1422,1425). After January 1, 2011, visit based rated codes may only be used for claims for Medicare/Medicaid dually eligible patients or for services that are billed for a patient on a monthly basis.

The SDOH strongly encourages providers to use episode rate codes as episode rate codes enable more accurate reporting with respect to the date of ancillary lab and radiology services and, when used properly, episode rate codes will always result in as much or more payment than use of a visit rate code for the same bundle of services.

3.6 UNITS OF SERVICE:

Generally, the APG reimbursement system does not recognize units of service. However, effective January 1, 2010, providers may bill multiple units of service for a limited group of procedures including physical and occupational therapy. Additional units-based procedures include nutrition counseling (e.g., CPT 97802 medical nutrition, indiv., 15 min.), crisis management (e.g., CPT H2011 crisis intervention service, 15 min.), patient education including diabetes and asthma self management services rendered by CDEs & CAEs , and health/behavioral assessments (e.g., CPT 96150 assess health behavior, initial).

Providers should not code multiple lines on a single claim with the same HCPCS code (except for dental procedures such as multiple teeth sealed, multiple fillings, etc. – see section 4.2) to signify the provision of multiple units of a single procedure/service. Rather, they should include the HCPCS code on one line along with the number of units of the service provided on that same line.

For physician administered drugs and all other services billed in multiple units, providers should bill for each drug or service on a single claim line and identify the units provided on that line. ~~Drug APGs are set to pay for the average units billed for each APG.~~ Generally drugs are grouped into APGs based on the costs of a typical dosage.

~~When multiple immunizations are rendered on the same date of service, the APG claim should include multiple codes for the administration of vaccine. The first administration code will pay at 100%; subsequent codes will be discounted at 50%.~~

For a complete list of units-based procedures and their respective unit maximums, please visit: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/units_based_procedures.pdf.

3.7 EMERGENCY ROOM – EPISODE OF CARE:

If a patient enters the Emergency Department (ED) before midnight and leaves after midnight, the Grouper/Pricer will treat the ED visit as a single episode of care. A single claim should be filed for each ED visit (episode of care) and the actual dates of service for each procedure should be reported on the claim. **All ED services should be billed using the ED rate code, 1402.**

3.8 USE OF MODIFIERS IN APGS:

The APG system will recognize the seven billing modifiers listed below. For a complete explanation on the use of these modifiers, see Section 2.5.

Modifier	*Description*	*Affects Payment?*
UD	340B Drugs	N
25	Distinct Service	N
27	Multiple E & M Visits	N
50	Bilateral Procedures	Y
52	Reduced Services	Y
59	Separate Procedures or Distinct Procedural Services	Y
73	Terminated Procedure	Y

3.9 UTILIZATION THRESHOLDS:

The Utilization Threshold Program continues to apply to clinic services billed as visits or episodes of care under APGs. Under the Utilization Threshold Program, it is necessary for clinic providers to obtain an authorization from the Medicaid Eligibility Verification System (MEVS) to render services to Medicaid patients. This authorization to render services will be given unless a recipient has reached his/her utilization threshold limit. If the individual's threshold has been reached, the clinic physician must submit a "Threshold Override Application" (TOA) in order to obtain approval for the additional services.

The Utilization Threshold Program has been revised to provide individual thresholds, which are refreshed quarterly, for every Medicaid recipient based on their health risk status. ~~These new thresholds will be implemented in 2009. Notification of these changes will be forthcoming in a Medicaid Update article.~~ As of March 1, 2010, revised TOA forms must be used. These forms may be obtained by calling the eMedNY call center at (800) 343-9000. The Utilization Threshold Guide is available online at: www.emedny.org/HIPAA/provider_training/training.html.

3.10 REMITTANCE:

The 835 remittance will include line level detail including the APG code, APG full weight, APG allowed percentage, APG paid amount, the payment based on existing operating reimbursement (the blend amount), "combined with CPT" (if reimbursement for a particular CPT/APG has been consolidated or packaged within another CPT/APG, this field indicates the CPT/APG to which payment has been consolidated/packaged), capital add-on amount, and the total payment for the claim. The 835 Companion Guide, which provides detail for all the APG remittance changes, is now available on the www.eMedNY.org website under NYHIPAADESK.

3.11 BILLING EDITS

Almost all of the current front-end edits used to process clinic claims will remain the same. Additional APG-specific edits have been developed as well including the following:

Claim Payer Pd Amt Not Equal to Sum of Line Payer Pd Amt: This edit fails if the Medicare or commercial insurance paid amounts on the lines do not add up to equal the amount entered in the header. The edit only pertains to the paid amount by the other carrier.
Rate Code Invalid for Clinic PAC/PAS: This edit fails if a claim is submitted with a rate code that is not a billable rate code, such as the APG add-on rate code. The non-billable rate codes are: 1647-1670, 1700-1784, 1811-1812, 2916-2939, 3001-3087, 3093-3096, 6501-6571, 7501-7571 (PAC/PAS No Bill Rate Code) and the APG rate codes 1403-1406 and 1409-1412.
APG Claim Document Limit Reached: If a single claim document contains an APG Rate Code (1401, 1402, 1407 or 1408) and the document already contains the maximum of 180 entries in the Base Rate Change Table (header 2, lower left), and if logic determines that a 181 is necessary, this edit is failed instead of exceeding capacity. The provider should resubmit the claim as two or more claims if there are numerous dates of service. This reduces the number of entries in the Base Rate Change Table.
All APG Lines Paid Zero: If the APG Grouper returns zero payment for all lines on an APG claim, this edit fails. If the APG Grouper assigns APG 999, this means the line is ungroupable and the edit fails. This edit only occurs if no line is groupable <u>or</u> if all lines are returned as paid zero <u>or</u> if there is a combination of paid zero and ungroupable. The end result is no payment for the entire claim for any line. Edit 02081 also occurs if the claim is for Medicare deductible/coinsurance amounts and all lines are returned from the grouper as zero paid.
Recipient Ineligible on Date of Service: Applied to the beginning date of service in the header. Dates of service on individual lines are not checked for eligibility.
Combined Use of Visit and Episode Rate Codes Not Allowed: Episode and visit rate codes should not be billed on the same date of service for the same recipient by the same provider under the same certification. The following rate code combinations are not allowable: Rate Code 1400 and Rate Code 1432; Rate Code 1413 and Rate Code 1441; Rate Code 1444 and Rate Code 1450; Rate Code 1501 and Rate Code 1489.
Combined Use of MR/DD/TBI and Non-MR/DD/TBI Rate Codes Not Allowed: MR/DD/TBI and non MR/DD/TBI rate codes should not be billed on the same date of service for the same recipient by the same provider under the same certification. The following rate code combinations are not allowable: Rate Code 1400 and Rate Code 1489; Rate Code 1400 and Rate Code 1501; Rate Code 1432 and Rate Code 1489; Rate Code 1432 and Rate Code 1501.

3.12 SAMPLE REMITTANCE FORMAT:

A sample of the paper remittance follows.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 12/19/2008
CYCLE 1635

TO: ABC HOSPITAL
P.O. BOX 999
ANYTOWN, NEW YORK 11111

ETIN:
CLINIC-APG
PROVIDER ID/NPI: 00987654/0123456789
REMITTANCE NO: 08122200001

OFFICE ACCOUNT NUMBER / CPT (1)	CLIENT NAME / APG (2)	CLIENT ID / COMBINED WITH CPT (3)	TCN / FULL WEIGHT APG AMOUNT (4)	DATE OF SERVICE / PCT APG WEIGHT (5)	RATE CODE / APG PAID (6)	CHARGED / CAPITAL ADD ON (7)	TOTAL PAID / EXISTING OPERATING COMPONENT (8)	STATUS	ERRORS
TCN: 08343-000789012-2-0 (9)	TOTAL PAID: 185.50				(10)				
1234567890	Bill Smith	AB12345C	08343-000789012-2-0	12/01/2008	1400	1000.00	106.02	PAID	
99213	00881		1.22020	100	45.25	15.00	48.77		
1234567890	Bill Smith	AB12345C	08343-000789012-2-0	12/01/2008		800.00	0.00	PAID	
85025	00408	99213	0.13340	0	0.00	0.00	0.00		
1234567890	Bill Smith	AB12345C	08343-000789012-2-0	12/01/2008		1000.00	24.94	PAID	
80076	00403		0.32690	100	12.00	0.00	12.94		
1234567890	Bill Smith	AB12345C	08343-000789012-2-0	12/01/2008		200.00	33.77	PAID	
90740	00416		0.44200	100	16.25	0.00	17.52		
1234567890	Bill Smith	AB12345C	08343-000789012-2-0	12/01/2008		50.00	20.77		
36415	00457		0.26740	100	10.00	0.00	10.77		

The paid amount for the first claim is determined by the sum of the APG Paid $83.50 (The amounts in column 6 already reduced to 25% in year 1), plus the sum of the Existing Operating Component $90.00 (The amounts in column 8 that are already reduced to 75% for year 1), plus the Capital Add-on amount in column 7, $15.00, plus any reductions. = Total Paid TCN $185.50.

NEW APG DATA ELEMENTS:

1. CPT: Reported procedure code
2. APG: APG code assigned by grouper
3. Combined With CPT: Pointer to other significant procedure that caused the packaging and therefore zero payment on this line
4. Full Weight APG Amount: Assigned grouper weight
5. PCT APG Weight: Related to grouper assigned Payment Action Code. This is additional weight factor applied to Full Weight
6. APG Paid: APG Paid Amount for outpatient is the amount after the 25%, 50% or 75% is applied over each of the first three years.
7. Capital Add-on: Amount added to Claim Payment (line 1).
8. Existing Operating Component: Amount added to outpatient payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines.
   a. Figure above EOC -Total line payment - includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount.
9. Total Paid TCN: Total Claim Payment
10. Rate Code: Will appear only on line 1 of claim

3.13 EAPG DEFINITIONS MANUAL AND EAPG GROUP/PRICER:

Providers may wish to obtain a copy of the 3M EAPG Definition manual to understand how CPT codes map to APGs.

3M's EAPG Definitions Manual is available through the 3M's Definitions Manual Website. Please see: http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/Definition_Manuals/.

3M also offers the EAPG Grouper/Pricer. The Grouper/Pricer is one integrated software tool. The grouper component assigns CPT and HCPCS codes to APGs; and the pricer component applies the appropriate weights and base rates and other payment rules to the APGs. The APG Grouper/Pricer software will be updated at least twice each year to accommodate updates of ICD-9 diagnosis codes, CPT and/or HCPCS codes and revisions in pricer logic.

The EAPG Grouper/Pricer is available through 3M Health Information Systems, Inc. and its authorized distributors. For information on how to acquire the EAPG Grouper/Pricer from 3M or its authorized distributors, please contact the 3M Health Information Systems, Inc. at (800) 367-2447 or visit: www.3mhis.com.

CHAPTER 4: NEW YORK SPECIFIC POLICY AND PAYMENT RULES

4.1 PHYSICIAN BILLING:

Physician services are carved-out of the APG payment for all services provided in ~~Emergency Departments and Ambulatory Surgery~~ hospital outpatient settings. When the hospital emergency department ~~or~~ ,ambulatory surgery, or hospital outpatient department rate codes are billed, the physician may always bill separately for his/her professional services ~~outside the APGs.~~ Physicians providing services in these settings should bill Medicaid for their professional services using the Medicaid Physician Fee Schedule. The HIPAA 837P billing format or the paper claim form EMEDNY-150002 may be used. Physicians should bill the global fee or when billing for the professional component of radiology services, the professional fee using the -26 modifier. ~~Reimbursement for physician professional services provided in hospital outpatient clinics will continue to be based on existing payment policy. If the physician is salaried by the facility and included in the facility's cost report, the APG payment to the clinic is considered payment in full for the service. In these cases, the physician is prohibited from submitting a claim based on the Medicaid fee schedule. If the physician is not salaried by the facility and has previously been billing Medicaid fee-for-service, the physician will continue to submit claims based on the Medicaid fee schedule for his/her professional services.~~ There is no change to the Medicaid policy which disallows payment of interns and/or residents, yet permits payment for supervising and/or teaching physicians under special conditions.

