APG Payment Methodology/Coverage:

Q: Is it accurate that up to 16 diagnoses will be accepted by the APG Grouper Pricer, but only the first six will be used to map to an APG?

A: Up to 18 diagnoses will be accepted by the APG Grouper Pricer, but only the first 11 will be used to map to an APG.

Q: If a clinic submits a claim for nail debridement (performed by a podiatrist) and an E&M (another diagnosis), will these procedures bundle?

A: The APG grouper pricer logic bundles E&Ms into significant procedures. Nail debridement is a significant procedure. The E&M will therefore bundle into the nail debridement when both procedures are performed on the same date of service.

Q: Please explain how nutrition services are reimbursed through the APG payment methodology. Nutrition codes do not seem to have a relative weight assigned.

A: There are seven HCPCS Codes assigned to APG 118- Nutrition Therapy. However only five (97802-97804 & G0270-G0271) have a procedure based weight and will reflect a line level payment if provided in conjunction with another type of service**.**

Q: Vision Therapy 92065 was on the Biofeedback list before. Is it still there? Is Vision Therapy covered under the APG system?

A: Procedure code 92065 - Orthoptic/pleoptic training currently groups to APG 427 (Biofeedback and other training) and has a procedure-based weight.

Anesthesia:

Q: Why is modifier 74 (procedure discontinued after administration of anesthesia) not included under APG's? Should we bill the procedure without a modifier?

A: Modifier 73, Terminated Procedure, should be reported if the surgical procedure is terminated prior to administration of anesthesia. If the surgical procedure is terminated after administration of anesthesia, the service is not covered by Medicaid.

Q: When should the after-hour codes, 99050 and 99051, be billed to Medicaid?

A: After hour add-on payments, billed using CPT codes 99050 and 99051, are 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 will be added to the otherwise applicable payment amount for each such visit. An evening visit is one which is scheduled and occurs after 6:00 p.m. A weekend visit is one which is scheduled for and occurs on Saturday or Sunday. A holiday visit is one which is scheduled and occurs on a designated national holiday

Ancillary:

Q: Do we have to include a CLIA number on the claim when we are coding ancillary services on the claim?

A: No, a CLIA number does not need to be entered on the claim when coding for ancillary services that have been ordered for the Medicaid recipient.

Q: If we order an ancillary service and the patient doesn't have it done, will it be deducted from our payment?

A: The ancillary service should not be reported on the APG claim until the clinic has received the results for the laboratory/diagnostic testing.

Q: Where do you put the modifier 90 on the claim?

A: The 90 modifier must be inserted on the same institutional claim form line with the respective CPT-4 procedure code being billed.

Q: As a Lab provider, do we bill Medicaid directly if we're not contracting with a clinic?

A: If a laboratory has not contracted with a clinic, the laboratory should bill Medicaid directly using the laboratory fee schedule.

Q: Can modifier 90 be used in episode rate billing? Or, is modifier 90 only applicable to visit rate billing?

A: Modifier 90 is applicable to both episode and visit rate code billing.

Q: If we do not contract for ancillary services, why do we need to provide the date that the test was done, not ordered?

A: The date must be provided on the claim irregardless of whether the visit or episode rate code is used for billing. For the visit rate code the provider must reassign dates of ancillary lab and radiology services at the line level to correspond to the date of the medical visit or significant procedure visit that generated the order for the ancillary service. For the episode rate code providers report the actual dates of service for all procedures which are part of the episode of care at the line level. The date of service for laboratory tests is the date that the specimen was collected from the patient. For radiology tests, the date of service is the date that the test results are reported to the ordering provider.

Q: Please define "in-house" for ancillaries. If we draw the blood but send the specimen out is this in-house or not?

A: If a blood specimen is drawn and sent out to a laboratory for processing and reporting this is not considered an in-house ancillary specimen. In-house refers to the lab test being performed on site at the clinic.

Q: If a clinic does not contract for ancillaries, but does the venipuncture on-site and sends the specimen to an outside lab for testing, how should this be billed to Medicaid?

A: The clinic should report the venipuncture as well as the lab tests ordered for their patient on their APG claim (without modifier 90), and the testing laboratory should bill Medicaid directly.

Q: If we choose not to contract with an outside vendor for ancillary services, will our base rate be re-adjusted to reflect that the clinic is not paying the testing laboratory?

A: The base rates will remain the same for all providers, regardless of provider contracting.

Q: If we do not contract with ancillary providers, but are required to list those charges on our encounter, will Medicaid reimburse the clinic for the ancillaries reported on the APG claim?

A: Ancillaries ordered by non-contracting providers must still be coded on the APG claim, but without the modifier 90. The clinic will not receive APG payment for these ancillaries. The ancillary vendor should bill Medicaid directly for services provided.

Q: Will the APG website identify hospital outpatient departments and D&TCs that are contracting for ancillary services?

A: Yes. The APG website will identify hospital outpatient departments and D & TCs that have contracted for ancillary services.

