APG Implementation

Ambulatory Care Payment Reform

Introduction and Overview

Background

- Existing Medicaid outpatient rate methodologies are broken, most payments are capped and ambulatory surgery rates are outdated.
- For example, most hospital clinic rates are capped at $67.50 plus capital and most DTC rates have been frozen since 1995.
- By failing to keep pace with the cost of care and medical advances, the current ambulatory care rates do not appropriately pay providers who deliver evidenced-based, state of the art care.

Background (cont.)

- New York's growing budget deficit will require significant gap closing measures.
- The State's almost $50 billion Medicaid program drives nearly 30% of General Fund spending.
- Ambulatory investments are made possible only through the reallocation of funds drawn from inpatient reform and rebasing.
- Payment restructuring coupled with targeted primary care enhancements are central to Medicaid reform.

Reform Objectives

- **Encourage** migration of services from inpatient to ambulatory/primary care settings.
- **Invest** in ambulatory care to provide more adequate reimbursement.
- **Develop** a new payment system to pay more for higher cost services and less for lower cost services.
- **Ensure** better payment homogeneity for similar/comparable services across ambulatory care settings.
- **Improved** clarity and transparency of payment structure and methodology.
- **Frequent** payment updates to recognize medical advances and changes in cost of service delivery.
- **Support** evidenced-based, state-of-the-art healthcare.

APG's Clinical Strengths

- Superior to "Threshold Visit" and outdated PAS rates.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 time to adjust to new payment methodology.

Scope of APG Services

- APGs, in the initial phase, will cover the following services:
  - *General Clinic*
  - *Specialty Clinic (HIV/AIDS, Renal, Oncology, PCAP)*
  - *Emergency Department*
  - *Ambulatory Surgery*
- APGs, in the initial phase, will not cover:
  - *Mental Hygiene*
  - *Other Managed Care FFS Carve Outs (e.g., school based health)*
  - *Ordered Ambulatory Services*
  - *FQHCs that do not opt-into APGs*

APG Enabling Statute Summary

	Start Date	Phase	Operating Rate	Capital Add-on
Hospital Programs				
Ambulatory Surgery Art. VII Section 18 (c)	Dec. 1, 2008	100%	Full APG payment	Downstate/Upstate
Emergency Room Art. VII Section 18 (d)	Jan. 1, 2009	100%	Full APG Payment	Facility Specific
Outpatient Clinic Art. VII Section 18 (a)	Dec. 1, 2008	25%	Year 1 Blend APG Payment (25%) and Avg. Per Visit CY 2007 (75%)	Facility Specific
Freestanding Programs				
Freestanding Clinic (D&TC's) Art. VII Section 18 (b)	Mar. 1, 2009	25%	Year 1 Blend APG Payment (25%) and Avg. Per Visit CY 2007 (75%)	Facility Specific
Ambulatory Surgery Centers Art. VII Section 18 (b)	Mar. 1, 2009	25%	Same Blend as Above	Downstate/Upstate

Total Ambulatory Care Investment Package

(Gross $ in Millions)	SFY 08/09 Budget (Approved)	SFY 09/10 (Full Annual) [1]	SFY 12/13 Full Investment [2]
Hospital Programs	**$56.7**	**$181.0**	**$406.0**
Outpatient Clinic	$19.0	$57.0	$282.0
Ambulatory Surgery	$26.7	$80.0	$80.0
Emergency Room	$11.0	$44.0	$44.0
Freestanding Programs	**$1.0**	**$12.5**	**$50.0**
Primary Care Investments Asthma and Diabetes Education Expanded "After Hours" Access Social Worker Counseling	**$14.0**	**$38.0**	**$84.0**
Physicians	**$30.0**	**$120.0**	**$188.0**
TOTAL	**$101.7**	**$351.5**	**$728.0**

[1] $181M is full annual values of SFY 08/09 investments. The actual approved amount for SFY 09/10 is $178M.

[2] $406M hospital investment contingent on reallocation of an additional $228M from MA inpatient to MA outpatient.

Primary Care Enhancements

Initiative	Description
Diabetes/Asthma Education Art. VII Section 18 (f) (ii) (A)	Establish coverage for diabetes and asthma education by certified educators in clinic and office-based settings.
Expanded 'After Hours' Access Art. VII Section 18 (f) (ii) (B)	Provide enhanced payment for expanded 'after hours' access in both clinic and office-based settings.
Social Worker Counseling Art. VII Section 18 (f) (ii) C	Reimburse for individual psychotherapy services provided by a social worker for children, adolescents, and pregnancy related counseling.
Smoking Cessation	Reimburse for pregnant women in the clinic or the office. Must be provided with a medical visit.

