

Frequently Asked Questions

A Collaboration of Treo Solutions with 3M™ HIS and New York State DOH

- 1. General Questions**
- 2. Software and Support Questions**
- 3. Systems Issues and Training Questions**
- 4. Training Questions**
- 5. Billing/Claims Processing Questions**
- 6. Primary Care Enhancement Questions**
- 7. Provider- Specific Questions**

1. General Questions

1.1 What are EAPGs?

3M™ Enhanced Ambulatory Patient Groups (3M EAPGs) are a patient classification system designed by 3M Health Information Systems to characterize the amount and type of resources used in an ambulatory care visit for patients with similar clinical characteristics. Use of APGs will result in higher payments for higher intensity services and lower payments for lower intensity services across all settings. APGs were developed to encompass the full range of ambulatory care services including those provided in ambulatory surgery units, hospital emergency rooms and outpatient clinics.

1.2 Why did NY Medicaid Select EAPGs for the outpatient reimbursement?

The New York State Dept. of Health provides a much more detailed discussion of this question. In general, they indicate that their current payment system is very old and no longer meets the needs of Medicaid or the hospitals that provide outpatient services. As they evaluated tools for an outpatient payment system to replace their existing system, the 3M EAPGS provided the best match.

1.3 Will the updated EAPG software conform to the NY State Department of Health Medicaid rates?

The 3M products will include NYSDOH relative weights and provide a mechanism for each user to enter their hospital (or group of hospitals) specific variables.

1.4 When will APGs be implemented?

The APGs reimbursement methodology will be phased-in over a four year period. The chart below shows the implementation schedule.

Provider Type	Initial Start Date	Phase-In
Hospital Outpatient Department	December 1, 2008	Starting Dec 1, 2008, 25% of payment will be based on APGs. The percentage will increase to 50% effective Jan 1, 2010; to 75% effective Jan 1, 2011; and to 100% effective Jan 1, 2012.
Hospital Emergency Room	January 1, 2009	100% of payment will be based on APGs starting Jan 1, 2009.
Hospital-based Ambulatory Surgery	December 1, 2008	100% of payment will be based on APGs starting Dec 1, 2008
Free-standing Diagnostic and Treatment Center	March 1, 2009	Starting March 1, 2009, 25% of payment will be based on APGs. The percentage will increase to 50% on Jan 1, 2010; to 75% on Jan 1, 2011; and to 100% on Jan 1, 2012.
Free-standing Ambulatory Surgery	March 1, 2009	Starting March 1, 2009, 25% of payment will be based on APGs. The percentage will increase to 50% on Jan 1, 2010; to 75% on Jan 1, 2011; and to 100% on Jan 1, 2012.

Initially, APGs will **not** be used for Medicaid payment for mental hygiene (mental health, chemical dependence, and developmental disabilities) services, other managed care fee-for-service carved-out services, or for ordered ambulatory services. FQHCs that opt to not utilize the APG payment methodology will also be exempted from APG-based Medicaid payment.

1.5 How are these services defined? By CPT/HCPCS, existing PAS or rev code?

For base rate development they were defined by rate code. For billing purposes they will be defined based on procedure codes. DOH will implement a list of procedures that must be billed against the Amb Surg base rate.

1.6 Does the APG methodology require approval of a State Plan Amendment by the Federal Centers for Medicare and Medicaid Services (CMS)?

Implementation of the APG payment methodology does require federal approval of a State Plan Amendment. Approval is expected by December 1, 2008.

1.7 Once the system is live, what assurance will be in place to ensure that payments are made properly?

Certain edits are built into the claims processing system to ensure that providers submit claims properly. In addition, the State will monitor actual payments against facility specific-projections of payments and providers should be able to do the same.

1.8 What is the relationship between APGs (as defined the April 2008 Amendments to the State Public Health Law requiring a new Medicaid payment methodology), and the EAPGs provided by 3M Health Information Systems?

It should be understood in this context that APGs is a generic acronym referencing the ambulatory patient grouping methodology developed by 3M Health Information Systems (3M). It was originally developed under contract with CMS (HCFA at that time) and subsequently revised several times.

In 2007, it became apparent that the APG system was in need of major modifications to reflect all of the changes taking place in health care. Because CMS had made the decision to move forward with APCs, it was not something in which they would invest. As a result 3M undertook the major effort to rework the APG system and bring it current with health care practice and coding/documentation requirements. The result of this effort was sufficiently different that it was appropriate to differentiate the new classification system from the old. The result is the new classification system 3M™ Enhanced Ambulatory Patient Grouping System (3M EAPGS), a proprietary classification system to 3M.