Q: If we are not contracting, how will we know what specific CPT code for ancillary radiology services to put on the claim if all we are getting are results?

A: The ancillary services provider (i.e., laboratory or radiology provider) will need to provide the ordering provider with the cpt codes that should be included on the clinic's APG claim.

Q: When using episode rate code, what date should be reported for ancillary services - test date or date of test results?

A: When using the episode rate code for billing for the ancillary services the provider must report the actual date of service for all procedures. For laboratory tests, the date of service is the date of specimen collection. For radiology tests, the date of service is the date that the test results are reported to the ordering provider.

Billing (Retro)/Rebilling/Claims Submission:

Q: Will we be penalized based on the 90 day rule, when a third party processes a claim 8 months after the date of service and the initial submission to Medicaid is 9 months after the DOS?

A: The policy regarding claim submission for dates of service greater than 90 days is found at:
http://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf

One of the acceptable reasons for late submission is "Third Party Processing Delay". Providers should use HIPAA Delay Reason Code "7" when submitting claims

beyond 90 days from the date of service and the reason for the delay is due to Medicare or other third party claims processing. Such claims must be submitted within thirty (30) days from the time submission came within the control of the Provider.

Q: What 90 day indicator do we use for the claims that we manually reprocess?

A: The 90 day rule does not apply to claim adjustments.

Q: What rate code should D&TCs use for DOS prior to 9/1/2009 - Rate Code 1610 or APG Episode Rate 1422?

A: For D&TCs - APG rate codes cannot be used for claims with dates of service prior to September 1, 2009. The only codes that are permissible are codes previously assigned to that facility (e.g., 1610, 1622, etc.).

Dental:

Q: I've been denied for some dental services, D5421, D0230 for code N19 (Proc. code incidental to primary procedure). CSC advised these were ancillary services and an office visit would need to be billed in order for these to be considered for payment. Is this correct?

A: D5421 (Dentures adjust part maxill) currently groups to APG 999 (unassigned). Since there is no corresponding line level payment for APG 999, a line item payment is not available for this procedure. D0230 (Intraoral periapical ea add) groups to APG 373 (Level I Dental Film). This is a "If Stand Alone Do Not Pay" procedure. Therefore, it will pay only when provided in conjunction with an oral evaluation, D0230.

Q: What is the rate code for dental visits? Do episode rate codes apply?

A: Dental services should be billed by D&TCs using APG visit rate code 1407(Visit) / 1422 (Episode). Dental APG rate codes 1428 (Visit) / 1459 (Episode) have been assigned to academic dental programs only (note - episode rate codes are not yet available for D&TCs but will be available in the near future). For more specific information on billing for dental services see Section 4.2 of the APG Provider Manual.

Q: Do dental claims have to be billed differently than other Article 28 medical clinic claims?

A: No, dental services should be billed using APG visit rate codes 1400/1432 by hospital OPDs, and 1407/1422 by D&TCs. Dental APG rate codes 1428/1459 have been assigned to academic dental programs only. For more specific information on billing for dental services see Section 4.2 of the APG Provider Manual.

Q: Will the episode rate code for dental, once activated, be retroactive?

A: No, the episode rate code will not be activated retroactive to September 1, 2009.

Episode and Visit Rate Codes:

Q: Please confirm the billing should be as follows: effective Jan 1, 2011, Medicaid-only billed with episode code, Medicare/Medicaid billed with visit code, Commercial/Medicaid billed with visit code?

A: Additional guidance will be issued to providers when the episode rate codes are activated for freestanding D&TC providers.

Q: What rate code should be used for a recipient who has Medicaid only? Do we use 1422 or 1435? What is the rate code for episode billing?

A: For D&TCs, rate code 1407 is the visit based rate code and rate code 1422 is the episode rate code. For enrollees with recipient exception codes 81 or 95, rate code 1435 is the visit rate code, while 1425 is the episode rate code. At this time, the episode rate codes are not active for freestanding D&TCs.

Q: How are payments affected when primary insurance does not cover the service?

A: For Medicare/Medicaid crossover patients, Medicaid generally defers to the Medicare payment decision, e.g., if Medicare denies payment because the service is determined to not be medically necessary, Medicaid cannot pay for that service.

If the enrollee has commercial insurance/Medicaid and the commercial insurance does not cover the service/procedure, Medicaid will pay for the service if it is medically necessary and the service is a Medicaid covered procedure.

Q: If modifiers (other than those on the APG modifier list) are present on claims that are to be reprocessed, how will this affect payment; will the modifier be ignored, or will the claim be denied?

A: Modifiers, other than those recognized in APGs, will not affect payment; however, facilities may choose to use them for purposes of following standard coding procedures.

DIALYSIS

Q: Will the episode rate code be replacing the visit rate code effective of 1/1/11?

A: Additional guidance will be provided when the episode rate codes are activated for D&TC provides.