Ambulatory Patient Groups

Ambulatory Patient Groups (APGs)

- APGs are a patient classification system designed to detail the amount and type of resources used in an ambulatory visit. Patients in each EAPG have similar clinical characteristics and similar resource use and cost.
- APGs were developed by 3M Health Information Systems to encompass the full range of Ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics.
- The APG classification system is also used as a reimbursement methodology by a number of payers.

THREE PRIMARY TYPES OF APGs

- **SIGNIFICANT PROCEDURES:** 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. Normally scheduled.
- **MEDICAL VISITS:** 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 181 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 Methodology and Payment Examples

Sample APG / HCPCS Crosswalk

APGs	APG Descp	HCPCS Code	HCPCS Descp
84	DIAGNOSTIC CARDIAC CATHETERIZATION	93501	Right heart catheterization
		93510	Left heart catheterization
		93511	Left heart catheterization
		93514	Left heart catheterization
		93524	Left heart catheterization
		93526	Rt & Lt heart catheters
		93527	Rt & Lt heart catheters
		93528	Rt & Lt heart catheters
		93529	Rt, lt heart catheterization
		93530	Rt heart cath, congenital
		93531	R & l heart cath, congenital
		93532	R & l heart cath, congenital
		93533	R & l heart cath, congenital
		S8093	CT angiography coronary

Sample APGs and Final Weights

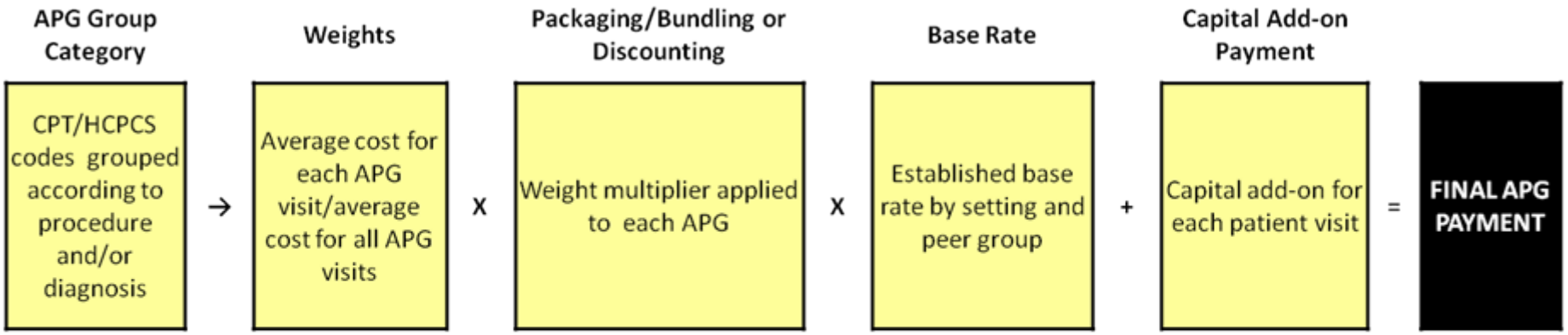
EAPG	EAPG Name	Type	Weight
30	LEVEL I MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	8.3113
31	LEVEL II MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	10.3281
32	LEVEL III MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	13.1830
40	SPLINT, STRAPPING AND CAST REMOVAL	Significant Procedure	1.6166
84	DIAGNOSTIC CARDIAC CATHETERIZATION	Significant Procedure	12.6153
112	PHLEBOTOMY	Significant Procedure	0.9094
116	ALLERGY TESTS	Significant Procedure	1.9176
271	PHYSICAL THERAPY	Significant Procedure	0.3497
280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY	Significant Procedure	10.7456
315	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY	Significant Procedure	0.3521
396	LEVEL I MICROBIOLOGY TESTS	Ancillary	0.1687
397	LEVEL II MICROBIOLOGY TESTS	Ancillary	0.2270
413	CARDIOGRAM	Ancillary	0.1870
414	LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY	Ancillary	0.1155
471	PLAIN FILM	Ancillary	0.6885
527	PERIPHERAL NERVE DISORDERS	Medical Visit	0.7120
562	INFECTIONS OF UPPER RESPIRATORY TRACT	Medical Visit	0.6893
575	ASTHMA	Medical Visit	0.9150
599	HYPERTENSION	Medical Visit	0.6952
808	VIRAL ILLNESS	Medical Visit	0.9073
826	ACUTE ANXIETY & DELIRIUM STATES	Medical Visit	0.9012

APG Payment Definitions

- **Consolidation (a.k.a., "Bundling")** – The inclusion of payment for a related procedure in the payment for a more significant procedure provided during the same visit.
- **Packaging** – The inclusion of payment for related ancillary services in the payment for a significant procedure or medical visit.
  - *The majority of "Level 1" APGs are packaged.*
- **Discounting** – A discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies.

