



STATE OF NEW YORK
DEPARTMENT OF HEALTH

Ambulatory Patient Groups Implementation

Ancillary Policy for Laboratories
September 23, 2010



Presentation Outline

- Status of APG implementation in DTCs
- Overview of APGs, with respect to ancillary (e.g., laboratory) billing policies
- Special payment rules and APG carve-outs
- APG resource materials for providers
- Question and answer period



Speakers

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APG Implementation Status



Status of APG Implementation

- APGs were implemented in hospital-based outpatient clinics and ambulatory surgery units on December 1, 2008.
- APGs were implemented in hospital emergency departments on January 1, 2009.
- APGs were approved by CMS on 6/14/2010 for free-standing clinics and ambulatory surgery centers retroactive to 9/1/2009.
- Ancillary billing policy for DTCs has been delayed until January 1, 2011.



APG Payment Methodology Overview

What are APGs?

- APGs are a classification/reimbursement system, developed by 3M HIS (remember the scotch tape people?)
- APGs are designed to detail the amount and type of resources used in ambulatory visits.
- APGs:
 - Predict the average pattern of resource use for a group of patients by combining procedures, medical visits and/or ancillary tests that share similar characteristics and resource utilization;
 - Provide greater reimbursement for higher intensity services and less reimbursement for low intensity services; and
 - Allow more payment homogeneity for comparable services across all ambulatory care settings (e.g., outpatient department and diagnostic and treatment centers).

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.
- **OTHER TYPES OF APGs:** Drugs, DME (not used in NYS, paid through fee schedule), Incidental to Medical Visit (always packaged), Per Diem, Inpatient-Only (not eligible for payment), Unassigned (not eligible for payment)

APG PAYMENT DEFINITIONS

- **Consolidation (or Bundling)**

- The inclusion of payment for a related procedure into the payment for a more significant procedure provided during the same visit.
 - CPT codes that group to the same APG are consolidated.

- **Packaging**

- The inclusion of payment for related medical visits or ancillary services in the payment for a significant procedure.
 - The majority of “Level 1 Ancillary” APGs are packaged.
 - (i.e. pharmacotherapy, lab and radiology)
 - Uniform Packaging List is available online at the DOH APG website.

- **Discounting**

- A discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies.
 - If two CPT codes group to different APGs, 100% payment will be made for the higher cost APG, and the second procedure will be discounted (generally at 50%).

Examples of Laboratory Test APGs

Test Category	Level of Test Complexity	APG
Pathology	Level I	390
	Level II	391
Pap smears		392
Blood and Tissue Typing		393
Immunology Tests	Level I	394
	Level II	395
Microbiology Tests	Level I	396
	Level II	397
Endocrinology Tests	Level I	398
	Level II	399
Chemistry	Basic	402

More Examples of Lab APGs

Test Category	Level of Test Complexity	APG
Chemistry	Level I	400
	Level II	401
Organ Or Disease Oriented Panels		403
Toxicology Tests		404
Therapeutic Drug Monitoring		405
Clotting Tests	Level I	406
	Level II	407
Hematology Tests	Level I	408
	Level II	409
Urinalysis		410
Blood and Urine Dipstick Tests		411
Simple Pulmonary Function Tests		412

Partial Crosswalk of Lab HCPCS Codes Grouping To APGs 396 and 402

EAPG	APG Description	HCPCS code	HCPCS code description
396	LEVEL I MICROBIOLOGY TESTS	86628	Candida antibody
		87045	Feces culture, bacteria
		87084	Culture of specimen by kit
		87086	Urine culture/colony count
		87149	Culture type, nucleic acid
		87177	Ova and parasites smears
402	BASIC CHEMISTRY TESTS	82271	Occult blood, other sources
		82540	Assay of creatine
		82962	Glucose blood test
		84450	Transferase (AST) (SGOT)
		84478	Assay of triglycerides

