

## **DOH Announces New Ancillary Billing Policy for Free-Standing Diagnostic and Treatment Centers**

In June 2010, the Centers for Medicare and Medicaid Services (CMS) approved the new Ambulatory Patient Group (APG) payment methodology for free standing diagnostic and treatment centers (DTCs) with an effective date retroactive to September 1, 2009. The visit based APG rate codes were activated July 18, 2010 with an effective date retroactive to September 1, 2009. The episode rate codes will be loaded to provider rate files with an effective date of July 1, 2011 to coincide with the implementation date of the ancillary billing policy. Under the episode rate code, providers will be able to bill for medical services and associated ancillaries and report the actual dates of service in which the services were rendered.

The APG payment methodology reimburses providers for services rendered based on the services' intensity and resource requirements. The APG payment methodology differs from a fee schedule payment in that it "packages" reimbursement of high volume and/or low cost services into higher intensity significant procedures and medical visits. However, when providers order ancillaries that are performed by and billed by a different provider, the clinic is overpaid since the ancillary provider is paid for the service rendered and the ordered ancillary service is "packaged" into the clinic's reimbursement of the medical visit or significant procedure. The purpose of the ancillary policy is to prevent this type of duplicative payment of services by "un-packaging" packaged ancillary services when APG billers order ancillary services that they do not perform.

DOH delayed implementation of the ancillary billing policy for free-standing diagnostic and treatment centers until July 1, 2011. A list of APGs designated as ancillaries subject to the ancillary policy is available on the APG website: [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/dtc\\_ancillary\\_policy.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/dtc_ancillary_policy.pdf). In previous guidance, providers were notified to code modifier 90 to identify ancillary services for which they were requesting payment. Providers must now code modifier **U6** instead of modifier 90. Please note that coding or not coding modifier U6 on your APG claim prior to July 1, 2011 will not affect your payment.

### **Ancillary Policy Summary**

All ancillaries ordered by the DTC or provided on-site (i.e., point-of-service testing) by the DTC must be coded on the APG claim along with the medical service(s) provided to the patient during the clinic visit. The DTC must code modifier U6 at the line level for each ancillary for which they are requesting payment. DTCs should use modifier U6 only if they either provided the ancillary on-site (in-house) or if the ancillary services provider will not be billing Medicaid directly for the ancillary, but rather will be reimbursed by the DTC. Modifier U6 should not be reported if the DTC did not provide the ancillary service on-site (in-house) and does not plan to pay the outside ancillary provider. In that case, the clinic provider would report the ancillaries on the clinic claim without modifier U6. By not coding the U6 modifier for services that are subject to the ancillary policy, the clinic is indicating to NYS Medicaid that the ancillary services provider will be billing Medicaid directly fee-for-service for the ordered ancillaries and that Medicaid should adjust their APG clinic claim accordingly.

Ancillary services should not be coded on a clinic claim until confirmation has been received that the ancillary services were actually performed. 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. The provider has 90 days after the receipt of the billing information related to the last ancillary completed to submit the claim.
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 services. This method is recommended if it is likely that cash flow or other issues would arise under the first billing option (above). 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.

Special Note on Carve-Outs: DTCs should not include ancillary services that have been carved out of APGs on their DTC APG claim. These should be billed fee-for-service directly to Medicaid by the ancillary provider. For a complete list of APG carve outs go to: [http://nyhealth.gov/health\\_care/medicaid/rates/apg/docs/apg\\_carve\\_outs.pdf](http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf). This list is updated regularly.

### **Contracting Option**

A DTC may choose to “contract” (defined as some form of agreement and/or arrangement to pay) with an ancillary services provider (or providers) for either laboratory services, radiology services, or all ancillary services. The DTC must contract for the ancillary services they agreed to contract for: laboratory services, radiology services, or all ancillary services. The DTC will then be required to reimburse the ancillary services provider(s) directly for applicable ancillary services ordered during an APG billable visit. The ancillary services provider(s) will not be permitted to bill Medicaid for these services. The DTC must code modifier U6 with all of their ordered ancillaries to indicate payment should be made to the DTC. <sup>[1]</sup> The DTC should also code modifier U6 with any ancillaries provided in-house.