Payment for physician services in hospital outpatient settings are carved out of APGs as of the following dates:

- **Ambulatory Surgery** – carved-out effective December 1, 2008
- **Emergency Departments** – carved-out effective January 1, 2009
- **Outpatient Clinics** – carved-out effective February 1, 2010

For additional information on physician billing outside of APGs please see the March 2010 Medicaid Update Article available online at: http://nyhealth.gov/health_care/medicaid/program/update/2010/2010-03.htm#fee.

All physician professional services are included in the APG payment made to free-standing Diagnostic and Treatment Centers (D&TC). Physicians providing services in such settings may not bill using the Medicaid physician fee schedule. The only exceptions to this policy are for free-standing D&TC dialysis clinics and ambulatory surgery centers. These specific clinics do not have physician services included in their APG payment. Physicians are permitted to bill based on the Medicaid fee schedule for care provided in these specialty clinics.

The services of other licensed practitioners (dentists, nurse practitioners, midwives and podiatrists), except for orthodontists, are always included in the APG payment to the facility and may not be billed separately to Medicaid in the clinic or hospital OPD setting.

▶ ***Note:*** Patient encounters with only a registered nurse or licensed practical nurse may not be billed under APGs except in those instances specified in Section 6.5 of this document.

4.2 DENTAL BILLING:

Dental services provided in the clinic setting (hospital or free-standing) are to be billed using the APG payment methodology. The only exception to this policy is orthodonture, which is to be billed to the dental practitioner fee schedule and not to APGs. Orthodontic procedures are identified as those D codes grouping to APG 371 – Orthodontics. Again, APG 371 is a non-payable APG. Providers will continue to be required to obtain prior approval for orthodontic procedures.

E&M codes should not be billed for any dental services. All dental services should be billed using only D codes

Effective January 1, 2010, medical visits will no longer package with dental procedures or exams. When a patient has a medical visit (i.e., with a practitioner other than a dentist) and a dental visit on the same day, both the medical visit and the dental exam will pay at the line level.

Effective February 1, 2010, dental professional services are included in the APG payment to the facility and may not be billed by dentists using the Medicaid dental fee schedule. Specifically, no D codes (other than those used for orthodonture) are billable against the practitioner fee schedule. Dentists and/or oral surgeons should not bill Medicaid fee-for-service for non orthodontic D codes but may submit a claim for their professional services to the facility (i.e., the APG biller). If a practitioner is enrolled in Medicaid as both a dentist and a physician he/she may submit a separate [non-APG] professional claim for services payable off the physician schedule.

If a procedure requires three encounters to complete, a clinic should claim for the applicable procedure code for each distinct date of service. However, APGs 373 Level I Dental Film, 374 Level II Dental Film, and 375 Dental Anesthesia will not pay if there are no other procedures claimed for the applicable date of service.

For dates of service beginning January 1, 2009, when multiple dental procedures are performed on the same date of service, the highest weighted procedure will pay at 100% and all other dental procedures will be discounted (at 50%). This will be the case even for procedures that group to the same APG. Multiple same APG consolidation has been eliminated for dental services.

The procedure code for dental sealants (D1351), should be coded once for each tooth that is sealed on a single date of service. If four teeth are sealed during a visit, the code D1351 should appear on each of four claim lines, each with the same date of service. Beginning on January 1, 2011, dental sealants will become a units-based procedure, to be coded on only a single claim line – with the number of teeth sealed shown in the units field.

The following are the dental ancillary procedure APGs: 373 Dental Film, 374 Level II Dental Film, 375 Dental Anesthesia, 376 Diagnostic Dental Procedures, and 377 Preventive Dental Procedures. All dental ancillaries pay at the line level. Multiple ancillaries that group to the same APG will be discounted by 50%, whereas multiple ancillaries that group to different APGs will be paid at 100%.

For APG dental billing the 837i claim format must be used, not the 837d claim form.

Dental code D9920 -- behavior management (for patients with mental retardation or a developmental disability) groups to APG 999 and will not pay under the APG reimbursement methodology.

Reimbursable services provided to recipients with recipient exception codes 81 or 95 will receive a 20% higher operating payment. This rate enhancement will begin July 1, 2010 for hospital clinics (using rate code 1501 for visit billing or 1489 for episode billing). Immediately upon the D&TCs transition to the APGs, and retroactive to September 1, 2009, free-standing clinics will receive the 20% rate enhancement for MR/DD/TBI patients under rate code 1435 (the MR/DD/TBI episode rate code 1425 is pended due to the lack of CMS approval of the Dec. 2009 D&TC State Plan Amendment).

Effective April 1, 2010, oral sedation in dentistry (D9248- Sedation (non-iv)) will be paid based on a procedure based weight. This code is to be used only for MR/DD/TBI recipients (as defined by recipient exception codes 81 or 95). Since there are currently no edits in place relative to this code, it is possible to improperly bill for this code. As with any violations of Medicaid billing policy, improper claims are subject to take back accompanied by possible legal action. Please check for the recipient eligibility prior to billing D9248.

4.3 VISION CARE BILLING:

Most vision care services are covered in the APG payment methodology. However two vision care services; “the fitting of spectacles: monofocal, bifocal, or multifocal” , “the fitting of spectacles and the eyeglass materials” are carved out of APGs and are billed using rate codes 1226 and 1227 respectively.

4.4 ANCILLARY LABORATORY SERVICES AND RADIOLOGY PROCEDURES:

Under the new APG payment methodology, payment for laboratory and radiology services ordered by practitioners in hospital-based outpatient clinics is made to the clinic. When the hospital or D&TC patient receives the ancillary service from someone other than the clinic, the clinic is responsible for paying the individual or entity providing the ancillary service, even in the absence of a contractual relationship between the two parties. The ancillary service provider may not bill Medicaid directly for lab or the technical component of radiology services related to an APG-reimbursed visit and therefore must bill the ordering clinic for the service provided to clinic patients. This ancillary billing policy will be implemented prospectively in DTCs, effective January 1, 2011.

For example, when a practitioner in Clinic A orders a lab test or radiology service that it is not able to provide and the patient goes to Provider B (separate hospital, lab or a radiology group) to receive the service, Clinic A will be responsible for billing eMedNY for the ancillary service and making arrangements to pay Provider B for the delivery of the service. Clinic providers may wish to develop or revisit existing contractual arrangements with laboratory and radiology providers to ensure the availability of ancillary services for their patients and to avoid payment issues upon the implementation of the new APG payment methodology. This payment policy also applies to hospital ED units in the event that the ED physician orders an ancillary laboratory or radiology service that is provided to the patient subsequent to the ED visit.

Hospitals are and effective January 1, 2011 D&TCs will be responsible for advising outside lab and radiology service providers on the order for the service when the payment for the ancillary service is subject to APG reimbursement and the APG ancillary billing policy. They must also advise radiology service providers if they want the provider to “read” the radiology results and bill Medicaid directly for these professional services. Alternatively, if the hospital provider plans to bill for “reading” the radiology result, the hospital should advise the radiology vendor not to bill for the professional component of the radiology service. Only one professional component per radiology procedure per recipient may be billed to Medicaid.

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Hospital-Based Outpatient Clinics:

The laboratory and radiology billing policy stated above is being phased-in for hospital-based outpatient clinics.

Transitional billing policy for the dates of service December 1, 2008 through June 30, 2009:

- Ancillary services for clinic patients should be billed using the 1400 APG rate code.
- Laboratory or radiology services which have historically been referred to an outside laboratory or radiology provider may continue to be billed directly to eMedNY by the ancillary service provider using the Medicaid fee schedule for this period. Medicaid will pay the laboratory or radiology services provider directly.
- All ancillary services provided by the hospital should be reported on a clinic claim, even those that map to a "never pay APG" or an "if stand alone, do not pay APG"[1] for correct coding purposes. This information will be used by the Department to update future base rates and weights.
- For laboratory services provided by the hospital facility, the date of service reported on a claim should be the date of specimen collection.
- For radiology procedures, the date of service reported on a claim should be the date the radiology service was actually provided.

For dates of service on and after July 1, 2009 through December 31, 2010:

- All laboratory and the technical component of radiology services, both those that are provided by the hospital facility as well as those that are referred to an outside laboratory or radiology provider, are the fiscal responsibility of the hospital outpatient clinic and should be included on an APG Medicaid claim. The hospital clinic must reimburse the laboratory or radiology provider directly. The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of the radiology service.
- All ancillary services should be reported on a clinic claim, even those that map to a "never pay APG" or an "if stand alone, do not pay APG" as the information will be used by the Department to update future base rates and weights.
- Ancillary services for clinic patients should be billed using either the 1400 or 1432 rate code for hospital-based outpatient clinics(after July 1, 2010 hospital OPDs may also use 1501 or 1489 rate codes for patients with MR/DD/TBI recipient exception codes).
- For facilities using the visit based rate codes 1400 or 1501, for all lab services and the technical component of radiology procedures (both those provided by the hospital as well as those referred to outside ancillary providers), the date of service reported on the claim should be the date of the medical visit/significant procedure, even if the laboratory or radiology procedure is performed subsequent to the clinic visit. This applies to all hospitals including those previously reimbursed under the PAC reimbursement methodology.
- For facilities using the episode based rate codes 1432or 1489, for all lab services and the technical component of radiology procedures (both those provided by the hospital as well as those referred to outside ancillary providers and performed on or after the medical visit or significant procedure that generated the ancillary service), the dates of service reported on the claim should be the actual dates the services were performed. This applies to all hospitals including those previously reimbursed under the PAC reimbursement methodology.

[1] For a complete listing of the "never pay" and "if stand alone do not pay APGs, please visit: www.nyhealth.gov/health_care/medicaid/rate/apg/#implementation_materials.

For dates of service on and after January 1, 2011:

- All laboratory and the technical component of radiology services, both those that are provided by the hospital facility as well as those that are referred to an outside laboratory or radiology provider, are the fiscal responsibility of the hospital outpatient clinic and should be included on an APG Medicaid claim. The hospital clinic must reimburse the laboratory or radiology provider directly. The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of the radiology service.
- All ancillary services should be reported on a clinic claim, even those that map to a "never pay APG" as the information will be used by the Department to update future base rates and weights.
- Ancillary services for clinic patients should be billed using the 1432 or 1489 (for MR/DD/TBI) episode rate codes for hospital based outpatient clinics, except for claims for Medicare/Medicaid dual eligibles.
- For all lab services and the technical component of radiology procedures (both those provided by the hospital as well as those referred to outside ancillary providers), the dates of service reported on the claim should be the dates the services were performed. This applies to all hospitals including those previously reimbursed under the PAC reimbursement methodology.

Freestanding Diagnostic and Treatment Center (D&TC) Clinics:

While the initial APG implementation date for D&TCs was March 1, 2009, D&TCs have been notified that the implementation date has been delayed pending federal CMS approval. Upon CMS approval of the APG payment methodology for D&TCs the Department will issue detailed billing guidance including the effective date of APG implementation which will likely be September 1, 2009. It is anticipated that for dates of service on or after September 1, 2009, eMedNY will automatically reprocess applicable paid diagnostic and treatment center claims as adjustment transactions using appropriate APG visit rate codes without regard to the ancillary billing policy. This will occur for claims for dates of service on or after September 1, 2009 received and processed by eMedNY up to at least one month after approval of the APG payment methodology for D&TCs by CMS . During this transition period, laboratory or radiology services which have historically been referred by D&TCs to an outside laboratory or radiology provider may continue to be billed directly to eMedNY by the ancillary service provider using the Medicaid fee schedule and Medicaid will pay the laboratory or radiology services provider directly.

Following this transition period through December 31, 2010:

Because the implementation of the ancillary billing policy in DTCs has been delayed until January 1, 2011, ancillary laboratory and radiology services which have historically been referred by DTCs to outside providers or vendors may continue to be billed directly to EMedNY by the ancillary service provider using the appropriate Medicaid fee schedule. During this time period, these ancillary services are not the financial responsibility of the DTC and should not be reported on the APG claim. However, any ancillary laboratory or radiology service provided directly by the DTC clinic or historically included in the clinic's former threshold or specialty payment (e.g. as with former PCAP rate codes) should be reported on the APG claim, even those that map to "a never pay APG" or an "if stand alone do not pay APG."

The ancillary billing policy will be implemented prospectively in DTCs, effective January 1, 2011. Additional guidance on the ancillary billing policy will be issued at that time.