APG Payment Methodology

APG PAYMENT CALCULATION OVERVIEW



Weight Multiplier (Consolidating or Discounting Logic)

- 100% for primary (highest-weighted) APG procedure
- 100% unrelated ancillaries
- 150% for bilateral procedures
- 50% for discounted lines (unrelated significant procedures performed in a single visit).
- 0% for bundled/consolidated lines (related ancillaries are included in the APG significant procedure payment)

APG Example 1 – COPD

(All procedures are grouped based on the same Date of Service)

Medical Visit										
CPT Code	**CPT Description**	**APG**	**APG Description**	**Payment Element**	**Payment Action**	**Full APG Weight**	**Pct. Paid**	**Allowed APG Weight**	**Sample Base Rate**	**Paid Amount**
99213	E & M, est. pt., low complexity (15 mins.)	574	Chronic Obstructive Pulmonary Disease	Medical Visit	Full Payment	0.6739	100%	0.6739	$ 173	$ 116
82565	Creatinine, blood	400	Level I Chemistry Tests	Uniformly Pkgd Ancillary	Packaged	0.1102	0%	0.0000	$ 173	$ -
71020	Radiologic, chest, two views, frontal and lateral	471	Plain Film	Uniformly Pkgd Ancillary	Packaged	0.6885	0%	0.0000	$ 173	$ -
	Total Payment					**1.4726**		**0.6739**		**$ 116**
	Current Payment (Threshold Visit)									**$ 114**
	Net Difference									**$ 2**
	Percent Difference									**2%**

Note: APG weights and base rates shown are for illustrative purposes only. The primary diagnosis was Chronic Obstructive Asthma (ICD-9 49320).

APG Example 2 – Family Planning

(All procedures are grouped based on the same Date of Service)

Family Planning										
CPT Code	CPT Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Sample Base Rate	Paid Amount
57505	Endocervical curettage	196	Level I Female Reproductive Procd	Significant Procedure	Full payment	4.8933	100%	4.8933	$ 173	$ 846
87490	Chlamydia trachomatis, direct probe technique	394	Level I Immunology Tests	Uniformly Pkgd Ancillary	Packaged	0.1688	0%	0.0000	$ 173	$ -
87590	Neisseria gonorrhea, direct probe technique	397	Level II Microbiology Tests	Ancillary	Full payment	0.2270	100%	0.2270	$ 173	$ 39
88305	Level IV Surgical pathology, gross and microscopic examination	390	Level I Pathology	Uniformly Pkgd Ancillary	Packaged	0.3762	0%	0.0000	$ 173	$ -
99215	Office or other outpatient visit	491	Medical Visit Indicator	Incidental	Packaged	1.1276	0%	0.0000	$ 173	$ -
	Total Payment					**6.7928**		**5.1203**		**$ 885**
	Current Payment (Threshold Visit: Family Planning peer group)									**$ 103**
	Net Difference									**$ 782**
	Percent Difference									**758%**

Note: APG weights and base rates shown are for illustrative purposes only.

APG Example 3 - 5 Tier HIV/AIDS - Low Intensity

(All procedures are grouped based on the same Date of Service)

Routine Visit (Equivalent to 5 Tier - Low Intensity)										
CPT Code	**CPT Description**	**APG**	**APG Description**	**Payment Element**	**Payment Action**	**Full APG Weight**	**Pct. Paid**	**Allowed APG Weight**	**Sample Base Rate**	**Paid Amount**
99213	E & M, est. pt., low complexity (15 mins.)	881	AIDS	Medical Visit	Full Payment	0.9932	100%	0.9932	$ 173	$ 172
85025	CBC w/diff	408	Level I Hematology Tests	Uniformly Pkgd Ancillary	Packaged	0.0857	0%	0.0000	$ 173	$ -
80076	Hepatic function panel	403	Organ or Disease Oriented Panels	Ancillary	Full payment	0.3618	100%	0.3618	$ 173	$ 63
90740	Hepatitis B vaccinations	416	Level III Immunizations	Ancillary	Full Payment	0.4323	100%	0.4323	$ 173	$ 75
36415	Venipuncture	457	Venipuncture	Ancillary	Full Payment	0.0675	100%	0.0675	$ 173	$ 12
	Total Payment					**1.9404**		**1.8548**		**$ 321**
	Current Payment (Rate Code 1699 - monitoring visit: excludes capital)									**$ 198**
	Net Difference									**$ 123**
	Percent Difference									**62%**

