

Welcome to the NYS Department of Health Program on Medicaid Prenatal Care Standards

Agenda

- Welcome
- Introduction and Overview
- NYS Medicaid Prenatal Care Standards
- Presumptive Eligibility
- Medicaid Coverage and Payment Policy
 - APGs
 - Primary Care Enhancements
 - Perinatal Home Health Care Visit Policy
- Q & A

Today's Speakers

- From the Office of Health Insurance Programs (OHIP):
 - Dr. Foster Gesten – Medical Director
 - Donna Scocco Mazzeo – Division of Coverage and Enrollment
 - Karen Kalaijian – Assistant Director, Division of Financial Planning and Policy

New York State Medicaid Prenatal Care Standards

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Outline

- Prenatal care in context of Medicaid Reforms
- Development of standards
- Content of standards

Medicaid Reforms

- From overinvestment in institutional care to appropriate investments in ambulatory and primary care
- Payments based on patient characteristics and service intensity
 - APR-DRGs (inpatient)
 - CRGs (plans)
 - APGs (outpatient clinics)
- Integration across delivery systems (FFS/MC)
- Primary care focus
- Prenatal care focus

Prenatal Care Legislation Enacted

- Statute acknowledging changes in program - Chapter 484 of the laws of 2009; Public Health Law and Social Services Law
 - Eliminates PCAP designation, certification and enhanced rates
 - Authorizes establishment of standards for all Medicaid providers – not in regulations
 - Income eligibility levels for presumptive eligibility
 - Presumptive eligibility by all Article 28s providers of prenatal care

Development of Prenatal Care Standards

- Prenatal care regulations, 10 NYCRR 85.40, written in 1990, had not been comprehensively updated since 2000
- Legislation in 2008 to review PCAP - New York State Senate Bill S6808/ Assembly Bill A9808
- Multi-stakeholder group to review and advise
 - Goal - standards for all providers and delivery systems
 - ACOG/AAP standards with emphasis on areas of concern and opportunity for Medicaid

Review Process

- Partnered with IPRO to review current PCAP standards, current ACOG standards, national guidelines, new literature, other states
- Stakeholder meetings in 2008 and lengthy comment period
 - Professional associations, providers, advocacy/consumer organizations, NYC Health Department, academic institutions, health plans, Association of Perinatal Networks



Major questions/ themes

1. What prenatal standards should be removed/ added/modified?
2. Are there new diagnostics/ treatment/ evidence for interventions that warrant inclusion?
3. Are there interventions that could impact rising rates of low birth weight/ preterm birth, including late preterm?
4. How specific/ flexible should standards be?
5. How strong is the evidence base for current PCAP standards, including non-clinical components?
6. What is the relationship between standards, provider capacity, access and reimbursement?

Major Points in Standards

- Care should meet accepted standards, use evidence based guidelines, as articulated by ACOG/AAP
- Comprehensive care principles from PCAP and 85.40 remain
 - Integration of psychosocial and medical
 - Reflect special needs of Medicaid population
- Consultation and referral - eliminate limits on when to transfer
- Risk assessment
- Focus on conditions of high prevalence and importance
- Coordinated care
- Use of ultrasound and screening for genetic disorders
- Postpartum services

Overview of Standards Content

A. Requirements

- Comprehensive prenatal care record
- Internal quality assurance and improvement
- Provider licensing requirements
- Culturally sensitive care/interpretation services
- Transfer of care
- Specialty physician consultation/referral

Standards Content

B. Access to care

- Provide care as quickly as possible
- Assist with Presumptive Eligibility
- 24/7 coverage; reminder/call backs/missed appointments

Standards Content

- C. Prenatal Risk Assessment, screening and referral
 - Encourage comprehensive early risk assessment by providers; review risk at each visit
 - Facilitate communication with plan case managers regarding pregnant, high risk members
 - Effectively and consistently identify women who may benefit from effective interventions (In Development)
 - NYS Risk Screening Form – identify risk (earliest visit) → referral → communication
 - Coordination of clinical providers, health plan, community programs, case management, home visiting programs, etc.
 - Benefits seen from models such as Healthy Babies (Philadelphia), Monroe Plan (Rochester)
 - Trends in LBW and NICU admissions
 - ‘One page- One fax-One form’



NEW YORK STATE DEPARTMENT OF HEALTH
PRENATAL CARE RISK SCREENING FORM

ADD TEMPLATE
10/1/08

Date completed: -- Date Sent: --

M M D D Y Y

M M D D Y Y

Medicaid ID/CIN#

Last Name First Name Maiden Name

Street Address City: State: Zip:

Home Phone: Work/Cellphone: SSN: DOB:

Health Insurance (Choose One) Medicaid FFS Medicaid Presumptive Eligibility Medicaid MC CHP
MC Plan (if enrolled) Member ID

PNC Provider Information
Organization Name
Last Name First Name
Provider Medicaid ID # NPW Home Provider FAX

Demographic information: Choose ALL that apply.
Race/ethnicity: Caucasian African American Hispanic Asian American Indian Other
Primary Language: English Spanish Other

Pregnancy information:
Initial Visit Date Gestational Age By LMP OR By Ultra sound
M M D D Y Y weeks weeks
Entry into PNC Gravida Para T P A B L LMP EDD:
M M D D Y Y M M D D Y Y

Pregnancy Risk Factors: Check all risk factors that apply.
Prior Current Prior Current Prior Current Prior Current
 Abdominal surgery Pre-term labor Fetal abnormality <16 yr or > 35
 C-Section n/a Preterm birth <37 wks Multiple gestation Depression
 Cervical incompetence n/a LEW <2500gms/54lbs HTN/Preeclampsia Alcohol use
 Placenta Abruption n/a Btwt >4500gms/10 lbs Gestational Diabetes Drug use
 Placenta Previa n/a Stillborn/fetal death STDs Tobacco use

Medical Risk Factor: Check all risk factors that apply.
Yes On Meds Yes On Meds Yes On Meds Yes On Meds
 Anemia Diabetes Mellitus Hypertension Eating disorder
 Asthma DVT/Pulmonary Embolism Kidney disease Underweight
 Auto-immune disorder Dental problem Thyroid disorder Overweight/Obese
 Cardiac history HIV/AIDS Seizures Psychiatric disease