For dates of service on or after January 1, 2011:

- Ancillary services for clinic patients should be billed using the APG 1422 or 1425 episode based rate codes for D&TC clinics, except for Medicare/Medicaid dual eligible patients .
- All laboratory and the technical component of radiology services, both those that are provided by the D&TC as well as those that are referred to an outside laboratory or radiology provider, are the fiscal responsibility of the D&TC and should be included on the APG Medicaid claim. The D&TC must reimburse the laboratory or radiology provider directly. The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of the radiology service.
- All ancillary services should be billed for clinic patients along with the medical visit or significant procedure if applicable using the APG 1422 or 1425 episode rate codes. For all lab services and the technical component of radiology procedures (both those provided by the clinic as well as those referred to outside ancillary providers) the dates of service reported on the claim should be the actual dates of service.

Clinic Claim Submission for Laboratory and Radiology Procedures:

Hospital outpatient clinics and D&TCs should not report any ancillary services on their APG claim until the services are completed and test results have been reported to the ordering provider. Hospital-based outpatient clinics and D&TC clinics have two billing options for reporting ancillary services on their APG claim:

1. Submit the APG claim (medical visit/significant procedure with ancillaries) upon confirmation that all ancillary services have been provided to the patient. This method is the preferred billing method.

2. Submit the APG claim for the medical visit/significant procedure only. After confirmation that all ordered ancillary lab/radiology services have been provided to the patient, the clinic may submit a claim adjustment that reports the office visit/significant procedure and all completed ancillary tests. This method may be used if cash flow or other issues arise but is not the preferred billing method. The rule mandating that claims must be submitted within 90 days does not apply to adjustments. A claim adjustment must be submitted within 30 days of the date the claim came under the control of the hospital-based outpatient clinic or D&TC clinic provider.

When Medicaid Is Secondary Payer:

When Medicare and other commercial insurance is involved and if the lab or radiology provider is required to bill Medicare or the commercial insurance directly, the ancillary provider should do so and then bill eMedNY for any balance due. The clinic should not report these ancillaries on their APG claim since they will not be paying the ancillary provider. If Medicare denies payment for the ancillary service because it is not covered by Medicare, the ancillary service provider should bill Medicaid directly.

Exceptions to the APG Ancillary Billing Policy: There are four exceptions to the uniform application of the APG billing policy for ancillary laboratory and radiology services provided on behalf of clinic patients. They include the following:

- Laboratory and radiology tests performed on behalf of Federally Qualified Health Centers that do not participate in the APG payment methodology;
- Procedure codes carved-out of APGs as specified in Section 4.20 (e.g. Coumadin, Clozaril, lead screen, HIV viral load, virtual phenotype, blood factors, etc.);
- Procedure codes which may be carved-out of APGS (optional carve-outs) as specified in Section 4.21 (e.g. pregnancy testing); and
- Laboratory and radiology services associated with specialty clinic rate codes carved-out of APGs as specified in Section 4.22, since these are not "APG" visits.

Utilization Thresholds and Laboratory/Radiology Ancillary Services: Utilization threshold limits will not apply to laboratory or radiology services incorporated in APG claims. **Note: see section below regarding billing for professional and technical component of radiology services.**

4.5 RADIOLOGY SERVICES – PROFESSIONAL PHYSICIAN COMPONENT AND TECHNICAL COMPONENT:

The professional component of radiology services is carved-out of the APG payment to the hospital or D&TC clinic and may be billed separately by the radiologist using the Medicaid fee schedule. This applies when a clinic patient receives radiology services from a clinic and the clinic is billing Medicaid under APGs for the patient encounter as well as those situations when a patient has been referred from another hospital outpatient department or free-standing clinic to a clinic and that clinic is billing the referring hospital/free-standing clinic for the radiology service (the referring hospital/free-standing clinic must bill for the radiology procedures on their Medicaid APG claim).

- The radiologist should use the radiology fee schedule (physician component) for radiology procedures provided to patients referred by other hospitals or free-standing clinics.
- The facility that provides the radiology services should bill the referring hospital or free-standing clinic for the technical component.
- The referring hospital or free-standing clinic must include the radiology procedure in the APG claim for the visit in which the radiology procedure was prescribed.

Note: The ancillary vendor may not bill the professional component of the radiology service if the hospital practitioner is planning to read and bill for this professional service. If the hospital plans to bill for the professional component of radiology service, the hospital should tell the ancillary vendor not to bill for the professional component of this service.

4.6 INPATIENT-ONLY SERVICES:

Under APG payment rules, certain surgical procedures may only be performed in the hospital inpatient setting. These procedures may not be performed on an ambulatory surgery or clinic outpatient basis. These designated 'inpatient only' procedures will not be reimbursed under the APG payment methodology. They will continue to be paid through the Diagnosis Related Groups (DRG) payment methodology. The APG Grouper will automatically reject these procedures for payment. The list of these procedures is available at the Department's Website at: www.nyhealth.gov/health_care/medicaid/rates/apg/docs/inpatient_only.pdf.

4.7 AMBULATORY SURGERY SERVICES:

Note: **The billing guidance below, relative to what rate code is the appropriate code to use when billing for an APG visit (or episode), applies only to those providers to which both clinic and ambulatory surgery rate codes have been assigned. If a provider only has clinic (and possibly ED) rate codes available, then they may bill anything not done in the ED to a clinic rate code and this policy guidance does not apply. If a provider only has ambulatory surgery rate codes available, then they may bill anything not done in the ED to an ambulatory surgery rate code and this policy guidance does not apply.**

Note: The only providers/locations that will be assigned an ambulatory surgery rate code are those that are certified to do ambulatory surgery.

Note: **Nothing in this policy mandates the setting in which a procedure may be performed; only the rate code to be used for purposes of claiming.**

Emergency Room - This policy does not apply to procedures performed in the emergency room. Any procedure performed in the emergency department must be billed using the APG emergency department rate code. Additionally, the policy described here does not obviate the need for DOH certification prior to performing those ambulatory surgery procedures that require certification. If a patient is initially seen in the hospital emergency room and the visit ultimately results in the provision of a same-day ambulatory surgery service (as defined herein) outside of the emergency room, the hospital should bill the visit under an ambulatory surgery rate code.

Effective December 1, 2008, an APG visit (or episode) may be billed against an ambulatory surgery rate code if the visit includes at least one procedure from the Ambulatory Surgery Procedures List (see link below). The APG Ambulatory Surgery Procedures List will not be regularly updated by DOH because it will be eliminated on July 1, 2010 (see below), however any "replacement codes" for codes on the published list will be considered to be on the list. Please see: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/ambulatory_surgery_list.pdf.

Effective January 1, 2010, any dentistry that is done in the operating room with the patient under general anesthesia and/or requiring intravenous sedation may be billed to the ambulatory surgery base rate.

Note: This policy will allow dental services provided in an operating room to be billed against the ambulatory surgery base rate. However, HCPCS codes beginning with a "D" (except for orthodonture codes) are not separately billable against the practitioner's fee schedule in the clinic setting and that policy extends into the operating room setting. Apart from D codes for orthodonture, D codes are only billable against the practitioner fee schedule in the office setting, not in the clinic, ambulatory surgery, or ED settings. A defined set of providers were allowed separate practitioner billing for D codes in the clinic and ambulatory surgery settings prior to February 1, 2010. Subsequent to that date, dental fee schedule billing is only allowable in the office setting or for orthodonture.

Effective July 1, 2010, this policy will be further modified as follows. If a visit is provided in an operating room, an ambulatory surgery rate code must be used on the claim. If a visit is provided to a patient under general anesthesia or intravenous sedation, the visit may be billed against the ambulatory surgery rate code (if the provider/location has been assigned the ambulatory surgery base rate). All other visits (excluding ED visits – see above) must be billed against a clinic rate code. **Again, this policy does not mandate the setting in which a procedure may be performed; only the rate code to be used for purposes of claiming.**

Pre-Surgical Testing: Pre-surgical testing for ambulatory surgery ordered by an OPD or D&TC clinic practitioner for a clinic patient during an APG reimbursable clinic visit should be billed under the APG policy for clinics described in Section 4.3 Ancillary Laboratory Services and Radiology Procedures. Pre-surgical testing ordered by a hospital ambulatory surgery unit or ambulatory surgery center practitioner for a patient referred to the ambulatory surgery facility should be billed by the ancillary provider on an ordered ambulatory basis using the Medicaid fee schedule.

Post-Surgical Testing (e.g., pathology): All post-surgical tests ordered by the hospital ambulatory surgery unit or ambulatory surgery center practitioner should be billed by the ancillary provider on an ordered ambulatory basis using the Medicaid fee schedule.

4.8 PRE-ADMISSION TESTING:

Inpatient Services: Pre-admission testing for an inpatient stay that is performed within 72 hours of the admission is included in the inpatient DRG.

4.9 DIALYSIS:

When billing for hemodialysis procedures, providers must use specific hemodialysis CPT procedure codes. Use of *CPT 90999, Unlisted dialysis procedure, inpatient or outpatient*, will be grouped to a peritoneal dialysis APG and will produce an incorrect payment.

4.10 MEDICARE/MEDICAID DUALLY ELIGIBLE BENEFICIARIES:

Medicaid will continue to pay the full annual Medicare Part B deductible as well as the full 20% Medicare Part B coinsurance amounts for all APG Medicare/Medicaid “crossover” claims - crossover claims will bypass the APG grouper.

However, clinics with rate codes 1407, 1435, and 1428 serving persons with an RE (recipient Managed Care exempt restriction) code of 95 on file in the eMedNY system and FQHCs will continue to be paid the higher of:

- The full Medicare Part B coinsurance amount, or
- The difference between the Medicare paid amount and the calculated APG payment.

4.11 SPECIAL BASE RATE FOR TRAUMATIC BRAIN INJURY (TBI) WAIVER RECIPIENTS AND CERTAIN RECIPIENTS SERVED BY OMRDD:

Effective September 1, 2009, D&TCs will receive an enhanced MR/DD/TBI base rate which will pay an additional 20% for patients with recipient exception codes 81 or 95. Medical services provided by D&TCs to recipients with eligibility exception codes 81 (TBI Eligible) or 95 (OMRDD/Managed Care) should be claimed using rate codes 1425(episode) or 1435(visit).

Effective July 1, 2010, hospitals will receive an enhanced MR/DD/TBI base rate which will pay an additional 20% for patients with recipient exception codes 81 or 95. Medical services provided by hospital OPDs to recipients with eligibility recipient exception codes 81 (TBI Eligible) or 95 (OMRDD/Managed Care) should be claimed using rate codes 1489 (episode) or 1501 (visit).

~~The SDOH is revising the recipient eligibility information provided during the eligibility verification process so that these two recipient exception codes will be reported to providers upon verification of recipient eligibility.~~

The Medicaid Eligibility Verification System (MEVS) will display up to three recipient exception or restriction codes including 81 and 95. If more than three exception codes apply to a single recipient, MEVS will report a code ZZ. Providers may contact CSC at 1-800-343-9000 to inquire whether the recipient has an undisplayed 81 or 95 code.

4.12 RECURRING THERAPIES:

Each occasion (date of service) is considered a distinct visit. When using episode billing rate codes, providers should not bill recurring therapy visits that have different dates of service on a single episode claim, but instead should bill each date of service on which recurring therapies were provided as its own episode of care (see episode payment description).

Beginning January 1, 2010 units of service will be recognized by the grouper so that providers may bill multiple units of service for certain procedures including certain recurring therapies such as physical therapy (e.g., CPT 97750 physical performance test, 15 min) and occupational therapy (e.g., CPT 97533). Weights for units-based procedures will reflect the amount of resource utilization required to provide a single unit of service and payments on a line basis will reflect the number of units provided.

For a complete list of units-based procedures and their respective unit maximums, please visit:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/units_based_procedures.pdf.

Additionally, several recurring therapy APGs will be exempted from “multiple same significant procedure APG” consolidation beginning January 1, 2010, so that they will discount rather than consolidate when combined with other same or related APGs (e.g., APGs 270 Occupational Therapy, 271 Physical Therapy, & 272 Speech Therapy and Evaluation).

For a complete list of APGs exempted from significant procedure consolidation, please visit:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_multiple_discounting.pdf.