Note: APG weights and base rates shown are for illustrative purposes only. The primary diagnosis was AIDS (ICD-9 042). For this visit, the following carved-out services were billed to the Laboratory Fee Schedule: 87900 ($80), 87901 ($350), and 87903 ($675).

APG Base Rate Development

APG Base Rates

- DTC base rates will be established for distinct peer groups based on one or more of the following factors:
  - *Service Setting (Free-Standing Clinic, Free-Standing Ambulatory Surgery Center)*
  - *Provider Type (e.g., General, Dental, Renal)*
  - *Patient Type (e.g., Mentally Retarded/Developmentally Disabled)*
  - *Region (Upstate, Downstate)*
  - *Procedure Type (e.g., Dental)*

Potential DTC Peer Groups

- General Clinic (includes all clinics except those designated by DOH as dental or renal clinics)
- General Clinic - MR/DD patient
- Dental Clinic
- Renal Clinic
- Ambulatory Surgery

Note: All of the above peer groups will be broken into Upstate and Downstate regions.

APG Base Rate Regions

- Downstate - New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange
- Upstate - The rest of the State

Base Rate Variables

- Case Mix Index (CMI)
- Coding Improvement Factor (CIF)
- Visit Volume
- Targeted Expenditure Level
  - *Base Year Expenditures*
  - *Investment*
- Reported Provider Cost by Peer Group (for scaling of investments)

Case Mix Index

- Definition - The average allowed APG weight per visit for a defined group of visits (based on peer group and time period of claims).

Coding Improvement Factor

- A numeric value used to adjust for the fact that the coding of claims subsequent to the implementation of APGs will become more complete and accurate (CMIs will increase).

Base Year Visits and Payment

- 2007 is the base year for DTC services moving to APGs on March 1, 2009.
- All revenues and visits for services moving to APG reimbursement will be used in the base rate calculation.

Base Rate Formula

(for initial implementation)

$$\frac{\text{Base Year Expenditures} + \text{Investment}}{\text{CMI} \times \text{CIF} \times \text{Base Year Visits}}$$

Sample Base Rate Calculation

Statewide DTC with Full Investment (for illustration purposes only – no such peer group exists)

$$\frac{\text{(2007 Payment)} \quad \$344{,}649{,}609 + \text{(Investment)} \quad \$50{,}000{,}000}{.8366 \times 1.10 \times 2{,}889{,}213} = \$148.43$$

(CMI) (CIF) (2007 Visits)