The New York APG initiative utilizes the 3M EAPGS as the classification system for their outpatient prospective payment system.

1.9 What is the difference between EAPGs, adopted by NY State Department of Health for Medicaid reimbursement and APGs available from NTIS?

3M EAPGS are an updated and enhanced version of APGs. The last version of the old APGs was in 1995. Much has changed in health care, clinical practice, and documentation of clinical care since then. The 3M EAPGS incorporates these changes so that it reflects the current health care paradigm.

3M EAPGS are not available through NTIS (National Technology Information Service), the distribution mechanism used by CMS for APCs and other software. APGs may be purchased from NTIS, but is the old version, last updated in 1995.

1.10 What is the difference between Ambulatory Patient Classifications (APCs, used by Medicare and the EAPGs used by NY State Department of Health for reimbursing outpatient claims?

APCs were developed by CMS for use in their Medicare Outpatient Prospective Payment System. They were designed for and are appropriate for a Medicare (primarily elderly) population. EAPG's were designed by 3M for all patient age population. The two systems differ in a number of respects, including:

	APCs	3M EAPGs
Packaging	APCs use a packaging concept for a specific set of services. They are always packaged and never receive additional payment. Should they appear alone, the claim is returned to the provider for correction. New conditional packaging logic has recently been added.	3M EAPGs have significantly more packaging than APCs. There are multiple types of packaging logic used within the grouping system. The result is that fewer line items receive separate payment.
Editing	APCs incorporate a fair amount of integrated editing logic to enforce correct coding and billing policies.	3M EAPGs have very limited editing 3M provides separate editing that is available with the 3M applications. These edits may be turned off as a whole or individually.
Medical groups	APCs classify medical visits based on CPT® ¹ evaluation and management (E/M) codes.	3M EAPGs uses diagnosis codes, which focuses on the patient's condition and why they came to see the physician, a more clinically meaningful approach.
Fee schedules	APCs make extensive use of fee schedules for payment.	3M EAPGs classifies these services into groups for determination of payment.
Reimbursement: Reimbursement is defined by the payer implementing the system. Refer to the NYSDOH website for details regarding their implementation of their 3M EAPG based payment system		

¹ CPT is a registered trademark, American Medical Association

2. Software and Software Support

2.1 Who can I contact to purchase EAPGS Software?

The 3M EAPGs can be obtained from 3M or a 3M authorized distributor. You can contact our 3M toll-free number 800-367 2447 or visit our EAPG Payer fact sheet at: <http://3mhis.com/PayerEAPG>. You can also obtain the EAPG software from 3M authorized distributors including TREO Solutions. Also, you can contact Treo Solutions (518) 426-4315 or acuda@treosolutions.com.

2.2 Will I be able to obtain the logic behind the EAPG software? If so, how do I get it?

There is a definitions manual that explains the standard logic for grouping 3M EAPGS as well as the standard consolidation and packaging logic. It is available from 3M by using the internet at URL: www.3MHIS.com. It is also provided with the purchase of 3M software.

The documentation supplied with all 3M software applications provides information regarding the grouper customization options used by NYSDOH, as well as detailed documentation of the pricing rules for NY Medicaid.

2.3 Does the 3M software support the definitions of visits used by the state of NY?

NYSDOH has defined visit based on the line item dates of service for ambulatory surgery and hospital outpatient clinics. This is considered multiple visit definition.

However, ED visits are defined by the claim. For ED visits, the claim is considered a single visit, regardless of the line item dates of service. This is called the single visit definition.

The 3M software is designed to support this definition.

2.4 When I purchase the EAPG grouper do I always get the EAPG Pricer? Will this vary depending upon my platform?

3M provides products in multiple versions and on multiple platforms in support the 3M EAPGS. In each case, the product includes the grouping logic, and pricing as defined by the NYSDOH.

2.5 When will the 3M Grouper/Pricer be available to hospital facilities?

The Grouper/Pricer will be available to providers at the end of July, 2008 as will the specifications for the Grouper/Pricer interface. Questions about the Grouper/Pricer may be directed to 3M at 1-800-367-2447.

2.6 What is the estimated time frame for 3M to train a hospital's IT staff on the software?

3M's training and customer support function is already in place for APGs. If support is needed, call 3M's toll free number 1-800-435-7776.

2.7 How much of the APG pricing will be included in the 3M Grouper versus the Pricer?

The Grouper/Pricer is one integrated software tool. The Grouper component assigns HCPCS codes to APGs; and the Pricer component applies the appropriate weights and base rates to the APGs.

2.8 How often will the APG Grouper/Pricer software be updated?

The APG Grouper/Pricer software will be updated at least two times per year (minimally, once to accommodate updates of ICD-9 diagnosis codes, and once to accommodate updates to HCPCS codes).