Psycho-Social Risk Factors: Check all risk factors that apply.
 Unmarried/NO partner Unemployed (patient) Physical disability Unplanned pregnancy
 No family support Husband/partner unemployed Sexual abuse Children in foster care
 Unstable housing Education <12 yrs Physical abuse Language barrier
 Homeless Transportation problem Risk of self harm
 No phone Mental disability Domestic violence

Referrals Made: Check actions taken by the provider &/or those refused by the patient
Yes Refused Yes Refused Yes Refused Yes Refused
 Community Case Manager High Risk OB Asthma Educator WIC
 Health Plan (MC if enrolled) Substance Abuse Diabetes Educator Nutrition Counseling
 Behavioral/Mental Health Tobacco Cessation Program Home Visit Provider Other
 Domestic Violence Dental Care Supplemental Nutrition Assistance Program (Food Stamps)

1) Does your patient want assistance with linkage or referral to services? YES NO
2) Do you want assistance with linkage or referral of your patient to services? YES NO

Provider/team member completing form (please print)
Name: _____ Title: _____

I attest that consent was obtained from the patient for the release of this information to the NYSDOH PNC Registry.
Provider team member signature: _____ Date: _____

Standards Content

- D. Psychosocial risk assessment, screening, counseling and referral
- Conducted at first visit; reviewed at each visit and formally repeated in 3rd trimester
 - Should include broad range of social, economic, psychological and emotional problems
 - Highlight tobacco use, substance use, domestic violence and depression

Standards Content

- E. Nutrition – screening, counseling and referral
 - Pre-pregnancy BMI and recommended weight gain – according to 2009 Institute of Medicine (IOM) guidelines
 - Exercise and lifestyle changes
 - Breastfeeding recommendations
 - Special considerations for underweight and/or overweight obese
 - Gestational diabetes screening for overweight

Standards Content

F. Health Education

- Based on assessment of individual needs
- Address issues such as avoiding harmful behaviors (alcohol, drugs, smoking)
- Environmental concerns/lead exposure
- Risk of HIV infection
- Labor and delivery
- Preparation for parenting – breastfeeding
- Newborn screening
- Family planning

Standards Content

G. Development of a Care Plan

- Addresses problems identified in risk assessment
- Relevant exchange of information between providers
- Assist in accessing medical, dental, nutritional, psychosocial, substance abuse services
- Coordinate labor and delivery site with prenatal care
- Pre-booking for delivery

Standards Content

H. Prenatal Care Services

- Clinical standards of care including:
 - HIV services
 - Dental care
 - Immunizations
 - Lead poisoning prevention/testing/mgt.
 - Medical indications for ultrasound
 - Screening for genetic disorders
 - Tests for fetal well-being

Standards Content

I. Postpartum Services

- Visit 4-6 weeks after delivery; no later than 8 weeks (sooner for complicated gestation or delivery)
- Services included in a visit
- Assess need for postpartum home visitation

Quality Monitoring – How will we assure that standards are met?

- Data from administrative data bases
 - Medicaid FFS/APG claims
 - Managed care encounter data
 - Managed care performance data – QARR/HEDIS
 - NYS vital records
- Data from other sources
 - Medical record review – IPRO
 - Managed care plan on-site surveys
 - D & TC clinic on-site surveys – Targeted
 - Member surveys
- Audit authority remains
- Current reports

Standards on DOH Website

- http://www.nyhealth.gov/health_care/managed_care/docs/nys_medicaid_prenatal_care_standards.pdf
- http://www.nyhealth.gov/health_care/medicaid/program/index.htm

Presumptive Eligibility

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Chapter 484 of the Laws of 2009

- Income eligibility levels for presumptive eligibility
- Presumptive eligibility by all Article 28s providers of prenatal care

What is Presumptive Eligibility (PE)?

Presumptive eligibility is a means for pregnant women who appear Medicaid eligible to immediately obtain Medicaid coverage for prenatal care services - pending a full Medicaid eligibility determination

Provider Responsibilities for PE Determinations

- Screen pregnant women for Medicaid eligibility
- Assist women who screen eligible in completing Medicaid application (DOH-4220)
- Provide pregnant woman with PE Determination letter

Provider Responsibilities for PE Determinations

- Submit screening to local upstate departments of social services within 5 days
- Assist women in the application process
- NYC-submit screening, application and documentation to MAP at HRA
- Upstate and NYC – assist pregnant woman in selecting Medicaid managed care plan
- Eligibility requirements and methods have NOT changed

Requirements to Perform PE Determinations

- No qualified provider application
- Complete on-line training, available at <http://www.bsc-cdhs.org/eLearning/>
- Must complete training and coordinate with county Social Services/HRA to perform PE
- SDOH will monitor organizations trained

Medicaid Prenatal Care Coverage and Payment Policy

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Outline

- Ongoing Implementation Activities
- Implications for PCAP Providers
- Status of APG Implementation
- Medicaid Payment Policy for Prenatal Care
- Primary Care Enhancements
- Perinatal Home Health Care Visit Policy

Ongoing Implementation Activities

Implementation Activities to Promote New Standards

- Provider Outreach and Communication
 - Special edition of Medicaid Update
 - Speaking engagements with stakeholders
 - Targeted training for Article 28s and PCAPs
- Revisions to DOH Prenatal Care Website
 - Post new prenatal care standards for providers
 - Identify providers of presumptive eligibility by county for consumers
 - Post new policy and billing guidance for prenatal care services
- Add Materials to DOH APG Website
 - Post new policy and billing guidance for prenatal care services
 - Post frequently asked Q and As targeted to prenatal care providers
 - Post updated APG Provider manual
 - Post announcements re: end-dating PCAP rate codes on “Known Issues List”

Implementation Activities (continued)

- Notify Article 28 providers of new requirement to perform presumptive eligibility determinations for pregnant women
 - How to register staff for on-line training
 - Need to designate PE coordinator
 - DOH monitoring activities
- Notify PCAP providers of Chapter 484 of the Laws of 2009
 - PCAP close-out/transition issues
- DOH Internal Activities
 - End-date PCAP rate codes (already done for APG billers)
 - Delete/amend regulations at 10 NYCRR Sections 85.40 and 86-4.36
 - Rescind PCAP state plan amendment.