Average Payment Per APG Visit = .8366 x 1.10 x $148.43 = $137

Current Operating Payment Per Visit = $119

Capital Add-Ons

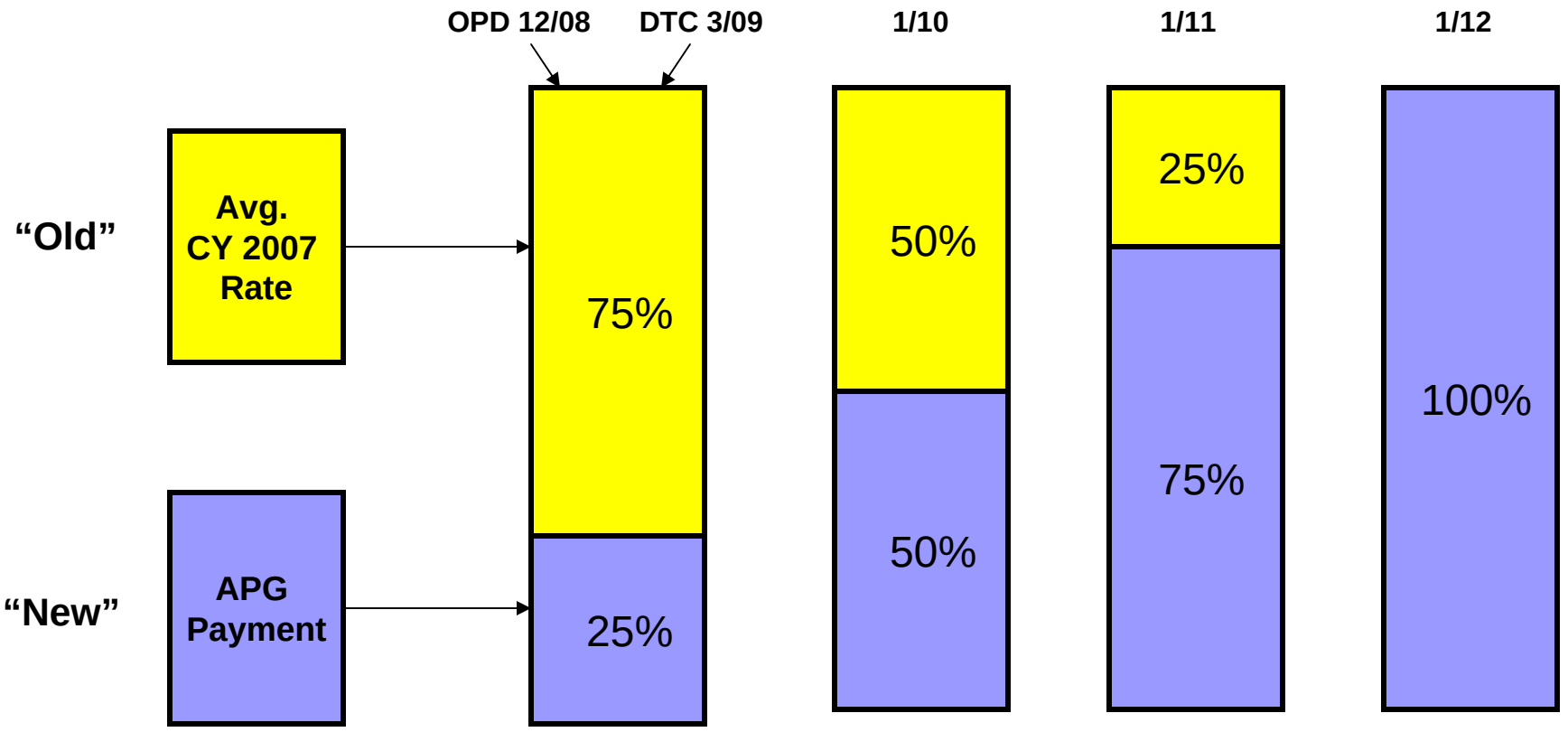
- DTC clinics will have provider-specific per visit capital add-ons, consistent with current practice.
- Ambulatory Surgery, consistent with current practice, will have a per-visit price for capital. However, this price will vary by peer group – not by procedure as it does now.

Reweighting/Rebasing Schedule

- APG relative weights will be updated regularly to keep pace with medical advances and changes in service delivery patterns.
- Each time the relative weights are updated the base rate will also be revised. Base rates may be revised more often than the relative weights is that is necessary to meet investment targets.
- The 3M grouper / pricer software will be updated at least twice a year based on changes to the code sets and modifications to the NYS-specific APG methodology.

APG Phasing and Blending Methodology

Hospital OPD and DTC Transition and "Blend"



Calculation of the Existing Per-Visit Payment – for Purposes of Creating the Blend

- The “blend” applies both free standing clinics and ambulatory surgery centers.
- Calculated on a provider-specific basis using CY 2007 claims data.
  - *Using all MA revenue divided by all MA visits (for services moving to APG reimbursement - excluding mental hygiene and other carve outs).*
- The calculated blend payment is frozen throughout the period of the phase-in.

Sample Blend Calculations

(all figures are statewide, preliminary, and subject to revision)

Avg. APG Operating Payment	Avg. Existing Operating Payment	Year 1 Blend (25%/75%)	Year 2 Blend (50%/50%)	Year 3 Blend (75%/25%)
$137	$119	$124	$128	$132

Note: These calculations are based on statewide averages and ignore peer groups. APG operating payments are actually visit specific.

Note: Existing payment for blend is provider specific, and thus will vary from provider to provider.

Special Payment Rules and APG Carve-Outs

Physician Billing Under APGs

- Physician services for DTCs are included in the APG rate (with limited exceptions).
- Physician services for Emergency Department and Ambulatory Surgery visits may be billed outside of APGs to the physician fee schedule.
- Physician services for OPD visits will bill based on existing payment policy.