2.9 Does the 3M software address the carve outs defined by the NY DOH?

No. This is not included in the 3M products.

2.10 On what platforms/operating systems is the software available?

3M provides solutions on the following platforms:

- Mainframe: Z/OS batch which can also function in a CICS environment.
- PC: Windows
- Embeddable JAVA-based application that can function on multiple platforms (e.g., Windows, UNIX, LINUX, etc.).

2.11 How will software interface with plan's existing claims processing system?

This depends on the type system and platform purchased from 3M.

- The mainframe platform offers an interfaced solution through file and memory methods
- The PC solution offers an interface using flat, fixed format files
- The JAVA solution is not standalone and needs to be embedded within the plan's environment. This solution uses a "push" interface method for passing variables to the software.

2.12 How is the EAPG Software installed?

This will depend on the platform. As a general concept, the purchaser of the software is responsible for the installation. 3M will provide reasonable telephone assistance so that this can be accomplished.

2.13 What type of customer support is provided with the EAPG Software? How do I access this support? What is the process for after hours support?

3M provides telephone support for all of its applications via a toll-free telephone line. There is no additional charge for reasonable use of this support beyond the annual license fees.

This support is available on a 24 hour basis. Critical issues will be addressed on a 24 hour basis. Non-critical issues are addressed during normal business hours: 8:00 am to 5:00 pm eastern time.

Support can be reached at 1(800) 435-7776.

2.14 What version of the EAPG product will be used on January 1, 2009?

It is anticipated that the NYS DOH Medicaid will use version 3.2 of 3M EAPGs beginning January 1, 2009. 3M products will be updated to support this version of the grouper. Grouper version 3.0 and 3.1 are also supported in the 3M products. From December 1, 2008 through December 31, 2008 NYS DOH Medicaid will be using version 3.1.

2.15 How often is the software updated? How do I get the updated version?

Software is updated quarterly based on the introduction of new codes. The updated software, with the exception of mainframe applications, is available for download from the 3M Customer Care website. Updates are provided as standard part of your annual license fee.

2.16 Am I required to purchase EAPGs?

No. There is no purchase requirement for products including 3M EAPGS. However, the system is complex enough that processing of large volumes of claims is not possible manually. Therefore, if determining grouping and reimbursement for claims is needed, grouping software from one of several vendors is advised.

3. Systems Issues and Testing

3.1 How will EAPG software price claims?

The software prices claims in accordance with the NY State Medicaid outpatient reimbursement rules. For more specific information on the New York State Department of Health reimbursement policies click on the link below to access their website.

http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm

3.2 What facility specific information must be obtained in order to calculate reimbursement for NY Medicaid claims (e.g. base rates, capital add-ons, and provider specific OPD benchmarks)?

Three specific items of information for each facility, and for each service type (ambulatory surgery, outpatient clinic, ED). These values will vary by hospital, location, and by service. The three items are:

1. Base rate
2. Existing payment amount
3. Capital add-on amount

Item 2, existing payment is only used for services that have a blended payment. For hospitals this is only the outpatient clinic services. The other two are paid 100% by EAPG grouping.

3.3 Where is this information available?

The NYSDOH has published these values on their web site.

3.4 What will I need to do to ensure my 835 remittance is updated to conform to EAPGs?

The fields that identify payment amounts all need to be included within an X12-835 remittance advice. Each plan that begins reimbursing based on 3M EAPGS will need to modify their remittance to include all pertinent information.

The NYSDOH has also defined new rate codes to identify service type/setting. These will need to be incorporated in the X12-837 claim submission received by each plan.

3.5 What happens if an individual provider is not ready to bill under EAPGs by December 1?

Essentially the only change required to bill APGs is the replacement of existing rate codes with new APG rate codes. Hospitals are expected to use the new APG Grouper access rate codes by December 1 on claims for OPD and ambulatory surgery services. If unable to bill APGs on this date, hospitals will have to submit claims, when they can, following the usual Medicaid rules for submission of delayed claims.

For paper claims delayed over 90 days from the date of service, a cover letter for each claim must be attached which specifies one or more acceptable reasons for the delay. Claims submitted electronically must specify the appropriate late submission reason code. For valid coding, refer to the electronic billing instructions

<http://www.emedny.org/HIPAA/index.html>

3.6 What is the APG readiness of the eMedNY claims processing system? When can testing begin?

eMedNY will obtain the final Grouper/Pricer from 3M at the end of July, 2008. The eMedNY System is undergoing testing to ensure successful APG implementation in December. Providers will be able to conduct their own APG testing beginning on September 8, 2008.