Generally, the APG discounting percentage is 50%, but several APGs including the aforementioned recurring therapies (e.g., APGs 270, 271, & 272) as well as several others (e.g., APGs 315 Counseling and Individual Brief Psychotherapy, 318 Group Psychotherapy, & 323 Mental Hygiene Assessment) discount at rates less than 50% (e.g., 10% for APG 317 Family Psychotherapy & 25% for APG 271 Physical Therapy).

For a complete list of APGs with variable discount percentages, please visit:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_discounting_percentage.pdf.

Beginning July 1, 2010, physical, occupational and speech therapy will be reimbursed through APGs in hospital OPDs and free-standing clinics even when performed on a referred or ordered ambulatory basis. However, hospitals that do not have an APG OPD rate code will continue to bill the ordered ambulatory fee schedule for these services.

4.13 BILLING FOR PHYSICIAN-ADMINISTERED DRUGS UNDER APGS:

Physician administered drugs that are carved-out of the APG payment should be billed using the fee schedule as an ordered ambulatory service at the actual acquisition cost to the provider.

A listing of carved-out drugs (including all drugs defined as chemotherapy drugs in APGs) is available online at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf.

All other drugs administered during a clinic encounter are included in the APG payment to the facility. Class I Pharmacotherapy drugs (APG 435) are included/packaged in the payment for the medical visit or significant procedure and therefore no additional payment is made at the line level. Class II – VI Pharmacotherapy drugs (APGs 436-~~439~~ 440) will be paid at the line level and have had their APG weights developed based on the weighted average of the Average Wholesale Price (AWP) less 15% using recent Medicaid paid claims data. Class II-VI Pharmacotherapy drugs should be claimed using actual acquisition cost; however, the APG will be paid at AWP less 15% (weighted average for the drugs that map to the specific APG) regardless of cost. ~~340B sites must always bill their actual acquisition cost (the 340B price).~~

▶ ***Note:*** Providers are required to report the National Drug Code (NDC) on all drug claims, except drugs obtained at a 340B price. Drugs obtained at the 340B price are identified by the UD modifier and it is not required that an NDC code be provided. See the Medicaid Update (December 2007 and April 2008) articles entitled *'National Drug Code Required on Medicaid Claims'* and *'Coming Soon: Easy Identification of 340B Priced Claims'* for details at these links:

http://nyhealth.gov/health_care/medicaid/program/update/2007/index.htm.

http://nyhealth.gov/health_care/medicaid/program/update/2008/index.htm.

Weights for drug APGs are set to reimburse for the average units/dosage billed for each APG. Providers should not code multiple lines on a single claim with the same HCPCS code to signify the provision of multiple units of a single drug. Rather, providers are expected to bill for that drug on a single claim line and identify the units provided on that line.

4.14 IMMUNIZATIONS IN APGs:

When seasonal flu, H1N1, and pneumococcal vaccines are provided in Article 28 hospital OPD or free-standing D&TC clinics (including SBHCs, county health dept. clinics, FQHCs, and part-time clinics), vaccine administration charges and vaccine charges, if applicable, must be billed as an ordered ambulatory service. All other vaccines (except those provided by the Vaccines for Children Program) are reimbursed through APGs when administered in the ambulatory care setting.

Effective January 1, 2010, vaccine administration codes (90465-90474, G0008-G0010, G9141) will group to APG 490 (incidental to medical visit/significant procedure) and will not pay separately at the line level.

Providers who are administering State-supplied vaccines to Medicaid enrollees under the age of 19 years through the Vaccines for Children program, must bill for the vaccine administration as an ordered ambulatory service (not APGs) using the procedure code for the vaccine, appended with the modifier SL (to indicate a State-supplied vaccine). Providers will be reimbursed a $17.85 administration fee.

4.15 MRIs IN APGs:

MRIs were previously carved-out of the clinic threshold rate. When an MRI was provided to a clinic patient, either on the same day that the patient was seen in the clinic or on a subsequent day, clinics were instructed to bill Medicaid for the MRI as an ordered ambulatory service. Under APGs, MRIs provided to clinic patients should not be billed as an ordered ambulatory service.

Clinics must bill for the MRI under the appropriate APG rate code (1400 or1432 for hospital OPDs and 1407 or 1422 for D&TCs). Payment will be made through the APG payment methodology. MRIs provided during an Emergency Department encounter should be included on the Medicaid claim under Rate Code 1402 and will be paid through the APG assigned for the visit. Effective January 1, 2010, medical visits will no longer package with MRIs and both the medical visit and MRI will pay at the line level.

4.16 UNIFORM PACKAGED APGS:

Uniform packaging refers to the inclusion of certain ancillary services into the EAPG payment for a significant procedure or medical visit. Below is a list of ancillary APGs that are always packaged into a significant procedure or medical visit.

380	ANESTHESIA
390	LEVEL I PATHOLOGY
394	LEVEL I IMMUNOLOGY TESTS
396	LEVEL I MICROBIOLOGY TESTS
398	LEVEL I ENDOCRINOLOGY TESTS
400	LEVEL I CHEMISTRY TESTS
402	BASIC CHEMISTRY TESTS
406	LEVEL I CLOTTING TESTS
408	LEVEL I HEMATOLOGY TESTS
410	URINALYSIS
411	BLOOD AND URINE DIPSTICK TESTS
412	SIMPLE PULMONARY FUNCTION TESTS
413	CARDIOGRAM
423	INTRODUCTION OF NEEDLE AND CATHETER
424	DRESSINGS AND OTHER MINOR PROCEDURES
425	OTHER MISCELLANEOUS ANCILLARY PROCEDURES
426*	PSYCHOTROPIC MEDICATION MANAGEMENT
427	BIOFEEDBACK AND OTHER TRAINING
435	CLASS I PHARMACOTHERAPY
471	PLAIN FILM

**SCHEDULED TO BE REMOVED ON 07/01/10*

For a complete up-to-date list of Uniform Packaging APGs, please visit: www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_uniform_packaging.pdf

4.17 "NEVER PAY" OR "ZERO PAYMENT" APGS:

There are a number of APGS that will not generate a payment by NYS Medicaid. Such APGs include procedures/services where:

- the procedures are not covered by Medicaid as a stand-alone service (e.g., respiratory therapy and recreation therapy);
- the medical supply is usually furnished by a provider not associated with the clinic, (e.g., motorized wheelchair provided by a durable medical equipment dealer);
- the medical service is not covered by Medicaid, (e.g., artificial fertilization); or
- the service may be billed by the clinic to Medicaid as either fee-for-service or ordered ambulatory (i.e., orthodontics billed fee-for-service and Class I through Class VI chemo drugs billed ordered ambulatory).
- the CPT code is invalid or inactive.

When these services are included on a claim billed to Medicaid by a clinic, a $0 dollar payment will be made. Although no payment will be made to a clinic for services/procedures that group to a "Never Pay" APG, clinic providers should still submit claims to Medicaid for these services. Medicaid will collect this claims data and use it to update provider base rates and weights for future Medicaid rate development (i.e., some of these services may be paid in the future).

When multiple services/procedures are billed to Medicaid, including some which are "Never Pay" APGs, payment will be made for procedures grouping to reimbursable APGs. Procedures grouping to "Never Pay" APGs will receive $0 payment.

For a complete up-to- date list of "Never Pay" APGs, please visit:
http://nyhealth.gov/health_care/medicaid/rates/apg/docs/never_pay_apg.pdf.

4.18 ORDERED AMBULATORY SERVICES:

An ordered ambulatory service is a specific service performed by a hospital or diagnostic and treatment center on an ambulatory basis upon the order and referral of a qualified physician, nurse practitioner, physician's assistant, licensed midwife, dentist, podiatrist, or the appropriate staff of a private practice not affiliated with the hospital or diagnostic and treatment center which is providing the ordered ambulatory service. The ordered ambulatory service is to test, diagnose or treat a recipient. The results of the ordered services are to be reported back to the non-clinic based ordering practitioner. Such services may include a singular occasion of service or a series of tests or treatments provided by or under the direction of a qualified practitioner. Ordered ambulatory services will continue to be billed using the published Medicaid fee schedule. Ordered ambulatory services should not be billed using APG rate codes and are not reimbursable through APGs.

Note: The one exception to this rule is that therapies (physical therapy, occupational therapy and speech therapy) may be billed by the facility using APGs and will pay more through APGs than through the ordered ambulatory fee schedule. Additionally, any services covered by Medicaid which are carved out of APGs (see section 4.20) may be billed to the ordered ambulatory fee schedule.

4.19 "IF STAND ALONE, DO NOT PAY" APGS

"If Stand Alone, Do Not Pay" APGs represent laboratory and radiology diagnostic tests which are included in the APG reimbursement to a hospital or D&TC for a significant procedure or medical visit and which do not qualify for a separate payment under APGs when they are the only services/procedures provided on a given date of service. When these ancillary procedures are billed in conjunction with a significant procedure or medical visit, as specified in Section 4.4 of this document, payment will be made. If laboratory and radiology services are contracted out, the hospital or D&TC must pay the contracted provider of service as the payment for the service will be included in the APG payment to the hospital or D&TC.

If the only APG claimed for a date of service is a "Never Pay APG"' or an "If Stand Alone, Do Not Pay APG,"' there will be no payment for the date of service (visit) on which the ancillaries were performed. However, payment for " If Stand Alone, Do Not Pay APGs " that are designated as "uniform packaged ancillary services ", as described in 4.16 , are included in the payment for the original visit that generated the need for these ancillaries.

***Note**:* As with "Never Pay" APGs, clinic providers should submit claims to Medicaid for services grouped to "If Stand Alone, Do Not Pay" APGs. Medicaid will collect this claims data and use it to update provider base rates and weights for future Medicaid rate development.

The updated full list of "If Stand Alone, Do Not Pay" APGs is available online at:

http://nyhealth.gov/health_care/medicaid/rates/apg/docs/stand_alone.pdf.

4.20 SERVICES CARVED-OUT OF APGS:

There are certain specific services and procedures which are carved out of the APG reimbursement methodology. These include: all chemotherapy drugs; certain specific therapeutic injectables; blood factors for hemophilia; medical abortion pharmaceuticals; certain family planning devices; all genetic testing and certain specific laboratory tests (including lead testing and HIV genotype testing). These carved-out services and procedures should always be billed to Medicaid using the ordered ambulatory fee schedule. Payment for therapeutic injectables and drug infusions will not exceed the practitioner's actual acquisition cost by invoice. In some instances entire APGs are carved-out while in other instances only certain procedures within an APG designation are carved-out.

For a complete listing of carved-out procedures, please visit:

http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf.

4.21 OPTIONAL CARVE-OUTS

There are optional carved-out procedures that may be billed to Medicaid as ordered ambulatory services when an APG claim is not billed for the clinic patient on the same date of service.

- **J1055:** Depo-Provera injection when it is administered by an RN or LPN within their scope of practice and there is a patient specific order from a licensed physician, nurse practitioner or nurse midwife and an APG visit is not billed.
- **81025**: Urine pregnancy test when it is administered by an RN or LPN within their scope of practice and there is a patient specific order from a licensed physician, nurse practitioner or nurse midwife and an APG visit is not billed.
- **86580**: TB intradermal test when it is administered by an RN or LPN within their scope of practice and there is a patient specific order from a licensed physician, nurse practitioner or nurse midwife and an APG visit is not billed.

The optional carve-outs are available online at:

http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf

4.22 SPECIALTY RATE CODES NOT SUBJECT TO APGS:

A number of specific clinic services are not included in the APG reimbursement methodology. These services, identified by rate code, will continue to be paid under the existing clinic threshold rate reimbursement methodology.

Medicaid Obstetrical and Maternal Services Program Health Supportive Services: MOMS Health Supportive Services Providers that have been assigned rate code 1604, will continue to bill for their services under the current payment methodology and rate code. These services will not be subject to the APG payment methodology.

Child Rehabilitation: Rate code 2887 will continue to exist as a carve-out to allow billing of child rehabilitation under existing payment rates.

Dialysis/Medicare Crossover: Rate code 3107, Monthly Medicare Dialysis, is used now by clinics when billing Medicaid for Medicare Part B deductible/coinsurance amounts. As noted in Section 4.10, Medicaid will continue to pay the full annual Medicare Part B deductible as well as the full 20% Medicare Part B coinsurance amounts for all APG Medicare/Medicaid "crossover" claims, including monthly dialysis for dually eligible beneficiaries. Rate code 3107 will continue to exist as a carve-out to allow dialysis clinics to bill Medicare co-pays and deductibles for dialysis patients.