Medicare / Medicaid Dual Eligibles

- Medicaid will continue to pay the full annual deductible as well as the full 20% Medicare Part B coinsurance amount for all APG Medicare / Medicaid “crossover” claims.
- For FQHCs and Peer Group 41 clinics, Medicaid will continue to pay the higher of:
  - *the full Medicare Part B coinsurance amount, or*
  - *the difference between the Medicare paid amount and the calculated APG payment.*

Inpatient Only

- Inpatient care will continue to be paid under DRGs.
- Certain specific surgical procedures identified within 3M the grouper / pricer must be done on an inpatient basis only.
  - *These procedures may not be performed on an ambulatory surgery or on a clinic outpatient basis.*

APG Visit Carve-Outs

- All items currently carved-out of the threshold visit rate will continue to be carved-out and paid off the referred ambulatory services fee schedule – with a single exception ….
  - *MRIs will no longer be carved-out of the threshold visit, but instead must be billed under APGs.*
- For a complete list of all APG carve-outs, including all drugs designated as chemo drugs, see DOH APG website.

Chemo Drugs are all Carved-Out

- Chemotherapy drugs were previously carved-out of the threshold rate only for patients billed to the oncology specialty rate code 3092.
- All chemo drugs will be carved-out of APG billing for all patients. These drugs will be billable as referred ambulatory services.
- The definition of a chemo drug will be any drug that groups to one of the five chemo drug APGs.
- Some of these drug have codes that do not begin with “J9” and may have other uses besides treating cancer. Nevertheless, any drug defined under APGs as a chemo drug will be billable only off the fee schedule and will pay at zero when claimed under the APG methodology.

Billing for Drugs

- Drugs carved out of APGs will be billed against the referred ambulatory fee schedule
- For drugs in APGs:
  - *Class 1 Pharmacotherapy drugs will be packaged, so the costs will be included in the weight of the primary APG (significant procedure or medical visit)*
  - *Drugs in Pharmacotherapy Classes 2 through 5 will be priced based on the Average Wholesale Prices (less 15%) of the drugs found in each group (this is consistent with the payment for drugs on the referred ambulatory fee schedule).*
    - *A weighted average of the AWPs within each drug class will be developed based on the historical utilization of each drug. These weighted averages will then be used to set the APG relative weights for the each of the various drug APGs.*

Carved-Out Injections

- Therapeutic injections continue to be carved-out as follows:
  - *Botulinum Toxin A*
  - *Botulinum Toxin B*
  - *Neupogen, Neulasta*
  - *Aranesp (for ESRD on dialysis)*
  - *Epogen, Procrit (for ESRD on dialysis)*

Other Existing Carve-Outs Will Continue

- Blood Factors/Hemophilia
- Medical Abortion Pharmaceuticals
  - *Misoprostol / Mifepristone*
- Family Planning Devices
  - *IUDs*
  - *Contraceptive Implant (Implanon)*

Lab Carve-Outs Remain Unchanged

- Laboratory Carve-Outs
  - *Lead screen*
  - *HIV viral load testing*
  - *HIV drug resistance test (Genotype, Phenotype, Virtual Phenotype)*
  - *Hepatitis C virus, genotype test*
  - *HIV Tropism assay*

DTC HIV/AIDS Rate Code Carve-Outs

- The following rate codes will not be subsumed within APG payment. They will continue to be billable under the existing rate codes and may occur on the same date of service (but not on the same claim) as an APG visit.
  - *1695 – HIV Counseling and Testing Visit*
  - *1802 – Post-Test HIV Counseling Visit (Positive Result)*
  - *1850 – Day Health Care Service (HIV)*

Tuberculosis Rate Code Carve-Outs

- The following DTC rate codes will not be subsumed within APG payment. They will continue to be billable under the existing rate codes and may occur on the same date of service (but not 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)*

Other Rate Code Carve-Outs

- The following DTC rate codes will not be subsumed within APG payment. They will continue to be billable under the existing rate codes and may occur on the same date of service (but not the same claim) as an APG visit.
  - *3107 – Monthly Dialysis Service (Medicare Crossover)*
  - *1604 – MOMS Health Supportive Services (Case Management)*
  - *5301 – Medical Evaluation (SSHP)*
  - *5388 – Pre-school Supportive Health Program (IEP)*
  - *5389 – School-age Supportive Health Program (IEP)*

Never Pay APGs

- “Never Pay” APGs are those services that are not covered under APG reimbursement.
- Examples of Never Pay APGs include:
  - *Respiratory Therapy*
  - *Cardiac Rehabilitation*
  - *Nutrition Therapy*
  - *Artificial Fertilization*
  - *Biofeedback*