3.7 What editing will be done with APG claims?

Almost all of the current front end edits used to process clinic claims will remain the same.

- Additional APG-specific edits are being developed. Editing changes include the use of new MMIS edits including the following:
 - 1. Edit 1044, used when from /to dates on the claim span more than one month;
 - 2. Edit 2001 used when the prior payer amounts in the claim header and line payments don't balance;
 - 3. Edit 1136, used when the rate code is invalid for a clinic; and,
 - 4. Edit 2081, used when all APG claim lines paid zero.

See the APG Implementation PowerPoint Presentation (Slides 118-121) for details on how these MMIS edits map to HIPAA 835/277 transactions.

3.8 What information will be included on the remittance form?

The 835 remittance will include line level detail including the APG code, APG full weight, APG allowed percentage, APG paid amount, the payment based on existing operating reimbursement (the blend amount), "combined with CPT" (this field indicates if reimbursement for a particular CPT/APG has been consolidated or packaged within another CPT/APG), capital add-on amount, and the total payment for the claim.

The 835 Companion Guide, which provides detail for all the APG remittance changes, is now available on the www.eMedNY.org website under NYHIPAADESK.

For providers who receive paper remittances please see the paper remittance in the [APG Implementation PowerPoint Presentation](#). (See Slides 125-128)

3.9 What are the rules for assigning and paying an APG at the line item detail level? (E.g. APCs currently edit at the detail level and will inform a provider if a specific line should have been bundled and therefore not paid separately.)

All CPT/HCPCS codes claimed for a visit (same date of service) should be included on the claim. The logic in the Grouper/Pricer will assign each line (CPT code) to the appropriate APG at the line level (i.e., every line on the claim will be assigned to an APG, though some may consolidate or package and pay zero at the line level).

3.10 How is the existing per-visit payment calculated for purposes of creating the blend (75% at initial implementation) for OPD and DTC claims?

Using 2007 claims data, a facility-specific "average rate of payment" is calculated for OPDs and for D&TCs by dividing all Medicaid revenue by all Medicaid visits for those services moving to APG reimbursement. The percentage of the total payment based on the old reimbursement methodology (e.g., 75% at initial implementation, 50% in 2010, etc.) is then applied to the facility-specific average payment throughout the period of the transition to full payment based on APGs. For further detail please see the [APG PowerPoint Presentation](#) (See Slides 80-83).

3.11 Some third party payments are reconciled at the claim line level, while other third party payments are reconciled at the claim header level. How will these payments be shown on the Medicaid invoice for APG payments?

The eMedNY system has been designed to accommodate both third party options. If payments are reconciled at the claim level, the eMedNY system will allocate that information to the line level (paid lines only) and process accordingly. When payments are reconciled at the line level there will be no allocation, and eMedNY will process

the line using the information submitted. If a line results in no payment, then the third party payments for that particular line will be bundled with a line that does pay. The 835 electronic remittances will portray the allocation and/or bundling that occurred during processing.

4. Training Questions

4.1 What will State DOH cover in its educational sessions to providers?

Educational sessions for hospital providers were conducted by NYSDOH, 3M, TREO Solutions, and CSC throughout June and July. Issues addressed included: APG policies and principles; APG grouping logic, weighting and pricing; APG carve outs, special payment rules and other APG implementation issues; and APG systems issues and testing schedules. The PowerPoint for this presentation is available by request.

4.2 Will training be provided to DTCs and free standing ambulatory surgery centers?

Yes, similar training for free-standing diagnostic and treatment centers and ambulatory surgery centers will be scheduled in fall 2008.

5. Billing / Claims Processing Questions

5.1 What constitutes a clinic visit in terms of services provided during the initial clinic visit, as opposed to ancillary services provided on subsequent days resulting from the initial clinic visit?

A visit will consist of all services listed on a claim document for a single service date. Each unique date of service on a claim will be considered a "visit." Since a claim may contain procedures for multiple service dates, there may be multiple visits on a single claim document.

Reimbursement for some ancillary services provided to assist in patient diagnosis or treatment will always be packaged in the APG payment for a significant procedure or a medical visit, even if the ancillary service is performed on a subsequent day. The list of ancillary procedures always packaged in the APG for a significant procedure or medical visit is referred to as the "Uniform Packaging List" and may be found here: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_uniform_packaging.pdf (PDF, 11KB, 1pg.)

5.2 Should same day services be reported on one claim if they occur in more than one outpatient clinic setting on the same date?