### **Non-Contracting Option**

A DTC may choose not to contract for ancillary services. If this option is chosen, the ancillary services provider(s) will bill Medicaid directly for all ancillary services ordered for the DTC’s APG patients. <sup>[1]</sup> The DTC must code all ancillary services, whether ordered or performed on-site, on their APG claim. The DTC may not code modifier U6 on any ordered ancillaries unless the U6 modifier is needed to indicate that the ancillaries provided on-site by the DTC. The DTC will receive APG payment for ancillaries provided on-site.

### **The Effect of Coding Modifier U6 – Contracting Option**

- If modifier U6 is coded with a non-packaging ancillary (e.g., APG 290 – PET Scan), then line-level payment will be made for the ancillary based on the applicable base rate, subject to the usual payment logic within the APG grouper-pricer software.
- If modifier U6 is coded with a packaging ancillary (e.g., APG 471 – Plain Film), then the ancillary will continue to package and will not pay at the line-level.

### **The Effect of Coding Modifier U6 – Non-Contracting Option**

- If modifier U6 is not coded on a non-packaging ancillary, then the DTC is indicating that the ancillary will be billed to Medicaid by the ancillary services provider. No payment will be made to the DTC for that ancillary service.
- If modifier U6 is not coded on a packaging ancillary, then the DTC is indicating that the ancillary will be billed to Medicaid by the ancillary services provider and the value of the ancillary (Ancillary APG weight \* regional base rate) will be subtracted from the APG payment for the visit. The DTC APG payment will be reduced since the value of the ancillary is already included in the DTC’s payment for the E&M (evaluation & management) and/or significant procedure that is also reported on the APG claim.

## **Notifying DOH of the Selected Option**

A list of DTCs that chose the contracting option is available on the APG website at the link below:

[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/dtc\\_contracting\\_for\\_ancil.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/dtc_contracting_for_ancil.pdf)

Additionally, providers can now contract with either laboratory providers, radiology providers, or both laboratory and radiology providers. DTCs included on this list are fiscally responsible for the ancillary services they've contracted for that are ordered for their APG patients. The DTC clinic must have a mechanism in place that notifies ancillary services providers that the clinic will be billing Medicaid for the ordered ancillaries. Ancillary services providers will need to monitor the DOH contracting list to ensure that they are billing Medicaid directly only for APG carve outs and ancillaries ordered by DTCs that are not included on the published list of contracting DTCs<sup>[1]</sup>. Please sign up for the eMedNY APG listserv to receive a notice when the list of contracting DTC providers is updated: [https://www.emedny.org/Listserv/eMedNY\\_Email\\_Alert\\_System.aspx](https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx)

Changes to the list of Contracting DTCs can be emailed to [APG@health.state.ny.us](mailto:APG@health.state.ny.us) with the following information:

- Name of DTC and Ancillary Provider
- NPI(s) (for all locations)
- An indication that the DTC has opted to contract for laboratory procedures, radiology procedures, or both laboratory and radiology procedures

Questions may be directed to the Division of Financial Planning and Policy by email to [APG@health.state.ny.us](mailto:APG@health.state.ny.us), or call 518-473-2160.

[1] If a clinic has not registered with DOH as a contracting provider, but has an existing contract with an ancillary services provider for the clinic to reimburse the ancillary services provider directly for specific procedures, the clinic may code U6 on their APG claim as long as the clinic reimburses the ancillary services provider directly and **the ancillary service provider does not bill Medicaid directly**. Also, if a contracting clinic patient goes to an ancillary services provider that the clinic does not contract with **and** if the ancillary services provider and the clinic cannot agree upon an appropriate ancillary service reimbursement amount, then the clinic and the ancillary services provider may agree to have the ancillary services provider bill Medicaid directly as long as **the clinic DOES NOT bill the U6 modifier on the APG claim (the ancillary should be coded on the APG claim without the U6 modifier)**.