Implications for PCAP Providers

Implications for PCAP Providers

- No longer will be recognized by NY Medicaid as specialty prenatal clinics.
- As with any other Medicaid enrolled Article 28 provider of prenatal care services,
 - must have “prenatal services” included on their operating certificate for all sites offering prenatal care,
 - must screen pregnant women for presumptive eligibility,
 - must provide comprehensive prenatal care services, consistent with new prenatal care standards,
 - must bill for prenatal care services using APG rate codes,
 - will be subject to monitoring and oversight for adherence to new prenatal care standards.

Implications for PCAP Providers (continued)

- DOH will no longer certify/approve new PCAP providers.
- PCAP Annual Reports will no longer be required.
- Routine PCAP site visits will no longer occur.
- PCAP rate codes will be end-dated upon implementation of APGs.
 - APGs are currently in use by hospital OPDs providing prenatal care, including PCAPs. Their PCAP rate codes have been end-dated.
 - APGs will be implemented in D&TCs providing prenatal care, including PCAPs, upon CMS approval.
- PCAP rate codes also will be end-dated for FQHCs.
 - FQHCs have the option of participating in APGs. FQHCs that opt not to use APGs will have their PCAP rate codes end-dated and be reimbursed for prenatal care services using their existing PPS rates.
 - FQHCs will be notified when their PCAP rate codes are end-dated.

Goals of Prenatal Care Legislation

- Build on the success of PCAP
- Increase access to quality, comprehensive prenatal care for **all** pregnant women with Medicaid
- Update comprehensive prenatal care standards
- Make them applicable to **all** Medicaid providers and to all pregnant women with Medicaid regardless of venue of care.

Benefits of APGs

- Under APGs, prenatal care providers will be paid for the services coded on the claim associated with each prenatal visit, rather than the outdated PCAP payment rate for the initial, follow-up and post partum visits.
- APG rate codes will be used instead of PCAP rate codes, for most services.
- APG payments will be based on the diagnoses of the patient and the services provided and will reimburse at higher rates for more complex patients.
- As with PCAP rates, the cost of properly coded ancillary lab and radiology services will be included in the APG payment to the prenatal care provider, except for the professional component of radiology services.
- APG claims will provide information on actual services provided.
- The APG methodology can rapidly accommodate changes in prenatal care standards and patterns of care delivery.

Status of APG Implementation

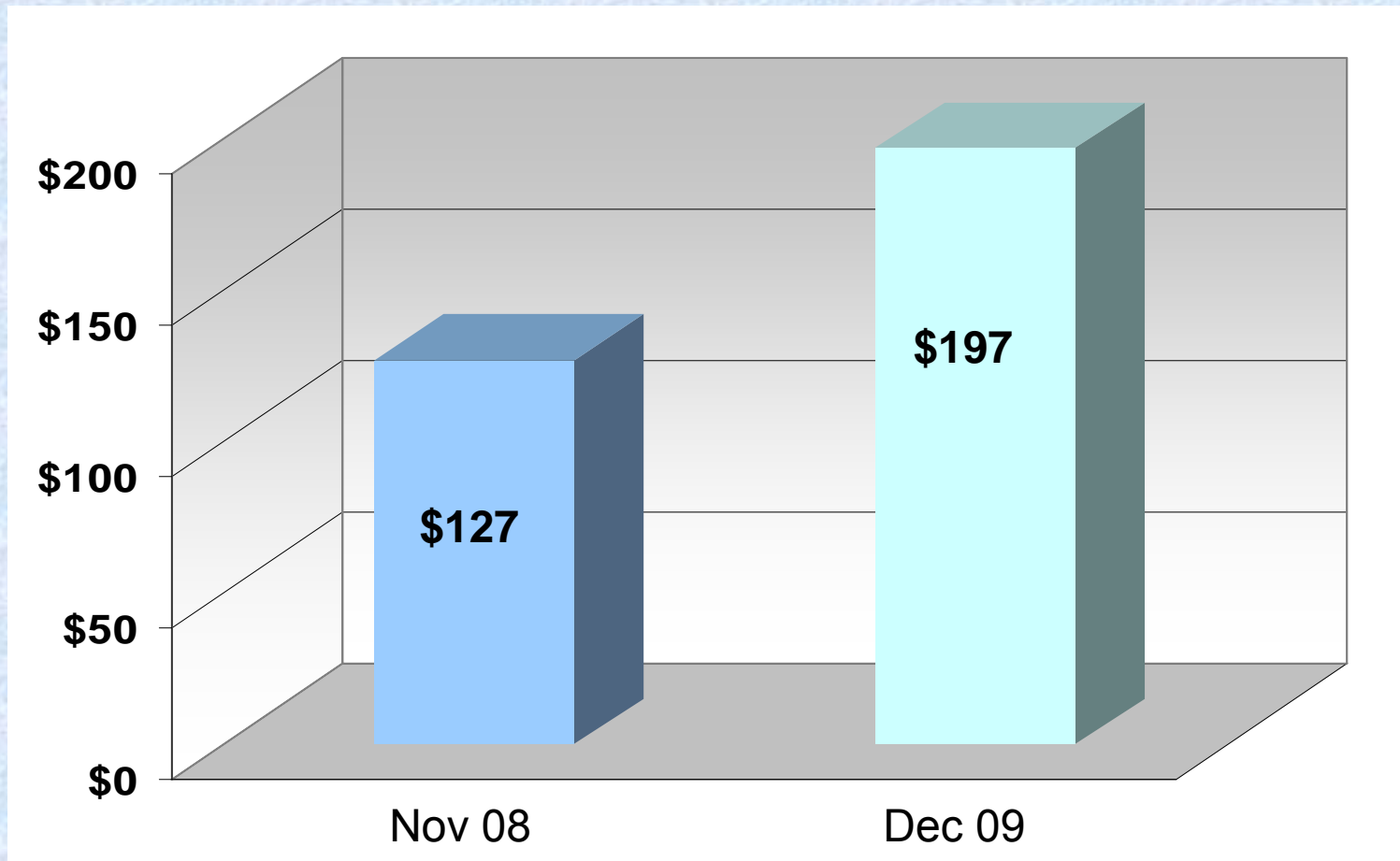
APG Time Line

- Chapter 53 of the Laws of 2008 established new Medicaid FFS payment methodology based on Ambulatory Patient Groups (APGs)
- Applicable to most hospital and clinic outpatient services
 - Implemented in hospital based outpatient and ambulatory surgery units December 1, 2008
 - Implemented in hospital emergency departments January 1, 2009
 - Will be implemented in freestanding D&TCs and ambulatory surgery units upon CMS approval, retroactive to September 1, 2009.
- Phased-in over several years
- Planned expansion of APG payment methodology to:
 - Programs licensed under OMH---March 31, 2010 (more likely later)
 - Programs licensed by OASAS---July 1, 2010
 - Programs licensed by OMRDD--- January 1, 2011