HIV Counseling/Testing: Rate codes 2961 (AIDS Clinic Therapeutic Visit), 2983/1695 (Post-Test HIV Counseling and Testing), 3109 (HIV Counseling – No Testing), and 3111/1802 (Post-Test HIV Counseling – Positive Result) are carved out of the APG payment methodology. Services provided under these rate codes may be billed to Medicaid fee-for-service. When a medical service is provided in addition to a service provided under the carved out rate codes, both an APG visit as well as the specific carved-out rate code may be billed.

Tuberculosis Directly Observed Therapy (TB/DOT): TB/DOT rate codes will not be subsumed within the APG payment methodology. They will continue to be billed under the existing rate codes and may occur on the same date of service (but not on the same claim) as an APG visit.

- **5312 - TB/Directly Observed Therapy (Downstate Level 1)**
- **5313 - TB/Directly Observed Therapy (Downstate Level 2)**
- **5317 - TB/Directly Observed Therapy (Upstate Level 1)**
- **5318 - TB/Directly Observed Therapy (Upstate Level 2)**

Federally Qualified Health Centers (FQHC): FQHCs 'opting in' to APGs will be able to continue to bill the following carved-out rate codes:

- **4011 – FQHC Group Psychotherapy**
- **4012 – FQHC Off-Site Visit**

~~***Newborn Hearing/Screening Service:*** Rate codes 3138 and 3139 are carved-out of APGs and hospitals should continue to bill for newborn screening services as they have in the past. Use of these rate codes will bypass the billing system edit that prevents services that are not episode-based from being billed during the same time period as a patient's inpatient stay~~.

4.23 MANAGED CARE PLANS:

The APG payment methodology is not applicable to Medicaid capitation payments to health plans for Medicaid managed care or Family Health Plus enrollees.

To the extent that Medicaid health plans are statutorily or contractually required to pay providers the Medicaid rate of payment for covered services provided to plan enrollees (e.g. payment to non-participating providers for emergency services or payment to academic dental centers for dental services), plans will need to determine the appropriate Medicaid payment under APGs.

Health plans may choose to rely on provider claims, or they may wish to purchase the EAPG Grouper/Pricer, a software product of 3M Health Information Systems, Inc. which assigns CPT codes from a claim to APGs and applies APG payment rules to generate the appropriate Medicaid FFS payment.

The Department of Health will post provider base rates and capital add-on amounts, as applicable, on the HPN and the Department's APG website so that health plans may populate these user-driven fields in the Grouper/Pricer software as necessary. See Section 3.13 of this document to learn how to purchase the EAPG Grouper/Pricer from 3M or any of its authorized distributors.

4.24 DUALLY LICENSED CLINICS AUTHORIZED TO DELIVER MENTAL HYGIENE SERVICES:

Article 28 providers holding multiple operating certificates (i.e. also authorized under Title 14, Article 31, 32 or 16 of the Mental Hygiene Law) must continue to bill mental hygiene services using the existing mental hygiene rate codes. These providers may only use the new APG rate codes for service delivered in Article 28 Clinics. Services that have historically been billed under the mental hygiene rate codes must continue to be billed against those codes and may not be billed under the APG reimbursement methodology until such time that APGs are implemented in facilities licensed under the Mental Health Law.

For additional information on implementation, please contact the following NYS agencies which govern mental hygiene:

Office of Mental Health (517) 474-6911
http://www.omh.state.ny.us/omhweb/clinic_restructuring/
e-mail: clinicrestructuring@omh.state.ny.us

Office of Alcohol and Substance Abuse Services (518) 485-2207
e-mail: APG@oasas.state.ny.us

Office of Mental Retardation and Developmental Disabilities
(518) 474-3558 Policy Issues – Bureau of Behavioral and Clinical Solutions
(518) 474-1745 Rate Setting Issues – Bureau of Cost and Revenue Solutions
(518) 402-4333 Provider Enrollment and Claiming Assistance – Bureau of Central Operations

4.25 OUT-OF-STATE PROVIDERS:

Rates of reimbursement paid to out-of-state hospitals and free-standing diagnostic and treatment centers for most outpatient services provided to New York's Medicaid beneficiaries will be based on New York's Ambulatory Patient Groups (APG) payment system. Out-of-state providers have been issued new rate codes by the State fiscal agent to enable billing for hospital outpatient, emergency department, and ambulatory surgery unit services, as well as for services provided by free-standing clinics and ambulatory surgery centers.

Effective immediately, rates of payment for out-of-state providers will follow these rules:

- Rates of payment for out-of-state providers in **counties** contiguous to New York City and New York's Dutchess, Putnam, Westchester, Rockland and Orange Counties will reflect the average APG payment for the same services applicable to New York State providers in those downstate areas. Out-of-state counties contiguous to the downstate rate region include: Sussex, Passaic, Bergin, Hudson, Essex, Middlesex, Union and Monmouth Counties in New Jersey; Pike County in Pennsylvania; and Litchfield and Fairfield Counties in Connecticut.

- Rates of payment for all other out-of-state providers will reflect the average APG payment for the same services applicable to providers in upstate New York.

- Out-of-state providers must bill using the appropriate APG rate code. Please view the chart below:

Setting	Service	APG Visit Rate Code	APG Episode Rate Code	Effective Date (Visit)	Effective Date (Episode)
Out-of-State Hospital	OPD/Clinic	1413	1441	12/01/08	07/01/09
Out-of-State Hospital	OPD – MR/DD/TBI *	1501	1489	7/1/10	7/1/10
Out-of-State Hospital	Ambulatory Surgery	1416	NA	12/01/08	NA
Out-of-State Hospital	Emergency Department	NA	1419	NA	01/01/09
Out-of-State Free-Standing DTC	Clinic *	1407	1422	09/01/09	09/01/09
Out-of-State Free-Standing DTC	Clinic - MR/DD/TBI *	1435	1425	09/01/09	09/01/09
Out-of-State Free-Standing DTC	Renal Clinic *	1438	1456	09/01/09	10/01/09
Out-of-State Free-Standing DTC	Ambulatory Surgery *	1408	NA	09/01/09	NA
* Pending CMS approval.					

4.26 NEWBORN SCREENING:

When APGs were first implemented, newborn screening rate codes 3189 and 3139 were carved-out of APGs. However, effective December 1, 2009, inpatient newborn hearing screening rate code 3138 was end-dated and costs for the service were included in the hospital's base rate. No additional billing for the service is applicable.

Rate code 3139 used in instances when newborn screening had to be completed on an outpatient basis (for screens missed prior to discharge or when a baby needed to be re-screened because an inpatient test required rechecking) will be end-dated effective July 1, 2010; and any newborn screening provided on or after July 1, 2010 on an outpatient basis may be billed using APGs.

CHAPTER 5: SPECIAL CLINICS

5.1 FEDERALLY QUALIFIED HEALTH CENTERS – FQHCS:

FQHCs may choose to be paid under the APG methodology, or may choose to continue to receive payment under the existing prospective payment system (PPS) rate methodology. Those few remaining FQHCs with products of ambulatory care (PAC) rates may choose to be paid under the APG methodology or may to continue to receive payment under the existing PAC methodology.

The SDOH will provide FQHCs a form they must complete and submit declaring whether they will opt-in to the APG reimbursement methodology ~~commencing December 1, 2008 (hospitals) and March 1 2009 (D&TCs).~~ Hospitals and D&TCs must return the form within the time frames specified by SDOH. Failure to submit the form timely will be considered a decision not to opt-in to APGs.

A FQHC that chooses to opt-in to APG reimbursement will remain under this system until such time as it notifies DOH in writing that it wishes to leave the system. Such notification may be filed prior to November 1 of each year and will be effective for dates of service on and after the following January 1. Similarly, an FQHC that does not initially opt-in to APG reimbursement may do so later by filing the form described above prior to November 1 of each year and will be effective for dates of service on and after the following January 1.

Each FQHC that chooses to participate in APG reimbursement will be eligible to receive supplemental payments reflecting the difference between actual APG reimbursement and the amount that otherwise would have been paid under the "PPS rate", if the latter is higher. The PPS rate is defined in PHL 2807(8)as an all inclusive cost-based threshold visit rate based on the average of each facility's 1999 and 2000 reported base year costs, trended forward annually using the Medicare economic index.

An "APG hold harmless calculation" will be done on a quarterly basis, two months subsequent to the end of each quarter, based on actual claims data. The calculated value of the hold harmless, adjusted for any over or underpayments from previous quarters, will be paid to the FQHC provider in a lump sum.

The calculation comparing the per-visit reimbursement under APGs to the PPS rate will be done on a "comparable services" basis. The amount paid for non-comparable services will be excluded from the calculation. The total APG payment for the remaining visits will be divided by the total number of remaining visits. The calculated APG per visit payment will be compared to the provider's PPS rate, trended to the period of the calculation and adjusted for ordered ancillary services.

FQHC group and off-site services will be carved-out of APG reimbursement. Medical home incentive payments will be in addition to APG payments. Consequently, they will not be subject to the supplemental payment policy. FQHCs that do not participate in APG reimbursement will, however, forgo the opportunity to bill for certain primary care enhancements that are built into the APG reimbursement system, such as diabetes and asthma education, cardiac rehabilitation, and screening, brief intervention and referral for treatment and expanded hours access. The Medicaid managed care wraparound (shortfall) payments will continue to be paid to FQHCs – both to those that choose to be paid under the APG reimbursement methodology as well as those that choose to continue to be paid under the clinic threshold rate PPS method. FQHC wraparound (shortfall) payments will continue to be paid using the existing FQHC shortfall rate codes.

FQHCs 'opting in' to APGs will be able to continue to bill the following carved-out rate codes:

- **4011** – FQHC Group Psychotherapy
- **4012** – FQHC Off-Site Visit

5.2 PRODUCTS OF AMBULATORY CARE (PACS):

Except for FQHC clinics with PAC rates that elect not to move to APGs, PAC rate codes will be replaced with the new APG rate codes. Under previous PAC payment methodology, PAC clinics were instructed to use the same date of service for the primary clinic visit as well as for all ancillary diagnostic tests or procedures provided on a subsequent date. This "same date of service" billing methodology will continue for PAC providers after they convert to the APG payment methodology. FQHC~~s~~ that are PAC provider~~s~~ will continue to bill using the appropriate PAC rate code.

5.3 PRENATAL CARE:

Chapter 484 of the laws of 2009 eliminated the PCAP designation, certification, and associated enhanced global fees. Except for FQHCs that elect not to participate in APGs, providers who have billed the PCAP clinic rates will be converted to the APG reimbursement methodology. PCAP rate codes 3101, 3102, and 3103 will be end-dated and replaced with APG rate codes 1400 or 1432 for (hospital-based OPD) or 1407 or 1422 for (D&TCs) upon APG implementation. When the PCAP rate codes are end-dated, FQHCs that have opted not to participate in APGs will be required to use their PPS rate code to bill for prenatal care services.

To ensure full reimbursement under the APG payment methodology, prenatal care providers must code all procedures performed during the patient encounter on the claim. All claims must include:

- the new APG rate codes;
- a valid, accurate ICD9-CM primary diagnosis code;
- valid CPT and/or HCPCS procedure codes reflecting services provided.

Other than the specific carved-out procedures identified in Section 4, all ancillary laboratory and radiology services provided or ordered by the prenatal care provider should be coded on the claim, and these services will be included in the APG payment for a significant procedure or medical visit (this policy will be implemented prospectively in D&TCs effective January 1, 2011). All general billing rules that apply to Article 28 clinics under the APG payment methodology also apply to prenatal care providers.