“Never Pay” APGs (Zero Payment)

APG	NEVER PAY APGs	Alternative Funding Source
65	RESPIRATORY THERAPY	
66	PULMONARY REHABILITATION	
94	CARDIAC REHABILITATION	
117	HOME INFUSION	
118	NUTRITION THERAPY	
190	ARTIFICIAL FERTILIZATION	
311	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	
312	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	
313	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	
314	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	
319	ACTIVITY THERAPY	
320	CASE MANAGEMENT - MENTAL HEALTH OR SUBSTANCE ABUSE	Mental Hygiene
371	ORTHODONTICS	Dental Fee Schedule
427	BIOFEEDBACK AND OTHER TRAINING	
430	CLASS I CHEMOTHERAPY DRUGS	Referred Amb
431	CLASS II CHEMOTHERAPY DRUGS	Referred Amb
432	CLASS III CHEMOTHERAPY DRUGS	Referred Amb
433	CLASS IV CHEMOTHERAPY DRUGS	Referred Amb
434	CLASS V CHEMOTHERAPY DRUGS	Referred Amb
450	OBSERVATION	
452	DIABETES SUPPLIES	Pharmacy
453	MOTORIZED WHEELCHAIR	DME
454	TPN FORMULAE	Medical Supply
456	MOTORIZED WHEELCHAIR ACCESSORIES	DME
492	DIRECT ADMISSION FOR OBSERVATION INDICATOR	
500	DIRECT ADMISSION FOR OBSERVATION - OBSTETRICAL	
501	DIRECT ADMISSION FOR OBSERVATION - OTHER DIAGNOSES	
999	UNASSIGNED	

“If Stand Alone, Do Not Pay” APGs

- “If Stand Alone, Do Not Pay” APGs generally consist of procedures performed as follow-up to an initial clinic visit for which APGs will not pay. These consist primarily of tests and other ancillaries.
- Mirroring the current reimbursement system, these procedures will also not pay under APGs when they are the only items claimed for a given date of service
- Examples include:
  - *Follow-up laboratory and diagnostic radiology testing (except MRIs) related to an initial patient encounter.*
  - *Immunizations.*
- Providers should still claim for these procedures in order to maximize the available data that can be used for future reweighting and rebasing.
- Note: For those “stand alone” ancillaries that do pay (viz., MRIs), there is no capital add-on.

“If Stand Alone, Do Not Pay” APGs

280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY	400	LEVEL I CHEMISTRY TESTS
284	MYELOGRAPHY	401	LEVEL II CHEMISTRY TESTS
285	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST	402	BASIC CHEMISTRY TESTS
286	MAMMOGRAPHY	403	ORGAN OR DISEASE ORIENTED PANELS
287	DIGESTIVE RADIOLOGY	404	TOXICOLOGY TESTS
288	DIAGNOSTIC ULTRASOUND EX OB AND VAS LOWER EXTR	405	THERAPEUTIC DRUG MONITORING
289	VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES	406	LEVEL I CLOTTING TESTS
290	PET SCANS	407	LEVEL II CLOTTING TESTS
291	BONE DENSITOMETRY	408	LEVEL I HEMATOLOGY TESTS
298	CAT SCAN BACK	409	LEVEL II HEMATOLOGY TESTS
299	CAT SCAN - BRAIN	410	URINALYSIS
300	CAT SCAN - ABDOMEN	411	BLOOD AND URINE DIPSTICK TESTS
301	CAT SCAN - OTHER	413	CARDIOGRAM
302	ANGIOGRAPHY, OTHER	414	LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY
303	ANGIOGRAPHY, CEREBRAL	415	LEVEL II IMMUNIZATION
330	LEVEL I DIAGNOSTIC NUCLEAR MEDICINE	416	LEVEL III IMMUNIZATION
331	LEVEL II DIAGNOSTIC NUCLEAR MEDICINE	435	CLASS I PHARMACOTHERAPY
332	LEVEL III DIAGNOSTIC NUCLEAR MEDICINE	436	CLASS II PHARMACOTHERAPY
380	ANESTHESIA	437	CLASS III PHARMACOTHERAPY
390	LEVEL I PATHOLOGY	438	CLASS IV PHARMACOTHERAPY
391	LEVEL II PATHOLOGY	439	CLASS V PHARMACOTHERAPY
392	PAP SMEARS	451	SMOKING CESSATION TREATMENT
393	BLOOD AND TISSUE TYPING	455	IMPLANTED TISSUE OF ANY TYPE
394	LEVEL I IMMUNOLOGY TESTS	457	VENIPUNCTURE
395	LEVEL II IMMUNOLOGY TESTS	470	OBSTETRICAL ULTRASOUND
396	LEVEL I MICROBIOLOGY TESTS	471	PLAIN FILM
397	LEVEL II MICROBIOLOGY TESTS	472	ULTRASOUND GUIDANCE
398	LEVEL I ENDOCRINOLOGY TESTS	473	CT GUIDANCE
399	LEVEL II ENDOCRINOLOGY TESTS		