1. If the services are provided at a clinic and in the emergency dept. on the same date, they should be reported on separate claim forms. When Medicare is the primary payer, providers may submit one claim for reimbursement of deductibles and coinsurance.
2. If a patient is seen in either the outpatient clinic or ED setting and then has an ambulatory surgery procedure on the same date, all codes associated with both visits should be reported on one claim using the ambulatory surgery rate code.
3. The rule limiting outpatient clinic visits to one threshold visit per day remains in effect under the APG system.

5.3 Medicare presently pays on a monthly basis for certain medical services that occur on a regularly scheduled basis, e.g., renal dialysis, physical therapy. How will APGs accommodate Part B coinsurance/deductible billings for dually eligible enrollees for monthly services?

For monthly billings of Medicare co-pays and deductibles for dual eligibles, continue to use existing rate codes. Do not use APG rate codes for this purpose.

5.4 What should be on a bill?

All claims should include the new APG grouper access rate codes. Claims should include complete and accurate CPT and HCPCS codes and primary diagnosis codes. All services and procedures mapped to an APG claim for the same date of service must be billed together on one claim.

5.5 How are recurring services such as therapies (PT, OT and RT) to be billed?

Each occasion of service is considered a distinct visit. Multiple visits on a single claim will be differentiated by the grouper using the dates of service. Multiple units of these services on the same date of service will be recognized by the grouper as a single unit. Reimbursement for PT, OT and RT will be based on the average number of units provided per visit on a system-wide basis (reflecting average service intensity), not on the actual number of units billed on the claim.

5.6 How will physicians' services be billed?

Physician services for emergency room and ambulatory surgery visits should be billed on a separate claim using the physician fee schedule. Billing for physician services for OPD visits will follow existing payment policy as stipulated in the physician billing manual (which is based on the treatment of physician costs in the provider's cost report). Physician services for D&TCs are generally included in the APG rate, other than for certain abortion and renal dialysis clinics.

5.7 Exclusions from Payment - Are these exclusions to be inclusive of the EAPG payment, or to be paid separately? If they are to be paid separately, how so?

86-8.10 (a-g) Reimbursements outside of APGs and as they are now, except the drugs are not a carve out from APGs and the language will be corrected. (h) These items are not reimbursable under APGs - some are reimbursable outside APGs (vision, orthodonture) - see DOH website for details. (i) These are not reimbursable when they are the only items that appear on a claim for a specific date of service - also explained on DOH website.

5.8 Are providers still required to bill under Medicaid rate codes such as 2870 for General clinics?

No, this rate code becomes obsolete for dates of service after 12/1/08 for hospital-based OPDs. Providers should use new grouper access rate code 1400 for hospital based OPDs.

Similarly, rate code 1610 will become obsolete for free standing D&TCs after 3/1/09. D&TCs should use new grouper access rate code 1407.

5.9 Some carve outs are only identified by Rate Code (i.e. 2961, AIDS Clinic, Therapeutic Visit), how does this rate code equate to CPT/HCPCS or Rev code?

Those rate codes do not equate to HCPCS codes. The providers can continue to use the carved out rate codes (instead of the APG rate codes) and code the actual CPTs/HCPCSs provided to the patient on the claim at the line level.

5.10 How will contracted Out Of State facilities that use NYS Medicaid as their reimbursement methodology be dealt with?

Out Of State will continue to be reimbursed under the existing methodology and will not use APGs.

5.11 Will the use of rate codes continue even after the APGs have been fully implemented?

Yes, once APGs are implemented, providers must submit claims using new APG Grouper access rate codes. It will appear in the same spot that the rate code was previously.

Setting	Service	Old Code ¹	New Code	Effective Date
Hospital	OPC/Clinic	2870	1400	12/1/08
Hospital	Amb. Surg.	3089 / 3090	1401	12/1/08
Hospital	ER	2879	1402	1/1/09
Free standing DTC	Clinic	1610	1407	3/1/09
Free standing DTC	Amb. Surg.	1804 / 1805	1408	3/1/09
Free standing DTC	Dental	-----	1428 ²	3/1/09
Free standing DTC	MR/DD/TBI	-----	1435 ³	3/1/09

Setting	Service	Old Code ¹	New Code	Effective Date
Free standing DTC	Renal	-----	1438 ⁴	3/1/09

REMINDER: Only services listed on your facility's Operating Certificate may be billed.

¹ Many other rate codes will become obsolete upon implementation of APGs. For a full list of rate codes subsumed with APG implementation see: http://nyhealth.gov/health_care/medicaid/rates/apg/docs/outpatient_rate_codes.pdf (PDF, 183KB, 4pg.)

² Rate code 1428 will be assigned only to designated dental providers.