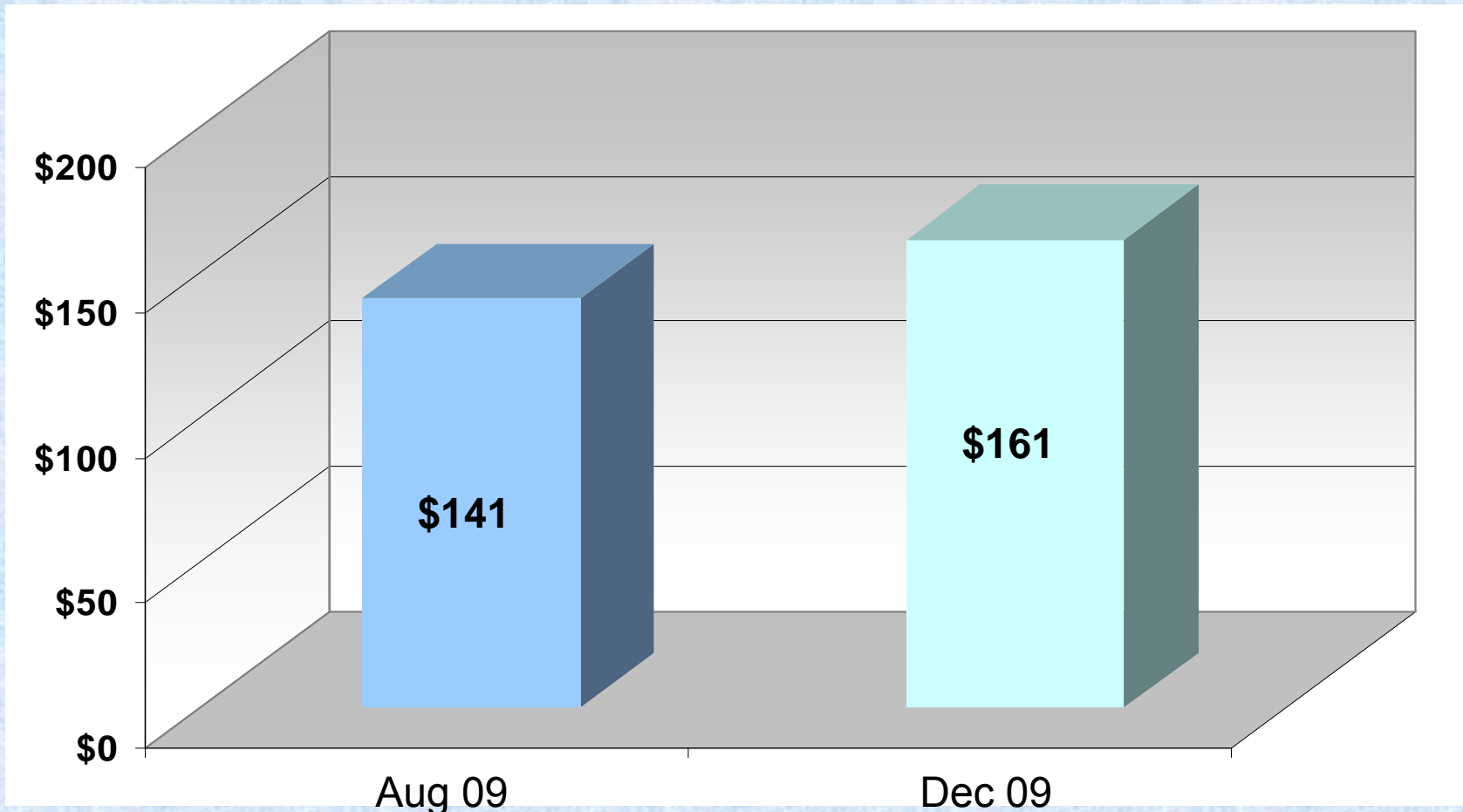
New York Has Invested Over \$600 M in Ambulatory Care

(Gross \$ in Millions)	Approved in SFY 08/09	Additional Funding Approved in SFY 09/10	Total Investment SFY
	<u>Budget</u> <u>(Full Annual)</u>	<u>Budget</u> <u>(Full Annual)</u>	<u>10/11</u> <u>(Full Annual)</u>
Hospital Programs	\$178.0	\$92.0	\$270.0
Outpatient Clinic	\$88.0	\$92.0	\$180.0
Ambulatory Surgery	\$40.0	\$0.0	\$40.0
Emergency Room	\$50.0	\$0.0	\$50.0
Freestanding Programs	\$12.5	\$37.5	\$50.0
Primary Care Investments	\$38.0	\$90.1	\$128.1
Asthma and Diabetes Education (08/09 Enacted)			
Expanded "After Hours" Access (08/09 Enacted)			
Social Worker Counseling (08/09 Enacted)			
Smoking Cessation (08/09 Enacted)			
Nurse Family Partnership (08/09 Enacted)			
Cardiac Rehabilitation (09/10 Enacted)	N/A		
SBIRT (09/10 Enacted)	N/A		
Smoking Cessation (09/10 Enacted)	N/A		
Primary Care Standards/Medical Home (09/10 Enacted)	N/A		
Adirondack Medical Home (09/10 Enacted)	N/A		
Physicians	\$120.0	\$68.0	\$188.0
Mental Hygiene Enhancements	N/A	\$2.7	\$2.7
Detoxification Services Reform			
TOTAL	\$348.5	\$290.3	\$638.8

Impact of Investment: Hospital Clinic Rates Up 55%



Impact of Investment: Diagnostic & Treatment Center Rates Up 15%*



* Awaiting CMS approval of APG implementation.