Q: Will the D&TC dialysis visit rate code, 1438, remain active as of 1/1/11? If a claim is submitted listing hemodialysis provided on 1/1/11, a lab provided on 1/2/11 and hemodialysis provided on 1/3/11, will the visit rate code 1438 be rejected?

A: In the above example, the D&TC dialysis visit rate code 1438 would be billed for the hemodialyis provided on 1/1/11 as well as the lab test provided on 1/2/11. The date of service for the lab test would need to be reassigned from 1/2/11 to 1/1/11. A separate claim line would then be submitted using rate code 1438 for the second hemodialysis session provided on 1/3/11. Note - when episode rate code 1456 is made available to freestanding renal providers, there will be no need to reassign the date for the lab service that occurs subsequent to the clinic date of service.

Q: If a patient receives hemodialysis on 1/1/11 and 1/3/11, will two episode rate code 1456 claims need to be submitted?

A: Yes. With the episode rate code, two separate 1456 rate code claims would need to be submitted; one for the 1/1/11 date of service and the second for the 1/3/11 date of service.

FQHCs:

Q: Is it now mandatory for FQHC's to opt into APG, or do we still have the option to opt-out?

A: FQHCs may choose to opt into the APG methodology, or may choose to continue to receive payment under the existing prospective payment system (PPS) rate methodology. Providers must notify the Department of their intent to opt into APGs

by November 1, 2010. The opt-in letter for calendar year 2011 is available at this link:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_fqhc_form.pdf

Mental Hygiene Agencies:

Q: Does the retro billing process apply to OASAS providers?

A: No, the claims reprocessing (retroactive to September 1, 2009) relates to Art. 28 general health clinic services and does not include OASAS chemical dependence clinic services.

Q: Do OASAS providers receive a capital add on payment?

A: OASAS clinic providers are not subject to the APG reimbursement methodology at this time. As the APG implementation date for OASAS clinic approaches, OASAS will be providing information on the components of the APG payment for chemical dependence clinic services.

Rate Codes:

Q: If the patient is Medicare/Medicaid dually eligible, what rate code should the D&TC use?

A: Claims for dual eligible patients should always be submitted to Medicare using APG visit rate codes. (e.g., 1407, 1435, 1447, etc.). The claim will automatically cross over to Medicaid for adjudication.

Q: When will the D&TC base rates be published on the DOH APG website?

A: The D&TC rates will be posted to the DOH APG website in the very near future.

Q: We have received letters from DOH indicating that the following rate codes have been added to our provider file: 1407, 1409, 1411, 1435, 1436, and 1437. Can you please explain why there are separate rate codes for the capital add-on and the existing blend? Do we need to bill with these codes?

A: The capital add-on rate code and the existing blend rate code are facility-specific components of the APG visit payment (rate codes 1409, 1411, 1436, and 1437). These rate codes should not be reported on the clinic's APG claim. When rate code

1407 or 1435 is billed, the appropriate capital add-on and existing blend are automatically assigned to the facility's payment.

Q: Does the APG grouper pricing logic calculate the 'existing payment portion of the blend'?

A: Yes, all of the necessary calculations to make the correct payment are automatically performed within the Grouper/Pricer.

Q: Will the rates for APG carve outs be posted on the HPN?

A: No, all information regarding APG carve outs are currently posted on the APG website at this link:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm

Q: Are rate codes 1407 and 1435 going to be deactivated?

A: No, once the episode rate codes are in effect, the current visit rate codes should be used primarily for recipients who are Medicare/Medicaid dually eligible.

Q: Which rate code should be used for materials such as glasses or contact lenses or durable medical equipment?

A: Rate codes 1226 and 1227 (Fitting of Spectacles) are assigned to a few providers that perform these services. The rate codes will be effective 09/01/09 to 12/31/10. The January 2011 APG crosswalk will recognize some of the glasses/contact lenses service and pay in APGs.

Q: If a D&TC previously billed on the 1500 claim form, does the D&TC now need to bill on the UB claim form to receive the APG rate?

A: APG rate codes cannot be submitted on UB-04 paper claim forms. APG rate codes may only be submitted on the 837 electronic billing format. Ordered ambulatory may be submitted on either the eMedNY 150001 or 150002 paper claim form or on the 837 Professional or 837 Institutional electronic formats. Refer to the APG manual to determine which procedures should be submitted under APG rate codes or ordered ambulatory respectively.

Mental Health Counseling:

Q: Can long term counseling be billed under Article 28 and processed through APG's, as opposed to the current Article 16 threshold visit methodology?

A: Mental health counseling services provided in an Article 16 clinic should continue to be billed under the Article 16 threshold visit methodology.

Q: We are an Article 28 D&TC clinic and provide family medicine services as well as mental health counseling. Should we use the 1407 rate code for individual/group counseling?

A: Yes. The 1407 rate code should be used for mental health counseling services provided in an Article 28 facility. Note – group counseling is only reimbursable when provided by a psychiatrist or psychologist.