Partial Crosswalk of Lab HCPCS Codes Grouping To APGs 390 and 392

EAPG	APG Description	HCPCS code	HCPCS code description
390	LEVEL I PATHOLOGY	85097	Bone marrow interpretation
		88130	Sex chromatin identification
		88184	Flowcytometry/ tc, 1 marker
		88302	Tissue exam by pathologist
		88314	Histochemical stain
		88323	Microslide consultation
392	PAP SMEARS	88142	Cytopath, c/v, thin layer
		88147	Cytopath, c/v, automated
		88174	Cytopath, c/v auto, in fluid
		G0123	Screen cerv/vag thin layer
		G0144	Scr c/v cyto,thinlayer,rescr

Sample APGs and Weights

APG	APG Name	Type	Weight
30	LEVEL I MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Sign. Proc.	7.1713
40	SPLINT, STRAPPING AND CAST REMOVAL	Sign. Proc.	0.9801
112	PHLEBOTOMY	Sign. Proc.	0.7853
116	ALLERGY TESTS	Sign. Proc.	1.8184
271	PHYSICAL THERAPY	Sign. Proc.	0.6827
315	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY	Sign. Proc.	0.6206
396	LEVEL I MICROBIOLOGY TESTS	Ancillary	0.1016
397	LEVEL II MICROBIOLOGY TESTS	Ancillary	0.2340
400	LEVEL I CHEMISTRY TESTS	Ancillary	0.0952
401	LEVEL II CHEMISTRY TESTS	Ancillary	0.2615
413	CARDIOGRAM	Ancillary	0.2289
414	LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY	Ancillary	0.1929
471	PLAIN FILM	Ancillary	0.3223
562	INFECTIONS OF UPPER RESPIRATORY TRACT	Medical Visit	0.7152
575	ASTHMA	Medical Visit	0.8845
599	HYPERTENSION	Medical Visit	0.7406
808	VIRAL ILLNESS	Medical Visit	0.8755

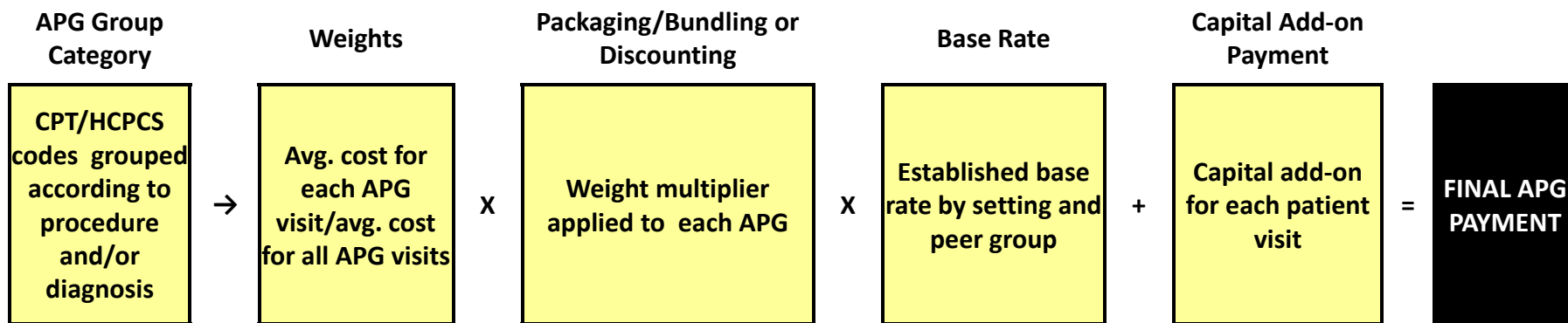


IMPORTANCE OF ACCURATE CODING BY THE CLINIC

- Under APG payment methodology, all clinic claims must include:
 - the new APG rate codes;
 - a valid, accurate ICD-9-CM primary diagnosis code(s); and
 - valid CPT and/or HCPCS procedure code(s) reflecting service provided.
- All lab tests ordered by the clinic must be reported by the ordering clinic using the appropriate CPT code on their Medicaid APG claim.

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
- 10%-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)



Laboratory Tests Ordered by Hospital OPDs and DTCs



Ancillary Billing Policy for Hospital OPDs and DTCs

- Providers will be given two billing options for “ordered” ancillaries:
 - 1) contract with outside providers for all their labs and radiology, or
 - 2) have the labs and radiology providers bill directly off the ordered ambulatory fee schedule.
- Under either option, all ancillary procedures (except APG carve outs) must be coded on the clinic’s APG claim.