³ Rate code 1435 will be assigned to providers who are also assigned rate code 1407 for use in billing for services for recipients with mental retardation, developmental disabilities or traumatic brain injury as indicated by recipient exception codes 81 or 95. Rate code 1435 will not be assigned to providers who only are assigned rate code 1428 or 1438.

⁴ Rate code 1438 will be assigned to providers in Peer Group 80: statewide dialysis.

5.12 If rate codes are required and a facility does not bill with them after 12/1/2008, should the claim be rejected?

It is possible the claim could erroneously be paid as ordered Amb. I am not sure. But they are using rate codes now (usually 2870) so I don't know where the confusion is coming from. Instead of using 2870 they will just use 1400.

5.13 Will the State implement an inpatient-only list similar to Medicare's list of procedures that are only payable if they are performed as an inpatient? Is Medicaid's list the same as that maintained by CMS for APCs?

The NY Medicaid program's "inpatient-only" list is available on the Department's State DOH APG website: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/inpatient_only.pdf (PDF, 56KB, 16pg.) The State's APG "Inpatient Only List" is different from CMS' APC "Inpatient Only List." Providers will need to maintain two lists--one for APCs and one for APGs. The APG list allows for more procedures on an outpatient basis.

5.14 Will SDOH issue guidance on the use of modifiers to support multiple services rendered on the same date of service

Guidance on the use of modifiers will be issued shortly.

5.15 How would the system handle an ancillary service on the same date of service as a clinic visit, but not related in any way to that visit?

The costs of "Uniform Packaging Ancillaries" are always included in the initial clinic visit APG, irrespective of the date of service. Ancillaries on the "Never Pay" list will not generate a payment. Other non-packaged ancillaries on the same date of service as a clinic visit will get paid irrespective of ordering date, but only if they are on the same claim. If they are not on the same claim, the second claim will be denied as a duplicate claim.

However, if a community physician not associated with the clinic ordered the ancillary service in the first instance, the ancillary service should be submitted as a separate claim as an ordered ambulatory service. Since this claim will not be filed under an APG rate it will not deny as a duplicate claim.

5.16 Will providers be expected to submit a claim for an ancillary service only?

It is important for providers to submit claims for standalone ancillaries under APG rate codes, even if they do not expect to get paid. This is important for future re-weighting and possible expansion of coverage for standalone ancillaries. Ancillary services for clinic patients should never be billed as ordered ambulatory services.

5.17 What is the definition of primary diagnosis code? For example, a patient may present to the ED with chest pain, but the final diagnosis may not be cardiac related, but instead may be determined to be indigestion. Which diagnosis should be entered on the claim? In which field on the electronic 835 does this information reside?

The definition of the primary diagnosis code is the ICD-9 code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). In the above example, the patient diagnosis should indicate gastric reflux.

Primary diagnosis is included on the electronic X12, 837 in Loop ID 2300: Reference Indicator H101-C022-02; X12 element #-1271; data element qualifier-1270-BK or AFF for ICD-10.

5.18 How will APGs process payments Medicare Part B coinsurance/deductible amounts for patients that have both Medicare and Medicaid coverage?

Under APGs, Medicaid will continue to pay the full Medicare Part B coinsurance and annual deductible amounts.

5.19 SDOH has indicated that it might begin to pay dental clinic claims based upon procedures as opposed to a visit rate. Right now we are paid the same amount under rate code 2870 regardless of procedures. Are we now going to be paid by procedure and if yes, does this mean that we will now need to bill on the HIPAA compliant 837D format as opposed to the institutional 837I?

In the short run, dental services will be paid under a set of dental APGs at the visit level. These dental APG payments will vary based on the intensity of procedures performed, but payment will remain at the visit level. In the future these same APGs may pay at the conclusion of a given procedure rather than at each visit. At that time a new dental rate code may be issued to access the Grouper/Pricer for procedure-based billing. Hospitals will still use the 837I format to claim.

5.20 It is our understanding that some hospital administered drugs that are carved out today (e.g. chemotherapy) will continue to be carved out and billed as ordered ambulatory. It is also our understanding that other drugs will either be paid separately or packaged under APGs and priced based upon Average Wholesale Prices less 15%. Are you expecting the 340B sites to bill you for these drugs as cost and how will you handle this in your grouper or claims edits? We would like clear instructions as to which drugs we should now be including on claims and how.

Physician administered drugs that are carved-out of the APG payment should be billed using the fee schedule as ordered ambulatory at the acquisition cost (by invoice) to the hospital provider, including 340B sites. Physician administered drugs not carved-out of the APG payment should be billed as a separate claim line in the clinic claim and will be paid as a component of the APG payment (not acquisition cost). The list can be found here: http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf (PDF, 31KB, 5pg.)