Effective January 1, 2010, new CPT codes have been added to the EAPG grouper/pricer to allow prenatal care providers who are APG billers to claim for prenatal risk assessment, prenatal care enhanced services, and nutrition screening and counseling when performed as part of a medical visit. These are "if stand alone do not pay" procedures meaning that they will not pay if they are the only service on a claim and not provided in conjunction with a significant procedure or medical visit. These new codes have procedure specific weights and limits on their use are further described below:

H1000-prenatal risk assessment	may be used to code comprehensive prenatal care risk assessment-will soon be tied to DOH standardized risk assessment form	may be billed once per pregnancy
H1005-prenatal care enhanced service package	may be used to code combined health supportive services including ante-partum management, prenatal care coordination and prenatal at-risk education	may be billed once during each prenatal visit
97802-97803-nutrition screening, counseling and referral-medical	may be used to code nutritional assessment, counseling and referral	may be billed up to two units, on a single claim line, per prenatal visit

The new prenatal care standards for Medicaid providers are outlined in a special edition of the Medicaid Update published in February 2010: http://nyhealth.gov/health_care/medicaid/program/update/2010/2010-02_special_edition.htm.

Additional information regarding Medicaid prenatal care standards, coverage and payment policies is also available on the APG website: http://nyhealth.gov/health_care/medicaid/rates/apg/#prenatal.

5.4 HIV DESIGNATED AIDS CENTERS (HIV DAC):

All providers who bill the HIV 5 and 7 tier rates will be converted to the new APG reimbursement methodology. Rate codes 2961, 2983/1695, 3109, and 3111/1802 will not be included in APGs. These rate codes are carved out of APGs and may continue to be billed fee-for-service to Medicaid. All other hospital based HIV rate codes will be end dated. HIV DAC clinics must report all procedures performed during the patient encounter. Payment will be based on the APG reimbursement methodology.

Other than the procedures identified in Section 4.20, all ancillary services provided by the HIV DAC provider are included in the APG payment. All general billing rules that apply to clinic APG billings also apply to HIV DAC providers billing under the APG payment methodology. The standards of care applicable to HIV DAC providers will remain in effect under APGs.

5.5 SCHOOL- BASED HEALTH CENTERS (SBHC):

Two new rate codes have been established for hospital-based and D&TC SBHC providers for services provided to both managed care and non-managed care enrollees.

- **1444/1450** – Hospital Outpatient APG – School Based Health Center rate codes 1444(visit) or 1450(episode) should be used for both a comprehensive annual exam and follow-up visit for managed care and non-managed care enrollees, effective April 1, 2009.

- **1447/1453** – D&TC APG – School Based Health Center rate code 1447(visit) or 1453(episode) should be used for both a comprehensive annual exam and follow-up visit for managed care and non-managed care enrollees upon APG implementation.

Previously established rate codes 2888 and 2889 for hospital-based providers and rate codes 1627 and 1628 for DTCs will become obsolete. Utilization Threshold (UT) service authorization will apply to all clinic services provided by School Based Health Centers.

5.6 INDIAN HEALTH CENTERS:

Medicaid services provided by federally recognized Tribal Clinics to Native Americans living on reservations are exempt from the APG payment methodology. However, Tribal Clinics with Department of Health Article 28 certification which serve non-native American Medicaid beneficiaries are required to submit claims for these individuals using the APG grouper access code (1407) with complete ICD-9, CPT/HCPCS coding to reflect the services provided.

5.7 FREE ACCESS TO FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES FOR MANAGED CARE ENROLLEES:

Individuals enrolled in Medicaid managed care plans may obtain family planning services from any qualified Medicaid fee-for-service provider without referral or approval by the health plan. In addition, Medicaid free access rules allow Medicaid managed care enrollees in all Medicaid plans to obtain family planning from their plan providers or from any out-of-network fee-for-service provider without referral or approval. Out-of-network providers of family planning services should use the appropriate APG rate codes to bill for family planning and reproductive health services provided to Medicaid managed care enrollees.

5.8 FAMILY PLANNING BENEFIT PROGRAM (FPBP):

The Family Planning Benefit Program provides Medicaid coverage for a range of family planning services to males and females of childbearing age with incomes below 200% of the poverty level. For more information please see the Medicaid Update February 2008 newsletter.

Special processing is needed for FPBP claims. Since a clinic claim document for a FPBP client may have a mix of family planning and non-family planning related procedures, DOH requires that only the claims with a V25 diagnosis and a FPBP payable procedure receive payment. This practice is accomplished by utilizing the grouper software ability to ignore line items. While these claims process through the grouper software, $0 reimbursement is calculated when the procedure code is not a FPBP payable procedure. ***Note:*** Listings of FPBP payable procedures are included in the May 2007 and February 2008 Medicaid Update.

CHAPTER 6: PRIMARY CARE ENHANCEMENTS

6.1 MENTAL HEALTH SERVICES BY LICENSED CLINICAL SOCIAL WORKERS AND LICENSED MASTER SOCIAL WORKERS IN ARTICLE 28 CLINICS:

Medicaid reimbursement will be available to Article 28 clinics for mental health counseling provided by Licensed Clinical Social Workers (LCSWs) and Licensed Master Social Workers under the supervision of an LCSW, psychologist, or psychiatrist **once federal financial participation is assured.** Reimbursement will be available only for mental health counseling services provided to: 1) adolescents and children under the age of 21 and 2) pregnant and post-partum women. Additional guidance will be provided regarding the effective date.

Reimbursement Requirements:

- An Article 28 facility that is offering mental health counseling by licensed social workers must have psychiatry or psychology certification on their Operating Certificate.
- Enrollees categorized as 'children and adolescents' are those under the age of ~~19~~ 21.
- Pregnant and postpartum women will be eligible for these services with:
  - a primary or secondary diagnosis of pregnancy (ICD codes: 630-677, V22, V23, V28) and for up to 60 days post-partum: and/or;
  - a primary or secondary diagnosis of postpartum depression (ICD code 648.4X).

Rate Codes for Outpatient Hospital Clinics and Free Standing Diagnostic & Treatment Centers:

- **4257** – Individual Brief Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face to face with the patient)
- **4258** – Individual Comprehensive Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face to face with patient)
- **4259** – Family Counseling (psychotherapy with or without patient)

***** Rate codes 4257 and 4258 cannot be billed together on the same day.

Rate codes for School Based Health Centers:

- **3257** - Individual Brief Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face with the patient)

- **3258** - Individual Comprehensive Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face with patient)

- **3259** - Family Counseling (psychotherapy with or without patient)

Following are the standards and record-keeping requirements for the provision and billing of LSW services:

Standards for Provision of Mental Health Counseling:

1. Article 28 clinic services must be provided under the direction of a physician. A written order from a physician, nurse practitioner or physician's assistant for the mental health counseling is required.

2. Mental health counseling provided in an Article 28 clinic is expected to be short term and of limited duration and provided incidental to general health care. Long term or on-going psychotherapy, as a treatment for a severe emotional disorder, would normally be provided in a clinic certified by the Office of Mental Health under Article 31 of the Mental Hygiene Law.

Recordkeeping Requirements:

In addition to the information that must be maintained in the recipient case record as specified in the Clinic Provider Manual, Policy Guidelines, Section I (P. 4) and Section II (P. 15), the case record must also include the following information at a minimum:

1. A signed and dated treatment plan that includes, but is not limited to, the recipient's diagnosis, the recipient's treatment goals, and the number of sessions ordered by the physician, nurse practitioner or physician's assistant. The practitioner involved in the treatment of the recipient must sign the treatment plan and, in doing so, is ordering the service and certifying the medical necessity of those services.

2. Dated and signed progress notes for each visit/contact identifying the session content and duration, as well as changes in goals.

3. Periodic assessment of recipient's progress towards his/her goal.

6.2 EXPANDED 'AFTER HOURS' ACCESS

Effective January 1, 2009 for hospital outpatient clinics and upon APG implementation for diagnostic and treatment centers, an add-on payment is available for visits which are scheduled and occur on evenings, weekends and holidays as defined by the Department of Health. The supplemental APG payment amount shall be added to the otherwise applicable payment amount for each such visit. An evening visit is one which is scheduled for and occurs after 6:00 p.m. A weekend visit is one which is scheduled for and occurs on Saturday and Sunday. A holiday visit is one which is scheduled and occurs on a designated national holiday.

The national holidays are:

New Years Day, Martin Luther King Day, Presidents Day, Memorial Day, Independence Day, Labor Day

Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day

▸ ***Note:*** **This add-on payment will also be available to physicians for scheduled office-based physician care during DOH-defined evenings, weekends and holidays.**

Providers should use the following CPT codes as appropriate:

- CPT 99050, Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.
- CPT 99051, Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

These CPT codes are not payable if they are the only CPT procedure(s) listed on the claim. They are reimbursed only when accompanied by a valid CPT code that represents a medical service/procedure.

6.3 ASTHMA AND DIABETES SELF-MANAGEMENT TRAINING:

Effective January 1, 2009, for physicians' offices and hospital outpatient departments, and upon APG implementation for Diagnostic and Treatment Centers, Medicaid reimbursement will be available for asthma and diabetes self-management training services (ASMT and DSMT) for Medicaid beneficiaries diagnosed with asthma and/or diabetes. This section addresses the criteria for ordering, providing and billing for these services.

Self-management training services must be ordered by:

- a physician;
- a registered physician's assistant;
- a registered nurse practitioner; or
- a licensed midwife

Self-management training services must be provided by:
the following professional entities who are NYS licensed, registered, or certified in their professional discipline, and are also certified as an educator by the National Asthma Educator Certification Board (CAE) or the National Certification Board for Diabetes Educators (CDE) to provide self-management training services to Medicaid beneficiaries.

ASTHMA (CAE)

- Registered Nurse
- Registered Nurse Practitioner
- Respiratory Therapist
- Physician (MD, DO)
- Pharmacist
- Physician Assistant

DIABETES (CDE)

- Registered Nurse
- Registered Nurse Practitioner
- Registered Dietician
- Physician (MD,DO)
- Pharmacist
- Physician Assistant
- Physical Therapist

Services must be provided at: a hospital outpatient department (OPD), a diagnostic and treatment center (D&TC), or Federally Qualified Health Centers (FQHC).

Services may be billed by:

- Physicians, registered nurse practitioners and/or licensed midwives, who are certified educators themselves, and whose fees are not included in the facility rate or APG, or by
- OPDs, D&TCs and/or FQHCs, who employ or contract with certified educators (proof of CAE and/or CDE employment is required).

PROGRAM SPECIFICS

Claims submitted for ASMT must have a diagnosis of Asthma (ICD-9 493.XX), and claims submitted for DSMT must have a diagnosis of Diabetes (ICD-9 250.XX, 648.0X, 648.8X, 775.0, or 775.1).

When a Medicaid provider does not directly offer ASMT or DSMT services, they may refer patients in need of educational services to either a Medicaid practitioner's office or a Medicaid-enrolled clinic that does employ or contract with CAEs and/or CDEs. Medicaid-enrolled clinics that render educational services to a non-registered clinic patient will be reimbursed according to the ordered ambulatory fee schedule.

Since only one clinic claim can be submitted per day, if multiple services are provided by different providers on the same day (e.g., an E&M service followed by asthma or diabetes self-management training), then only the NPI of the major service provider for that day should be entered on the claim form.

A ***newly diagnosed*** patient with asthma or diabetes ***OR*** a patient who has a ***medically complex condition*** (i.e., exacerbation of the condition, poor control of the condition, diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription of a new medication or equipment, mental health diagnosis, learning disability and/or an unstable medical condition) will be allowed:

- Up to 10 hours of self-management training during a continuous 6 month period

Enrollees with asthma and/or diabetes who are *medically stable* can receive:

- Up to 1 hour of self-management training in a continuous 6 month period

Asthma Self-Management Training CPT Codes: (Group sessions may have no more than 8 patients.)

98960 – Individual education for 30 minutes (Groups to APG 428)
98961 – Group education session, 2-4 patients, 30 minutes (Groups to APG 429)
98962 – Group education session, 5-8 patients, 30 minutes (Groups to APG 429)

Diabetes Self-Management Training HCPCS Codes:

G0108 - Diabetes outpatient self-management training services, individual, for 30 minutes (Groups to APG 428)
G0109 – Diabetes outpatient self-management training services, group, <=8 patients per 30 minutes (Groups to APG 429)

Notes: ~~Facilities with APG reimbursement will be able to bill the same self-management training procedure code multiple times, depending on how many 30-minute sessions are provided for a given beneficiary on a given date of service. Reimbursement will be at 100% for the first procedure code, and at 50% for subsequent procedure codes.~~ Facilities with APG reimbursement will be able to bill multiple units of the same patient education/self management procedure code. The procedure code **must** be listed on one line of the claim with the appropriate number of units. A maximum of 4 units may be billed per day. **These codes must not be coded on multiple lines.**

If the same code is billed on multiple lines, reimbursement will be at 100% for the first procedure code and 50% for each subsequent line of the same code which will result in incorrect payment. FQHCs who opt to keep their threshold PPS rate will be reimbursed at that rate regardless of how many patient education/ self-management sessions are provided on a given date of service. For more detailed information regarding asthma and diabetes self-management training services, please see the October 2008 Medicaid Update newsletter at: http://www.nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#dia.