APG Methodology Consistent with Rate Reform Goals

- Medicaid rates should:
 - Be straightforward and transparent
 - Buy value-high quality, cost effective care
 - Encourage care in the right setting
 - Reinforce health planning and policy priorities
 - Be updated periodically
 - Pay for Medicaid patients
 - Comply with federal Medicaid rules
 - Be consistent with state budget constraints

What are APGs?

- A classification system designed to identify the amount and type of resources used in ambulatory visits that:
 - Predicts the average pattern of resource use for a group of patients by combining procedures, medical visits and/or ancillary tests that share similar characteristics and resource utilization;
 - Provides greater reimbursement for higher intensity services and less reimbursement for low intensity services; and
 - Allows more payment homogeneity for comparable services across all ambulatory care settings (e.g., outpatient department and diagnostic and treatment centers).

APG's Clinical Strengths

- Superior to outdated “threshold visit” rates.
- Payment varies based on service intensity.
- Payment homogeneity for comparable services across ambulatory care settings
 - relative payment “weights” do not vary by setting
 - base rates do vary to recognize differing cost structures between settings.
- Emphasizes diagnosis and procedures over service volume.

APG's Methodological Advantages

- Recognized and tested payment system.
- Enables prospective pricing for Ambulatory Care.
- Grouping and payment logic similar to DRGs.
- Uses standard HIPAA-compliant code sets (HCPCS and ICD-9 codes)
- Uses current HIPAA compliant claim formats.
- Greater clarity and transparency of payment structure and methodology.
- Features more frequent payment updates to:
 - Better acknowledge the impact of medical advances, and
 - Accommodate changes in service delivery patterns.
- Four year transition using “blend” to allow providers time to adjust to new payment methodology.

THREE PRIMARY TYPES OF APGS

- **SIGNIFICANT PROCEDURE**

- A procedure which constitutes the reason for the visit and dominates the time and resources expended during the visit. Examples include: excision of skin lesion, stress test, treating fractured limb.

- **MEDICAL VISIT**

- A visit during which a patient receives medical treatment (normally denoted by an E&M code), but did not have a significant procedure performed. E&M codes are assigned to one of the approximately 200 medical visit APGs based on the diagnoses shown on the claim (usually the primary diagnosis).

- **ANCILLARY TESTS AND PROCEDURES**

- Ordered by the primary physician to assist in patient diagnosis or treatment. Examples include: immunizations, plain films, laboratory tests.

APG Payment Definitions

- **Consolidation or Bundling**
 - The inclusion of payment for a related procedure into the payment for a more significant procedure provided during the same visit.
 - CPT codes that group to the same APG are consolidated.
- **Packaging**
 - The inclusion of payment for related medical visits or ancillary services in the payment for a significant procedure.
 - The majority of “Level 1 APGs” are packaged.
(i.e. pharmacotherapy, lab and radiology)
 - Uniform Packaging List is available online at the DOH APG website.
- **Discounting**
 - A discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies.
 - If two CPT codes group to different APGs, 100% payment will be made for the higher cost APG, and the second procedure will be discounted at 50%.

IMPORTANCE OF ACCURATE MEDICAL CODING

- Under APG payment methodology, all claims must include:
 - the new APG rate codes;
 - a valid, accurate ICD-9-CM primary diagnosis code*; and
 - valid CPT and/or HCPCS procedure codes reflecting services provided.

*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 chiefly responsible for the services provided.

- Reimbursement for an Evaluation and Management (E & M) visit is 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.
- Secondary diagnoses or additional codes that describe any coexisting conditions should also be coded, as certain significant conditions may be used in place of the primary diagnosis to group the medical visit, and could result in higher payment.

Specialty Rate Codes Not Subsumed Under APGs

(for complete list see DOH APG website)

- Moms Health Supportive Services (1604)
- Dialysis/Medicare Crossover (3107)
- HIV Counseling and Testing by AIDS Designated Centers
- Tuberculosis DOT
- Newborn Hearing/Screening Services(3139)
- CMCM/Targeted Case Management
- FQHC Group Psychotherapy (4011)/Off-site Services(4012)
- Screening for Orthodontic Treatment (3141)
- Mental Health Counseling by LCSW and LMSWs (new)

Services and Procedures Carved Out of APGs

(For complete list see [DOH APG website](#))

- Chemotherapy Drugs
- Specific therapeutic injectables
- Specific Blood Factors/Hemophilia
- Some Medical Abortion Pharmaceuticals
- Certain Family Planning Devices
- All Genetic Laboratory Tests
- Some other designated laboratory tests
 - Lead tests
 - HIV viral load testing
 - HIV drug resistance tests
 - Hep C virus, genotype tests

Medicaid Payment Policies Related to New Prenatal Care Standards

Payment Policies: Commonly Asked Questions

- Urine Pregnancy Test-(81025)
 - Considered a packaged ancillary when performed in conjunction with an E&M medical visit (no separate line payment)
 - Must be billed using ordered ambulatory fee schedule when performed by a RN/LPN (within scope of practice and under a patient specific order) and patient does not see a physician, PA, RNP or LM. In such instances an E&M code may not be billed by the clinic.
- Screening for Presumptive Eligibility
 - PE screening is not a medical service and is not reimbursable under APGs.
- Interpreter/Translation Services
 - Translation services are not currently reimbursable under APGs.

Payment Policies: Commonly Asked Questions

- Prenatal Care Enhanced Service Package (H1005)
 - new code added to grouper/pricer 1/1/2010
 - may be used to code combined health supportive services including antepartum management, prenatal care coordination, and prenatal at risk education
 - maps to APG 490 and has a procedure specific weight of .0690
 - must be billed in conjunction with a medical or significant procedure visit to be reimbursed
 - may be billed once for each prenatal visit billed under APGs.