Payment for Level I drugs is included in the payment for the medical visit or significant procedure and therefore no additional payment is made at the line level. Level II-IV drugs are paid at Average Wholesale Price (AWP) less 15% at the line level by APG. Level I-IV drugs should be claimed as they are now using acquisition cost; however, the APG will be paid at AWP less 15% regardless of cost. 340B sites must bill actual costs.

5.21 Only six modifiers are used in the Grouper/Pricer. What would you do with the other modifiers if they were valued on the claim?

Other modifiers will not affect payment; however, facilities may choose to use them for purposes of following standard coding procedures.

5.22 Will there be a capital add-on for the DTC's?

Yes, it will be the same add-on the D&TC now receives.

5.23 How will the capital add-on for ambulatory surgery be calculated?

The capital add-on for ambulatory surgery services will no longer be based on PAS group. It will be based on the average capital amount facilities are currently receiving as a peer group by region.

5.24 Our physicians do not currently bill Medicaid fee-for-service for ED or ambulatory surgery services. How will our physicians be paid under APGs?

All physician services for hospital-based ambulatory surgery on or after December 1, 2008 and in the hospital emergency department on or after January 1, 2009 must be billed separately by the physician. Payment will be made based on the published Medicaid Physician Fee Schedule. Physicians and physician medical groups who are not already enrolled in fee-for-service Medicaid will need to do so in order to be paid.

5.25 How and what enrollment do we now need to do for physicians in the emergency department and ambulatory surgery. Do we now need to form a physician group for these physicians and do they need a group NPI? Will we need to bill these services on the 837P? The same CPT codes will potentially be on both the physician and the institutional claim so will there be any edit logic, audit or claiming issues?

Emergency department and ambulatory surgery physicians enrolled in Medicaid may bill directly for their services.

If physicians don't have an NPI or are not enrolled in the Medicaid program, they should obtain a NPI and enroll as a participating provider in Medicaid. For more information on how to obtain an NPI, visit <https://nppes.cms.hhs.gov>. To enroll in Medicaid, visit <https://www.emedny.org/info/ProviderEnrollment/index.html>. Questions about communicating NPI information to NYS Medicaid should be directed to the eMedNY Call Center at 1-800-343-9000.

Physicians will bill using 837P.

Yes, the same CPT codes will be used on both the physician and institutional claim. Medicaid will pay both the physician and the facility for the Medicaid services provided even though the same CPT/HCPCS codes will appear on both claims. There will not be any edit logic, audit or claiming issues.

5.26 Are part time clinics included in APGs?

Yes - part time clinics will be paid under APG methodology for APG covered services.

5.27 When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for payment purposes. Have these significant procedure consolidation decisions been based on clinical factors or claims payment data history?

Significant procedure consolidation decisions have been made by peer physicians using clinical data.

5.28 Effective January 2006, SDOH eliminated the separate EPO rate code (the presentation documentation still makes reference to this rate code of 3106) and stated that the EPO should be billed as ordered ambulatory and since these charges are typically recorded under the dialysis service itself, we might split the claims. Since there will not be a separate rate code for this or any other carved out lab etc, should they be on the same claim as the associated visit charge (such as EPO with a dialysis visit) or does the APG ancillary charge need to be billed on a separate claim. We need to understand how the system will handle these charges if they are included as a line item on a single claim for that date of service or if they must be separately billed.

Just like the other carved out drugs, bill this ancillary charge on a separate claim as a referred ambulatory service.

6. Primary Care Enhancements

6.1 Would you provide more information on expanded "after hours" access.

Effective January 1, 2009, clinics will receive additional reimbursement for services provided during appointments scheduled on weekends, evenings and holidays. Facilities may bill for these services using the rate codes 1400 or 1407, as appropriate, with the appropriate CPT code -99050 or 99051. Payment will be made through the APG.

6.2 Would you provide more information on mental health counseling by licensed social workers?

Effective January 1, 2009, Article 28 clinics will be reimbursed for mental health counseling provided by licensed social workers (LSW). Reimbursement is limited to counseling provided to children/adolescents (under age 19) and pregnant and postpartum women. Coverage is available for individual and family counseling. Group counseling is not covered.

Pregnancy and pregnancy-related mental health counseling must be accompanied with a primary or secondary diagnosis of pregnancy (ICD codes: 630-677, V22, V23, V28), and up to 60 days with a primary or secondary diagnosis of postpartum depression (ICD codes 6448.4X).