Claiming for “Never Pay” and “If Stand Alone Do Not Pay” APGs

- If the only items on a claim for a particular date of service (APG visit) are “Never Pays” or “If Stand Alone, Do Not Pays”, then the visit will be paid at zero.
- If every item on a claim (for all dates of service), consist of these types of items, the claim will be denied. Data from these denied claims can still be used for future reweighting.

Managed Care Carve-Outs

- Rate codes that are currently used for the purpose of billing FFS Medicaid for MMC patients will remain active following the implementation of APG reimbursement.
- When MMC carved-out services are provided to a MMC recipient, these existing MMC rate codes must be used.
- When MMC carved-out services are provided to a FFS recipient, the APG rate codes must be used.
- Examples of MMC carved-out rate codes include:
  - *1627 Comprehensive Physical Exam (SHP)*
  - *1628 Routine Visit (SHP)*

Modifiers in APGs

- APGs will recognize several billing modifiers.
  - ***25 - distinct service***
    - *Separately identifiable E&M service on the same day as a significant procedure (subject to DOH policy requirements)*
  - ***27 - additional medical visit***
    - *Separate medical visit with another practitioner on the same date of service (subject to DOH policy requirements)*
  - ***52 - terminated procedure***
    - *Discontinued outpatient hospital/ambulatory surgery procedure that does not require anesthesia*
  - ***73 - terminated procedure***
    - *Discontinued outpatient hospital/ambulatory surgery procedure, after some preparation, but prior to the administration of anesthesia*
  - ***59 - separate procedure***
    - *Distinct and separate multiple procedures (with same APG)*
  - ***50 - bilateral procedure***

FQHC Implementation Issues

Options for FQHCs

- On or after March 1, 2009, FQHCs may be paid under the APG methodology, or under the existing prospective payment system rate methodology.
- FQHCs currently on PAC rates in lieu of PPS may opt for the APG methodology, or continue with PAC rates.
- The payment methodology selected by the FQHC would apply to all claims submitted for a specified period of time (probably one year).
- FQHC wraparound (shortfall) payments for managed care enrollees will continue to be paid - using the existing FQHC shortfall rate codes.

Implementation Schedule

- FQHC APG fiscal impacts will be available in late September.
- DOH will offer the APG option, in writing, to FQHCs in October.
- FQHCs must agree to accept APGs by signing written agreement offered by DOH before the end of year.
- For FQHCs signing agreement, payments on or after March 1, 2009 will be based on APG methodology.
- DTCs can submit test claims to eMedNY using new APG rate codes beginning in December.

Agreement

- Written Agreement will specify:
  - *Effective period for use of APG methodology;*
  - *Actions that will be taken if aggregate payments under the APG payment methodology are less than the calculated aggregate payments under the PPS payment methodology during the term of the agreement.*

Advantages of Switching to APGs

- At least for first year, hold harmless payment will be made to FQHCs to extent aggregate payment under APG methodology is less than that expected under the PPS methodology.
- FQHCs will be able to access certain primary care enhancements only available under APGs (e.g. CDE and CAE; extended hours payments, etc.)

Additional Training and Resources for FQHCs

- Currently assessing DTC needs for additional training re: coding and claims submission.
- Further training will be scheduled later in the fall.
- Negotiating pricing with 3M for DTC purchase of grouper/pricer software.

Supporting Material & Contact Information

Supporting Materials

- Available on DOH website (http://www.nyhealth.gov/health_care/medicaid/rates/apg/)
  - *Implementation Schedule*
  - *APG Documentation*
    - *APG Types, APG Categories, APG Consolidation Logic*
  - *Payment Examples*
  - *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*
  - *Paper Remittance*
  - *Frequently Asked Questions*
- Coming Soon
  - *APG Policy Manual*
  - *Ambulatory Surgery List*

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*