Payment Policies: Commonly Asked Questions

- Nutrition Screening, Counseling and Referral-Med Nutrition (97802-97803)
 - new codes added to grouper/pricer 1/1/2010
 - may be used for nutrition assessment and counseling
 - map to APG 490 and have procedure specific weight of .1793
 - must be billed in conjunction with a medical or significant procedure visit to be reimbursed
 - may bill up to two units, on a single claim line, per prenatal visit when service is provided.
- Prenatal vitamins
 - Prenatal vitamins are covered by Medicaid as a pharmacy service.
 - Not reimbursable to clinics under APGs
 - Clinics may choose to provide vitamins or issue a fiscal order to be filled at a pharmacy.

Payment Policies: Commonly Asked Questions

- **Obstetrical Ultrasound**
 - Considered an ‘if stand alone, do not pay,’ ancillary laboratory service
 - Must be billed on a claim with an E&M medical visit or significant procedure
 - Maps to APG 470 with a new weight of .9405, will pay at the line level
 - Payment to clinic will not include professional component of radiologic service.
- **Lead Poisoning Prevention Testing**
 - Lead testing is carved out of APGs.
 - Providers of these services should bill Medicaid using the laboratory fee schedule.
- **Screening for Genetic Disorders**
 - Effective 1/1/2010 all genetic testing is carved out of APGs
 - Providers of these services should bill Medicaid using the laboratory fee schedule.

Payment Policies: Commonly Asked Questions

- HIV Testing and Counseling
 - Rate codes for HIV Counseling and Testing (2983/1695), Post Test HIV Counseling (3111/1802), HIV Counseling Visit-No Testing (3109), AIDs Therapeutic Visit (2961), and Day Health Care Services(1850) are assigned to Aids Designated Centers and are carved-out of APGs.
 - Prenatal clinics that are also AIDS Designated Centers may bill for the HIV Counseling and Testing services listed above using the appropriate rate codes in addition to submitting an APG claim for prenatal services provided on the same date of service.
 - All other medically necessary HIV services are reimbursable under APGs.

Payment Policies: Commonly Asked Questions

- Immunizations
 - Seasonal flu, H1N1 and pneumococcal flu vaccines are carved-out of APGs and should always be billed using the ordered ambulatory fee schedule.
 - All other immunizations, when performed in conjunction with an E &M medical visit, should be billed through APGs and the clinic will be paid for vaccine and its administration (two separate cpt codes on two separate lines).
 - When an immunization (including HPV and Hep-B) is performed by an RN/LPN (within their scope of practice and under patient specific order) and the patient does not see a physician, PA, RNP or LM, the clinic may submit an APG claim for the vaccine and the administration but an E&M code should not be claimed.
 - For immunizations of persons under age 19, the vaccine is covered under the Vaccines for Children Program. In such instances the prenatal clinic should bill for vaccine administration using the procedure code for the vaccine, appended with the “SL” modifier (to indicate a state supplied vaccine).

Payment Policies: Commonly Asked Questions

- **Physician Services**

- Payment for physician services will be included in the APG payment to DT&Cs.
- Effective 2/1/2010 in hospital OPDs, a separate physician claim can be submitted in addition to the APG claim for any services billable against the fee schedule, regardless of the employment status of the physician. (Consistent with existing Medicaid policy, interns and residents may not bill for their professional services in OPDs, but supervising and teaching physicians may bill under specified conditions).

- **Dental Services**

- Dental and clinic services provided on the same date of services and associated ancillaries must be billed on a single claim using APG rate codes.
- Effective 1/1/2010, non-dental medical visits will pay at the line level when coded on the same claim as dental procedures or exams (i.e., medical visits will no longer package with dental procedures when performed on the same date of service).
- Multiple same APG discounting (rather than consolidation) applies to all dental procedures including dental sealants.
- Effective 2/1/2010, dentists may not bill the fee schedule for professional services in clinic settings except for orthodontia.

Lab and Radiology Ancillary Billing Policy

- Under APGs, most lab and radiology services provided by the clinic or referred to an outside provider are the fiscal responsibility of the clinic even in the absence of a contractual relationship between the parties.
- The medical visit and/or significant procedure as well as all ancillary lab and radiology services must be reported on the APG claim.
- The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of a radiology service.

Patient Referral to Ancillary Service Providers

- Clinics may have contracts with laboratory and radiological vendors for ancillary services.
- However, recipients cannot be directed to use contracted vendors, as they may use any enrolled provider.
- Some clinics have reported that they make appointments for their patients with contracted lab/radiology vendors to encourage the use of contracted providers.
- Clinic is responsible for paying the individual or entity providing the ancillary service even in the absence of a contractual relationship with the ancillary service provider.
 - *Payment amounts for ancillary services are negotiated between the ordering clinic and ancillary services provider.*

Clinics are responsible for:

- Advising outside lab and radiology service providers that the ordered test is part of a clinic visit and subject to APG reimbursement.
- Instructing the lab/radiology provider that the ordering clinic should be billed for the ancillary service.
- Reimbursing the laboratory/radiology provider for all ancillary procedures ordered as part of a clinic visit which have been provided to the patient.

Billing Options

- APG Visit Payment
 - *Use rate code 1400 (OPD) or 1407 (D&TC)*
 - *“Reassign” the actual date of service for the ancillary to the same date of service of the medical visit or significant procedure at the line level.*
 - *Ancillary will not be viewed by the payment system as a stand alone.*
 - *OPDs should not use visit rate codes after December 31, 2009, except for claims for Medicare/Medicaid dual eligibles.*
 - *APG Episode Payment*
 - *Use rate code 1432 (OPD) or 1422(D&TC).*
 - *Report the actual dates of service for E&M/significant procedure and dates of service for each associated lab/radiology ancillary at the line level.*

Episode Based Payment

- An episode is defined as all medical visits and/or significant procedures that occur on a single date of service and any associated ancillary services that occur on or after the date of the medical visit and or significant procedure.
- Effective 1/1/2010, episode rate codes should always be used by OPDs except when submitting claims for Medicare/Medicaid dually eligible patients.

Episode payment (cont.)

- Only a single episode (e.g., medical visit and/or significant procedure on a single date of service plus associated ancillaries, regardless of their dates of service) may be coded on a claim.
- If procedures from two different episodes of care are coded on the same claim, unwarranted discounting or consolidation could occur, resulting in underpayment to the APG biller.
- As with the visit payment, 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 will be reimbursed.