6.3 Will mental health counseling by licensed social workers be reimbursed through an APG?

Counseling by licensed social workers will not be reimbursed through an APG. Three (3) new rate codes will be established: Individual Brief, Individual Comprehensive, and Family Counseling. Claims billed with one of these new rate codes will need to be accompanied with a profession code of LMSW (Licensed Master Social Worker) Profession Code 072 or LCSW (Licensed Clinical Social Worker) Profession Code 073 in order to be paid. Facilities will be notified when the new rate codes become available.

6.4 How will reimbursement for smoking cessation counseling for pregnant women be handled?

Effective January 1, 2009, Medicaid will cover smoking cessation counseling provided to pregnant women. This counseling will complement existing Medicaid covered benefits for smoking cessation coverage, which include prescription and non-prescription smoking cessation products.

- Eligible beneficiaries are pregnant females who smoke.
- Claims must have a principle diagnosis of pregnancy (ICD-9-CM Pregnancy Diagnosis Codes: 630-677, V22, V23, V28)
- Smoking cessation counseling may be provided by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife during a medical visit (no group sessions).
- Counseling should be billed under rate codes 1400 or 1407 with one of the following two CPT codes:
 - 99406-Intermediate smoking cessation counseling, >3 minutes up to 10 minutes.
 - 99407-Intensive smoking cessation counseling, >10 minutes.

6.5 How will diabetes and asthma education be reimbursed?

Effective January 1, 2009, Medicaid will cover asthma and diabetes self-management training.

- Education services must be ordered by a physician, physician's assistant, nurse practitioner, or licensed midwife.

- Education services may be provided by NYS licensed, registered, or certified health care professional that is also certified as a diabetes or asthma educator by either the National Certification Board for Diabetes Educators or by the National Asthma Educator Certification Board.
- Educators must be employed by an Article 28 clinic or an office practice.

A newly diagnosed asthmatic and/or diabetic or one who has a medically complex condition such as exacerbation of condition, poor control of condition, diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription for new equipment, etc. will be allowed up to 20 hours of self-management training during a continuous 12 month period. Asthmatic and/or diabetic enrollees who are medically stable can receive up to 2 hours of self-management training in a continuous 12 month period. Self-management training can be delivered in a group or individual session.

Diabetes self management training should be billed under rate codes 1400 or 1407 with one of the following CPT codes:

- G0108-Diabetes outpatient self management training services, individual, per 30 minutes.
- G0109-Diabetes outpatient self management training services, group, per 30 minutes.

Asthma self management training should be billed under rate codes 1400 or 1407 with one of the following CPT Codes:

- 98960-Individual education for 30 minutes
- 98961-Group education session, 2-4 patients, 30 minutes
- 98962-Group education session, 5-8 patients, 30 minutes

6.6 Are the primary care enhancements billable by an Article 28 facility, or are they available only in PPAC clinics?

The primary care enhancements may be provided by an Article 28 facility, as long as they possess the appropriate Health Department certification, e.g., a facility that is offering mental health counseling by licensed social workers must have the authority to do so on their operating certificate.

7. Provider-Specific Questions

7.1. How will School Based Health Clinics be paid under APGs?

School-based health services provided to patients not enrolled in a managed care plan will be reimbursed using APGs. School-based health services provided to managed care enrollees will not be paid using APGs. Managed care carve-out services will continue to be paid fee-for-service by Medicaid under the clinic threshold rate methodology. Previously established rate codes must be used for these billings - rate codes 2888 and 2889.

7.2. How will PAC provider billing be different under APGs? Is the APG grouper different that the PAC grouper?

The APG grouper is different from the PAC grouper. The APG grouping logic is available in the [3M™ Enhanced Ambulatory Patient Grouping System Definitions Manual](#). The PAC grouper will be replaced by APGs (except for the few FQHCs that remain under the PAC reimbursement methodology).

7.3. How will PAS provider billing be different under APGs?

The PAS grouper will be replaced by the APG grouper and the PAS grouper access rate codes will no longer be used.

7.4 If a medical visit occurs during provision of MMTP services, how is this to be billed under APGs?

All MMTP services, including required medical exams under the MMTP program, should continue to be billed under rate code 2973, Methadone Maintenance Treatment Program, weekly. Medical visits that are distinct from the methadone service can be billed separately under APGs.

7.5 Will FQHCs be subject to APGs?

Pursuant to federal law, FQHCs may choose to be paid under the APG methodology or continue to be paid under the prospective payment system methodology. The payment methodology an FQHC chooses will apply to all claims submitted by the FQHC. For FQHCs that opt for the APG reimbursement methodology, short fall payments for visits provided to Medicaid managed care and FHPlus enrollees will continue to be paid using the existing FQHC shortfall rate codes. The shortfall amount will be based on the FQHC's PPS rate.