6.4 SMOKING CESSATION COUNSELING:

In support of the U.S. Department of Health and Human Service's Clinical Practice Guideline 2008 Update *"Treating Tobacco Use and Dependence,"* Medicaid began covering smoking cessation counseling to pregnant women, effective January 1, 2009, in practitioner's offices and in hospital OPDs. This counseling complements Medicaid covered benefits for smoking cessation coverage, which include prescription and non-prescription smoking cessation products. These codes group to APG 451. Effective January 1, 2010, Medicaid will cover smoking cessation counseling during a medical visit to pregnant and postpartum women and children and adolescents ages 10 to 21.

Reimbursement for smoking cessation counseling (SCC) must meet the following criteria:

- Services must be provided face-to-face.
- ~~ONLY available~~ for Medicaid-eligible pregnant females, women up to 6 months postpartum, and children and adolescents ages 10-21 who smoke. ~~The claim must have a diagnosis of pregnancy (ICD-9-CM Diagnosis Codes: 630-677, V22, V23, V28).~~
- Practitioners and clinics must use the appropriate ICD-9 diagnosis code:
  - 305.1 – Tobacco use disorder. (Use for children and adolescents ages 10 up to 21).
  - 649.03 – Tobacco use disorder complicating pregnancy, childbirth or the puerperium – antepartum. (Use for pregnant women who smoke).
  - 649.04 – Tobacco use disorder complicating pregnancy childbirth or the puerperium – post-partum. (Use for post-partum women who smoke).
- Smoking cessation counseling must be provided by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife during a medical visit (no group sessions), and is only payable when accompanied by ~~an~~ the appropriate E&M code (99201-99205, 99211-99215) and/or the appropriate preventive medicine code (99383-99386, 99393-99396). EXCEPTION- an E&M code is NOT necessary for practitioners billing for Global Obstetrical Care, which is billed at the end of pregnancy.
- Currently physicians, nurse practitioners, ~~and~~ licensed midwives and ~~(whose fees are not included in the facility rate or APG)~~; Article 28 hospital outpatient departments will be allowed to bill for SCC;
- Upon approval of the APG payment method by CMS, D&TCs and FQHCs that bill using APGs will be allowed to bill for SCC.
- Pregnant women will be allowed ~~up to~~ 6 counseling sessions ~~within a continuous 12-month period~~ during their pregnancy.
- Postpartum women will be allowed 6 counseling sessions during the 6 month postpartum period.
- Children and adolescents ages 10-21 will be allowed up to 6 counseling sessions in a continuous 12-month period.
- Providers should bill for these services using the following CPT procedure codes:

  99406 – Smoking cessation counseling, 3 to 10 minutes
  99407 – Smoking cessation counseling, greater than 10 minutes

  Only one procedure code per day may be billed.

For additional information please see the ~~October 2008~~ December 2009 Medicaid Update online at: http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-12.htm#smo.

6.5 PATIENT ENCOUNTERS WITH A REGISTERED NURSE OR A LICENSED PRACTICAL NURSE:

Patient encounters with **only** a registered nurse (RN) or a licensed practical nurse (LPN) generally are not reimbursable under Medicaid except in the following limited circumstances:

- A RN administers chemotherapy or other infusion drugs under a physician's order in a clinic setting. An APG claim should be billed to Medicaid for the administration. An E&M code should not be reported on the APG claim.

- A RN or LPN administers an immunization (other than seasonal flu, H1N1, or pneumococcal – which are carved out of APGs, see section 4.14) within their scope of practice under a patient specific order and the patient does not see a physician, physician's assistant, nurse practitioner or licensed midwife. An APG claim should be billed to Medicaid for vaccine administration and the vaccine material(s) for each administration. An E&M code should not be reported on the APG claim.

    - administration codes 90465 – 90474 must be reported on the APG claim in addition to the vaccine and tax ID codes 90476 – 90749 for each immunization administered.

    - ~~If more than one immunization is administered on the same date of service, under APG payment rules the first administration will pay at 100%; and the subsequent administrations will be discounted and pay at 50%~~. Effective January 1, 2010, vaccine administration codes group to APG 490 (incidental to medical, significant procedure or therapy visit), and will not pay separately at the line level.

- A RN or LPN performs a urine pregnancy test upon a patient specific order of a licensed physician, physician's assistant, nurse practitioner, or nurse midwife and the patient does not see a physician, physician's assistant, nurse practitioner or nurse midwife. An APG claim should not be billed to Medicaid in this instance. Urine pregnancy test, 81025, should be billed to Medicaid using the laboratory ordered ambulatory fee schedule. (See Section 4.21).

- A RN or LPN administers Depo-Provera within their scope of practice under a patient specific order and the patient does not see a physician, physician's assistant, a nurse practitioner or a licensed midwife. An APG claim should not be billed to Medicaid. Depo-Provera, J1055, should be billed to Medicaid using the ordered ambulatory fee schedule (see Section 4.21).

- A RN or LPN performs allergy injections upon a patient specific order of a licensed physician, physician's assistant, nurse practitioner, or nurse midwife and the patient does not see a physician. An APG claim should be billed to Medicaid for the injection. An E&M code should not be reported on the claim.

RNs and LPNs may provide service only within their respective scopes of practice as defined by the State Education Department laws, rules and regulations. Providers may obtain specific information about practitioner scope of practice at: http://www.op.nysed.gov/nurse.htm.

6.6 SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT):

Effective January 1, 2010, Medicaid pays for Screening, Brief Intervention and Referral to Treatment (SBIRT) for Medicaid beneficiaries in hospital emergency departments and hospital outpatient departments. The coverage will become effective in diagnostic and treatment centers upon APG implementation. SBIRT is an evidence-based practice that has been proven successful in identifying and treating medical problems early in order to avoid more serious problems and save medical costs.

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service setting.

The SBIRT model is designed to identify individuals with or at risk of substance use-related problems, assess the severity of substance use and the appropriate level of intervention required and provide brief intervention or brief treatment. The goal is to make screening for substance use a routine part of medical care, use motivational interviewing techniques to increase patient insight and awareness regarding substance use and motivation toward change and, for those identified as needing more extensive treatment, provide referral to a chemical dependence treatment program.

The following two HCPCS procedure codes should be utilized to bill Medicaid for SBIRT:

- **H0049** - Alcohol and Substance Abuse Screening
- **H0050** - Alcohol and Substance Abuse Brief Intervention; Per 15 minutes

This initiative will be paid through the APG reimbursement methodology for Medicaid fee-for-service beneficiaries. Both of these HCPCS codes will group to APG 324, Mental Health Screening & Brief Intervention.

Additional information about SBIRT is available on the OASAS Website at:

http://www.oasas.state.ny.us/AdMed/FYI/sbirt.cfm.

6.7 CARDIAC REHABILITATION:

Effective January 1, 2010, New York Medicaid will cover medically necessary cardiac rehabilitation for fee-for-service enrollees when ordered by a physician. Cardiac rehabilitation programs must be comprehensive and include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling.

The American Heart Association/American Association of Cardiovascular and Pulmonary Rehabilitation (AHA/AACVPR) defines cardiac rehabilitation (CR) as coordinated, multifaceted interventions designed to optimize a cardiac patient's physical, psychological, and social functioning, in addition to stabilizing, slowing, or even reversing the progression of the underlying atherosclerotic processes, thereby reducing morbidity and mortality

To be reimbursed by Medicaid, cardiac rehabilitation therapy must be provided:

- in an Article 28 hospital outpatient department; or
- in a physician's office; or
- Upon APG implementation in Freestanding Diagnostic and Treatment Centers (D&TCs) or Federally Qualified Health Centers (FQHCs) that bill using APGs.

The following practitioners may administer cardiac rehabilitation in a clinic setting: Physicians, Physician Assistants, Nurse Practitioners, Physical Therapists, Physical Therapy Assistants, and Registered Nurses. Medicaid coverage of cardiac rehabilitation is consistent with Medicare's coverage guidelines. Coverage is subject to the following conditions:

- The facility meets the definition of a hospital outpatient department or a freestanding D&TC, i.e., a physician is on the premises and available to perform medical duties at all times while the facility is open, and each patient is under the care of a hospital or clinic physician;
- The facility has immediately available all cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator;
- While in session, the program is conducted in an area set aside for its exclusive use; and,
- The facility is staffed by necessary personnel to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area and immediately available and accessible for an emergency at all times while the exercise program is being conducted. It does not require that a physician be physically present in the exercise room. However, the physician must be in close proximity considered immediately available and accessible.

To be eligible for covered cardiac rehabilitation services, Medicaid beneficiaries must have a qualifying cardiac event with an ICD-9 diagnosis supporting medical necessity as follows:

- acute myocardial infarction within the preceding 12 months (all ICD-9 codes beginning with 410 or 412 or V58.73); or
- stable angina pectoris (all ICD-9 codes beginning with 413 or V58.73); or
- heart or heart-lung transplant (ICD-9 V42.1); or
- heart valve repair/replacement (ICD-9 V42.2, V43.3); or
- previous coronary artery bypass (CABG) surgery (ICD-9 V45.81); or
- percutaneous transluminal coronary angioplasty - PTCA - or coronary stenting (ICD-9 V45.82). ***Note:*** Congestive heart failure in the absence of other covered conditions is NOT included as a covered condition for cardiac rehabilitation.

The frequency and duration of the program generally consists of 36 sessions, occurring 2-3 times per week for 12-18 weeks. No prior authorization is necessary for this phase. Prior authorization will be required for cardiac rehabilitation beyond the initial 36 sessions for patients who do not meet the exit criteria. Prior authorization must be obtained by a physician or nurse practitioner. The additional 36 sessions (2-3 times per week for 12-18 weeks) may be granted when:

- the patient's qualifying diagnosis was not V42.2 or V43.3 (valvuloplasty or valve replacement); and;
- the patient is benefiting from cardiac rehabilitation; and
- the patient has failed to meet the exit criteria after completion of the first 36 visits.

Exit Criteria:

Qualifying Condition	*Exit Criteria*
Ischemic Heart Disease	Exercise tolerance = 7 METS*
Post MI Post CABG Post PTCA or Stent Angina Pectoris	Six minutes of exercise during a treadmill or stress imaging test without significant ischemia or dysrythmia
Post heart or heart-lung transplant	Peak oxygen consumption (VO2) of greater than 90% of predicted

*Metabolic Equivalent Task units. METS measure the energy (oxygen) used by the body during activity. A stable level of exercise tolerance is 7 METS.

Please Note: *Patients with valvuloplasty or valve replacement are eligible for the initial 36 visits ONLY.*

A visit including one or more of the following services is considered one routine cardiac rehabilitation visit. The same rate of reimbursement will be allowed for each visit. A visit does not require that all of the services be performed. In order for the visit to be reimbursable, at least one of these services must be performed:

- continuous ECG telemetric monitoring during exercise;
- ECG rhythm strip with interpretation and physician's revision of exercise prescription; and
- limited examination for physician follow-up to adjust medication or other treatment changes.

Each session must last a minimum of 60 minutes. One session per day is reimbursable. Two or three sessions are allowed per week. Sessions at a frequency of less than two per week will be considered not medically necessary.

Other Covered Services Include:

- New patient comprehensive evaluation, including history, physical, and preparation of initial exercise prescription. One is allowed at the beginning of the program if not already performed by the patient's attending physician.
- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. Allow one at the beginning of the program and one after 3 months (usually upon completion of the program).
- Other physician services, as needed.

In a clinic setting, cardiac rehabilitation is billed under Ambulatory Patient Groups (APGs) with one of the following rate codes as appropriate: 1400, 1407, 1413, 1422, 1425, 1432, 1435 or 1441.

The CPT Codes for Cardiac Rehabilitation Include:

- 93797, Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session); and
- 93798, Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session).