Claims Submission

- Two billing options available;
 - *Submit the APG claim (medical visit/significant procedure with ancillaries) upon confirmation that all ancillary services have been provided to the patient.*
 - *Must be submitted within 90 days of the date of service.*
 - *This is the preferred billing method.*
 - *Submit the APG claim for the medical visit/significant procedure only.*
 - *Must be submitted within 90 days of the date of service.*
 - *After confirmation that all ordered ancillary services have been provided the clinic may submit a claim adjustment that reports the office visit/significant procedure and all completed ancillary tests.*
 - *If a claim for the medical visit/significant procedure has already been submitted without the lab/radiology ancillary services, an adjusted claim should be submitted for the lab/radiology ancillary service within 30 days of receipt of the ancillary results.*
- If the ancillaries are provided more than 90 days after the clinic visit, then the clinic should submit an adjusted claim to report the ancillaries.
- A 90 day letter is not needed for claim adjustments.

Billing for Prenatal Care Services

- Providers must use new episode rate codes to submit claims for prenatal care services for most women.
 - Hospital OPD-1432
 - Freestanding D&TC-1422 (upon APG implementation)
- Claims for women with Medicare/Medicaid dual eligibility must be submitted using APG visit rate codes.
 - Hospital OPD-1400
 - Freestanding D&TC-1407 (upon APG implementation)
- New MR/DD/TBI rate codes pay a 20% bump for patients with RE code 95 or 81.
 - Hospital OPD MR/DD/TBI-1489(episode)/1501(visit)
 - Freestanding D&TC MR/DD/TBI-1425(episode)/1435(visit)
- See DOH APG website for complete list of APG rate codes.

Primary Care Enhancements

Smoking Cessation Counseling

- Medicaid now reimburses office based providers and Article 28 OPDs for smoking cessation counseling for pregnant and postpartum women and children and adolescents ages 10 through 20.
- Reimbursement for these services will be available to D&TCs upon APG implementation.
- This counseling complements existing Medicaid benefits for smoking cessation, which include prescription and nonprescription smoking cessation products.

Smoking Cessation Counseling (Cont.)

- Smoking Cessation Counseling Benefit:
 - **ONLY** available to pregnant and postpartum women (up to six months postpartum); and to children and adolescents ages 10 through 20, who smoke.
 - Must be provided face-to-face by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife **during a medical visit**. (No group sessions).
 - May be billed by a physician, an RNP, an LM, or Article 28 OPD, D&TC, or FQHC that bills using APGs.
 - Pregnant women will be allowed six (6) counseling sessions during their pregnancy.
 - Postpartum women will be allowed six (6) counseling sessions during the 6 month postpartum period.
 - Children and adolescents ages 10 through 20 will be allowed up to six (6) counseling sessions in a continuous 12-month period.

Smoking Cessation Counseling ...cont.

- Reimbursement requirements
 - Claims must include the appropriate SCC CPT procedure code. Only one procedure code per day may be billed.
 - 99406- Intermediate SCC, 3 to 10 minutes
 - 99407- Intensive SSC, greater than 10 minutes
 - Since SCC must be provided during a medical visit, the appropriate CPT Evaluation & Management codes and or the appropriate Preventive Medicine codes must be included, **except** an E&M code is not necessary for practitioners billing for Global Obstetrical care at the end of a pregnancy
 - Practitioners and clinics must use the appropriate ICD-9 codes:
 - 305.1 tobacco use disorder. (use for children and adolescents 10-20)
 - 649.03 tobacco use disorder complicating pregnancy, childbirth or the puerperium-antepartum. (use for pregnant women who smoke)
 - 609.04 tobacco use disorder complicating pregnancy, childbirth or the puerperium-postpartum. (use for postpartum women who smoke)

Mental Health Counseling by Licensed Clinical Social Workers (LCSW)/ Licensed Master Social Workers (LMSW)

- Reimbursement available to Article 28 clinics
- For mental health counseling to pregnant and postpartum women and adolescents and children up to age 21
- When ordered by a physician and provided by Licensed Clinical Social Workers (LCSWs) or Licensed Master Social Workers (LMSWs) under direction of an LCSW
- Effective upon CMS approval.
- Reimbursement will cover mental health counseling services provided to pregnant women up to 60 days post-partum (based on the date of delivery or end of pregnancy)
- Counseling is expected to be short term, of limited duration and incidental to general health care.

Mental Health Counseling by LCSW/LMSW (Cont)

- Women must have a primary or secondary diagnosis of pregnancy or postpartum depression.
- Three new rate codes for levels of mental health counseling are as follows:
 - 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).

Asthma & Diabetes Self-Management Training

- Medicaid now also covers asthma and diabetes self-management training (ASMT and DSMT) services for persons diagnosed with asthma and/or diabetes when such services are:
 - ordered by a physician, registered physician assistant, registered nurse practitioner or a licensed midwife, and
 - provided by a New York State licensed, registered or certified professional who is also certified as an educator by the National Asthma Education Certification Board (CAE) or the National Certification Board for Diabetes Educators (CDE) who is practicing within the scope of practice appropriate to his or her respective discipline as defined by the NYSED Office of the Professions.
- Services are billable in physicians' offices and OPDs and DTCs upon APG implementation when provided by employed or contracted CAEs or CDEs.
- If a provider does not offer ASMT or DSMT, he/she may refer a patient to a Medicaid practitioner or clinic that does employ or contract with CAEs or CDEs.
- An FQHC may bill for this service only if it has elected to be reimbursed under APGs.

ASMT Services

- ASMT services are to be provided by a NYS licensed, registered, or certified health care professional, who is certified as an educator by the National Asthma Educator Certification Board (NAECB).
- ASMT services may be rendered in:
 - Physicians' offices
 - Hospital Outpatient Departments
 - Free-Standing Clinics
- Newly diagnosed patients or patients with medically complex conditions (such as poor asthma control, exacerbation of asthma, complications, etc.) will be allowed up to 10 hours of ASMT during 6-continuous months.
- Medically stable patients may receive up to 1 hour of ASMT services in 6- continuous months.
- Self management services may be provided in individual sessions or in group sessions of no more than eight patients.
- In APGs, billable at line level using units, max 4 half hour units per visit.

DSMT Services

- DSMT services are to be provided by a NYS licensed, registered, or certified health care professional, who is certified as an educator by the National Certification Board for Diabetes Educators (NCBDE).
- DSMT services may be rendered in:
 - Physician's offices
 - Hospital OPDs
 - Free-Standing Clinics
- Newly diagnosed patients or patients with medically complex conditions (such as poor diabetes control, exacerbation of diabetes, complications, etc.) will be allowed up to 10 hours of DSMT during 6 continuous months.
- Medically stable patients may receive up to 1 hour of DSMT services in 6 continuous months.
- Self management services may be provided in individual sessions or in group sessions of no more than eight patients.
- In APGs, billable at line level using units, max 4 half hour units per visit.

Expanded Payment for “After Hours” Access

- A supplemental payment amount is available for appointments scheduled to occur on evenings, weekends and holidays as defined by the Department of Health.
- This payment is effective for patient visits in physician offices and OPDs for services provided.
- Patient visits in D&TCs will be eligible for this additional reimbursement for services provided upon implementation of APGs.
- This payment will be added to the otherwise applicable payment amount for each such visit.
- Clinic reimbursement for expanded hours access will be added to a facility's APG payment for services rendered.

Service	HCPSC	APG or Rate Code	OPD-statewide average payment	D&TC-statewide average payment	Max Units per visit
Diabetes SMT-Ind	G0108	428	\$22.76	\$19.72	4
Asthma SMT-Ind	98960	428	\$22.76	\$19.72	4
Diabetes SMT-Group	G0109	429	\$11.38	\$9.86	4
Asthma SMT-Group	98961/ 98962	429	\$11.38	\$9.86	4
Smoke CC, 3-10 min	99406	451	\$18.15	\$15.73	units na
Smoke CC, >10 min	99407	451	\$18.15	\$15.73	units na
Social Worker Counseling-Individual-Brief	90804	4257	\$41.00	\$41.00	units na
Social Worker Counseling-Comprehen.	90806	2458	\$62.00	\$62.00	units na
Social Worker Counseling-Family	90846/ 90847	4259	\$70.00	\$70.00	units na
After Hours	99050/ 99051	488	\$12.52	\$10.85	units na

Perinatal Home Health Visit Policy

Medicaid Coverage of Perinatal Home Health Care Visits

- Medicaid provides payment for **medically necessary** home health care services to eligible persons by enrolled providers.
- Home health services include skilled nursing home health care visits to pregnant or postpartum women.
- A skilled nursing prenatal or postpartum visit includes three components:
 - A **comprehensive assessment** (medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills); and
 - **Skilled nursing care** for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring; and
 - **Communication of findings**, plans and patient needs to the mother or child's physician and/or case manager.

Perinatal Home Health Visits

- Who is eligible to receive services?
 - Pregnant or postpartum women with full or presumptive Medicaid eligibility
- Who is eligible to provide services?
 - Certified Home Health Agencies enrolled in Medicaid
 - Licensed Home Care Agencies under contract with CHHAs enrolled in Medicaid.
- Under what conditions ?
 - Always requires a physician's order,
 - Must be medically necessary, and
 - Must ordered by patient's attending physician and documented in the plan of treatment.

Required Conditions...cont.

- **Exception:** In the absence of an attending physician or when the physician may not be reached in a timely manner, the County Health Commissioner or Medical Director's order is acceptable for an initial home visit.
- Prior approval may be required for coverage of home health visits for women enrolled in a Medicaid or Family Health Plus Plan.
- Women enrolled in Medicaid are presumed eligible for one medically necessary postpartum home health care visit.

Medical Necessity Criteria

- High medical risk pregnancy as defined by ACOG, AAP guidelines;
- Identified need for home monitoring or assessment for a medical condition complicating pregnancy;
- No or inconsistent prenatal care; or
- Identified need for home assessment for suspected environmental or psychosocial risk.

Other Requirements

- Federally Required Documentation for CHHA Visits
 - Written plan of care based on comprehensive assessment after a minimum of an initial home visit;
 - Timely notification/communication with attending physician on significant changes;
 - Referral and coordination with appropriate health, mental health, social services and other providers;
 - Review and revision of the plan of care plan at least monthly; and
 - An appropriate discharge plan.
- Medicaid Limits on Billing
 - Cannot bill for both infant and mom for same visit.
 - Cannot bill as CHH visit and MOMs visit.

Supporting Materials

- **Link to DOH APG Website**
[http://www.nyhealth.gov/health_care/medicaid/rates/apg/\)](http://www.nyhealth.gov/health_care/medicaid/rates/apg/)
- **Link to APG Policy and Billing Guidance Provider Manual**
[http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual\)](http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual)
- **Medicaid Update Link for Article on Smoking Cessation Counseling:**
http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-12.htm#smo
- **Medicaid Update Link for Article on LCSW/LMSW:**
http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-03.htm#med
- **Medicaid Update Links for Articles on Diabetes and Asthma Self Management:**
http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-03.htm#cer
http://www.nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#dia
- **Medicaid Update Link for Article on Enhanced Payment for Expanded "After Hours" Access:**
http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-12.htm#inc

Additional Supporting Materials

- The following is available on the DOH website
 - (http://www.nyhealth.gov/health_care/medicaid/rates/apg/)
 - Provider Manual
 - (http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual)
 - PowerPoint Presentations
 - Revised APG Rate Code Lists
 - Updated APG Weights and Procedure Specific Weights
 - Significant Procedures List with which Medical Procedures Do Not Package
 - Uniformly Packaged APGs
 - Inpatient-Only Procedure List
 - Never Pay and If Stand Alone Do Not Pay Lists
 - Carve-Outs List
 - List of Rate Codes Subsumed in APGs
 - Frequently Asked Questions

Contact Information

- **Grouper / Pricer Software Support**
3M Health Information Systems
 - Grouper / Pricer Issues 1-800-367-2447
 - Product Support 1-800-435-7776
 - <http://www.3mhis.com>
- **Billing Questions**
Computer Sciences Corporation
 - eMedNY Call Center: 1-800-343-9000
 - Send questions to: eMedNYProviderRelations@csc.com
- **Policy and Rate Issues**
New York State Department of Health
Office of Health Insurance Programs
Div. of Financial Planning and Policy 518-473-2160
 - Send questions to: apg@health.state.ny.us