Either of these codes will group to APG 94, Cardiac Rehabilitation (a significant procedure APG). These APG rate codes are applicable for cardiac rehabilitation payment. When cardiac rehabilitation is provided in a physician's office, the physician can bill using these CPT codes. Payment for these procedure codes can be found in the Physician Medicine Fee Schedule at www.emedNY.org.

Patients who participate in cardiac rehabilitation programs may require medically necessary services beyond the normal service limits. These service limits are established and based on each beneficiary's clinical information, including diagnoses, procedures, prescription drugs, age and gender. As a result, most Medicaid beneficiaries will have service limits increased to clinically appropriate levels and will not need additional services authorized. However, when indicated, the physician may request approval of higher limits by submitting a Threshold Override Application (TOA).

6.8 MEDICAL HOME:

Upon CMS approval, office-based practitioners and Article 28 clinics (OPDs, D&TCs and FQHCs) recognized as *Physician Practice Connections-Patient Centered Medical Homes* (PPC®-PCMH™) by the National Committee for Quality Assurance (NCQA) will be able to receive medical home incentive payments for primary care services provided to Medicaid patients. Once the program is implemented, NCQA will provide a monthly list of PPC®-PCMH™ recognized providers to New York Medicaid for use in claims processing.

In order for Article 28 Clinics (OPDs, D&TCs and FQHCs) to receive fee-for-service incentive payments from New York Medicaid, the following conditions are required:

- claims must include one of the following Evaluation and Management codes: 99201- 99205 or 99211- 99215 or Preventive Medicine codes: 99381-99386, 99391-99396.
- In a clinic, the billing clinic's NPI must be included on the claim.

To ensure receipt of incentive payments, recognized providers must assure that NCQA has the 4 digit extension of the zip code (zip +4) for each practice site certified by NCQA as a patient centered medical home. Article 28 clinics must also have their billing NPI on file with NCQA. Failure to provide practice site NPI numbers (practitioner group NPI or clinic NPI) and the zip+4 for each recognized service location, will jeopardize incentive payments by NY Medicaid. **Recognized practitioner groups and clinics can e-mail their practice site NPI (Medicaid billing NPI#) and their zip + 4 information to NCQA at ppc-pcmh@ncqa.org.**

Notes:

- Practices with Registered Nurse Practitioners (RNP), including Article 28 facilities and office-based practitioners, are reminded to include the RNP(s) on their NCQA PPC®-PCMH™ application. This will enable Medicaid to appropriately process Patient Centered Medical Home incentive payments for primary care nurse practitioner services.
- In the event that both a practitioner working in a clinic (who submits a professional claim) and the clinic have a medical home designation, only the clinic will receive the enhanced payment.
- New York Medicaid providers participating in the Adirondack Medical Home Demonstration Project are not eligible for incentive payments through the Statewide Patient Centered Medical Home Program.

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Questions/Information:

For more information on how to achieve NCQA certification as a NCQA PPC® -PCMH™ provider you should contact NCQA Customer Support at (888) 275-7585, or visit the NCQA Website at www.ncqa.org. Since New York Medicaid is recognized as a sponsoring organization, providers will receive a 20 percent discount from NCQA toward the cost of the PPC®-PCMH™ application. For more detailed information about the Statewide Patient Centered Medical Home Program, please see the December 2009 Special Edition of the Medicaid Update, available online at: http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-12spec.htm.

Additionally, the February 2010 Medicaid Update includes information about Medical Home. Please visit: http://nyhealth.gov/health_care/medicaid/program/update/2010/2010-02.htm#cur.

Please contact the Bureau of Managed Care Finance at (518) 474-5050 with any questions regarding health plan medical home payments for network providers.

Required NCQA Disclaimer: The Physician Practice Connections®-Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program is developed, owned and managed by the National Committee for Quality Assurance (NCQA). To learn more about the PPC®-PCMH™ Recognition Program, refer to the program's Website at: www.ncqa.org/ppcpcmh.aspx. NCQA is not involved in any determination of clinician incentive payments under the New York State Medicaid Medical Home Program.

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7. CONTACT INFORMATION:

For Issues/Questions Regarding:	Contact:
BILLING, REMITTANCE, AND TRAINING	**Computer Sciences Corporation** eMedNY Call Center (800) 343-9000 e-mail: eMedNYProviderRelations@csc.com
GENERAL POLICY, RATES, WEIGHTS, CARVE-OUTS, PAYMENT RULES, OR IMPLEMENTATION ISSUES	**NYS Department of Health** Office of Health Insurance Programs Division of Financial Planning and Policy (518) 473-2160 e-mail: apg@health.state.ny.us
GROUPER/PRICER SOFTWARE SUPPORT	**3M Health Information Systems** (800) 435-7776 Website: www.3mhis.com

8. FREQUENTLY ASKED QUESTIONS AND IMPLEMENTATION MATERIALS:

Please visit our Website to review FAQs at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm#frequently_q

Implementation materials are also available on the Department's Website at:
http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm

Please Note: Although every effort is made to keep this policy manual updated, the charts and lists are subject to change. The actual payment amounts and whether a service will be reimbursed through the APG payment methodology are based on the current version of the grouper/pricer and the APG data dictionary.

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Glossary of Terms

Allowed APG weight – The relative resource utilization for a given APG after adjusting for consolidation, packaging, and discounting.

Ambulatory Patient Group (APG) – A defined group of outpatient procedures, encounters or ancillary services as specifically identified and published by the Department, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis codes and CPT-4 and HCPCS procedure codes.

Ambulatory Surgery Permissible Procedure – Those surgical procedures designated by the Department as reimbursable as ambulatory surgery.

Ancillary Services – APGs designated by the Department reflecting tests and procedures ordered by physicians to assist in patient diagnosis and/or treatment.

APG Relative Weight – A numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

APG Software System – The New York State specific version of the APG computer software developed and published by Minnesota Mining and Manufacturing Corporation (3M) to process CPT-4 and ICD-9 code information in order to assign patient visits to the appropriate APG category or categories and apply appropriate bundling, packaging and discounting to assign the appropriate final APG weight and associated reimbursement.

Base Rates – The numeric value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG relative weight to determine the total allowable Medicaid operating payment for a visit.

Base Year – Reporting and claiming period that the APG relative weight is based.

Blended Operating Payment – The Medicaid operating payment for a visit calculated by using a percentage of the operating amount derived under the APG reimbursement methodology and a complementary percentage of the existing payment for purposes of blending.

Capital Add-On –A per visit add-on provided to cover the Department of Health approved cost of capital. This add-on shall be applicable to allowable medical visits and significant procedures. In some cases the APG payment itself may cover the allowable capital cost. In such instance there shall be no capital add-on accorded to the APG reimbursement. The Department will determine which APG payments include capital and therefore do not require a capital add-on. Capital add-ons shall be computed on a provider-specific basis, except for those capital add-ons applicable to hospital-based ambulatory surgery and free-standing ambulatory surgery, which will instead be computed on a peer group basis.

Carve-Outs – Those procedure codes that do fall under the defined APG in terms of provider and service type that are omitted from the APG claim. The list of procedures carved out of APGs has been developed, published, and will be updated by the Department of Health.

Case Mix Index – The actual or estimated average final APG weight for a defined group of APG visits.

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Coding Improvement Factor – A numeric value used to inflate a case mix index, and reduce a base rate, to adjust for the probability that the coding of claims subsequent to the implementation of APG reimbursement will be more complete and accurate than was the case prior to the implementation of APG reimbursement.

Consolidation – Also known as **bundling,** consolidation is the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single visit.

Current Procedural Terminology – Fourth Edition (CPT-4) – The systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 and HCPCS are maintained by the American Medical Association and the federal Centers for Medicare and Medicaid Services and are updated annually.

Discounting – The reduction in APG payment that results when unrelated additional procedures or ancillary services are performed during a single patient visit.

Episode – A unit of service consisting of all services on a claim, regardless of the coded dates of service. Under episode billing, an episode shall consist of all medical visits and/or procedures that are provided by a clinic to a patient on a single date of service plus any associated non-carved out ancillaries, regardless of the date of service of those ancillaries. For emergency departments, the significant procedures and/or medical visits comprising the non-carved out ancillary services portion of an episode need not be on a single date of services and may instead be on consecutive dates of services. Multiple episodes shall not be coded on the same claim.

Final APG Weight – The allowed APG weight for a given visit as expressed in the applicable APG software, and as adjusted by applicable consolidation, packaging and discounting and other applicable adjustments.

Final Payment Rate – The base amount that forms the final dollar value used to calculate each provider's reimbursement amount, when multiplied by the APG weight.

Free-standing Ambulatory Surgery – Surgery and related services provided in an ambulatory surgery center that is certified under Article 28.

Free-standing Clinic Services – Ambulatory services provided in a clinic that is certified under Article 28.

Grouper/Pricer – The New York State specific Grouper software developed by Minnesota Mining and Manufacturing (3M), with modifications for payable APGs made to support the New York State Medicaid Program.

Hospital-Based Ambulatory Surgery – Surgery and related services provided in an ambulatory surgery center that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

Hospital-Based Clinic Services – Ambulatory services provided in a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

Hospital-Based Emergency Services – Emergency and related services provided in an emergency department that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

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HCPCS Codes – The Healthcare Common Procedure Coding System. A numeric coding system maintained by the American Medical Association (AMA) used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

If Stand Alone, Do Not Pay APG – An APG that will not be reimbursed if it is the only APG for the visit (based on the procedure code mapping using the grouper/pricer software). If the only APGs for a visit consist of "if stand alone, do not pay" APGS and/or "never pay" APGs there will be no payment for the visit. Payment for these types of visits will not be denied but paid at zero dollars. Providers should bill for these types of visits to allow for proper rebasing of the APG payment system. The list of "if stand alone, do not pay" APGs have been developed, published and will be updated by the Department of Health.

Inpatient-Only Services – Services that have been designated by the Department of Health as appropriate for provision only on an inpatient basis. APG claims that code to these services will be denied. The list of services have been developed, published and will be maintained by the Department of Health.

International Classification of Diseases, 9th Revision (ICD- 9) Codes – Is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnoses, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

Medical Visit APG – An APG representing a visit during which a patient received medical treatment but did not have a significant procedure performed.

Modifier Code – A code that can be put on a Medicaid claim for the purpose of affecting the allowed payment under the APG reimbursement methodology.

Never Pay APG – An APG that New York State Medicaid does not provide reimbursement. The list of never pay APGs have been developed, published and will be updated by the Department of Health.

No Blend APG – An APG which has been determined by the Department of Health that there will be no blend with the existing payment for purposes of the final payment calculation. These APGs will be paid at their full APG relative weight. The list of no blend APGs have been developed published and will be updated by the Department of Health.

Packaging – Those circumstances in which payment for routine ancillary services or drugs have been included in the applicable APG payment for a related significant procedure or medical visit.

Peer Group – A group of providers or services that share a common APG base rate. Peer groups may be established based on geographic region, types of services provided or categories of patients.

Glossary of Terms

Procedure Based Weight – A numeric value that reflects the relative expected average resource utilization (cost) for a specific procedure as compared to the expected average resource utilization for all other APGs. In the APG payment methodology, a procedure-based weight overrides the APG weight.

Rate Period – A defined time span which applies to a given set of base rates and version of the 3M grouper/pricer. Each rate period will have an associated base year, though a single base year may apply to multiple rate periods.

Rebasing – The re-determination of the base rate amount or other applicable components of the final payment rate from more recent Medicaid cost report data as determined by the Commissioner.

Region – The Downstate Region will consist of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region will consist of all other counties in New York State.

Re-weighting – The adjustment of all APG weights to reflect changes in relative cost.

Recruitment and Retention Add-On – A per visit add-on was provided to freestanding clinics to cover the approved cost of recruitment and retention, as described in the Workforce Recruitment and Retention section of Attachment 4.19-B of the State Plan, which was implemented retroactively on September 1, 2009 and was in effect through March 31, 2011. The Recruitment and Retention was eliminated for dates of services on or after April 1, 2011.

Significant Procedure APG – An APG incorporating a medical procedure that constitutes the primary reason for the visit in terms of time and resources expended.

Visit – A unit of service consisting of all the APG services performed for a patient that are coded on the same claim and share a common date of service.