Payment and Billing Policy For Contracted Lab Services

- Lab services ordered by clinic practitioners for clinic patients (for services subject to APGs) are included in the APG payment to the clinic for the clinic visit.
- Clinics must make arrangements to pay laboratory providers for services provided to clinic patients.
- Clinics must report laboratory tests on the APG claim for services provided to clinic patients.
- Lab providers may not bill eMedNY directly for lab services related to an APG reimbursed clinic visit.



Payment and Billing Policy For Non-Contracted Lab Services

- Lab services ordered by clinic practitioners for clinic patients (for services subject to APGs) are not included in the APG payment to the clinic.
- Clinics must still report laboratory tests on the APG claim for services provided to clinic patients.
- Lab providers should bill eMedNY directly for lab services related to an APG reimbursed clinic visit.



Ancillary Billing Policy for Hospital OPDs and DTCs that Contract for Lab Services

- If a clinic desires reimbursement for any ancillary they must code modifier 90 on the same line as the ancillary.
 - Again, all ancillaries must be coded on the APG claim (except APG carve outs)
- All clinics may code modifier 90 on ancillaries performed in-house.
- Only those clinics that contract with ancillary vendors may code modifier 90 on ordered ancillaries!

Modifier 90

- Modifier 90 is only to be used for:
 - In-house ancillaries performed by any APG biller, or
 - Ancillaries ordered by APG billers from an ancillary vendor under contract with the APG biller
- Ancillaries ordered by non-contracting clinics must still be coded on the APG claim, but not with modifier 90.

Modifier 90 (Cont.)

- The effect of modifier 90:
 - If modifier 90 is coded on a non-packaging ancillary, the clinic will receive payment for the ancillary, subject to the usual APG payment logic. (IN-HOUSE ANCILLARY OR CONTRACTING PROVIDER)
 - If modifier 90 is coded on a packaging ancillary, the clinic will receive payment for the ancillary via “packaging” (i.e., payment will be included on the line for the E&M code).
 - If modifier 90 is not coded on a non-packaging ancillary, no payment will be made for that ancillary. The ancillary vendor may bill Medicaid directly.
 - If modifier 90 is not coded on a packaging ancillary, the value of the ancillary will be subtracted from the APG payment because the payment for that ancillary was included in the line for the E&M code. The APG biller was not entitled to that payment because an ancillary vendor will be billing Medicaid directly for the procedure.



How Can a Lab Determine What a Clinic is Being Reimbursed for Lab Tests under APGs?

- It is not always possible for a lab to identify payment amounts to clinics for specific lab tests reimbursed to clinics under APGs.
 - *For packaged lab tests, APG reimbursement to a clinic reflects the average costs of the ancillary services provided, but no line level payment is shown on the APG remittance.*
- For non-packaged lab tests, a line item payment is made to the clinic.
- If a clinic contracts with a lab for testing, payment amounts will need to be negotiated.

Hospital OPD Laboratory Testing as “Ordered Ambulatory” Services

- When a private practitioner, a free-standing clinic, or another hospital orders lab tests from a hospital-based lab, the lab services are considered ordered ambulatory services.
- Ordered ambulatory services are not reimbursed under APGs.
 - *Ordered ambulatory services will move to APG reimbursement on January 1, 2012.*
- The hospital-based laboratory may bill Medicaid directly for any lab tests that are provided on an ordered ambulatory basis, unless the hospital has contracted with the entity that ordered the tests.
 - *Assuming the ordering entity is an APG biller.*



In Summary

- Payment for lab services for clinic patients are included in the APG payment for clinic providers who contract with an outside lab.
 - Labs should not bill eMedNY for lab services provided to these clinic patients.
 - Clinics who contract are required to pay labs for services rendered.
- Payment for lab services for clinic patients are not included in the APG payment for providers who do not contract for those services.
 - Laboratories may bill fee-for-service for lab tests provided to non-contracting clinics.



Special Payment Policies

APG Carve Outs

- Lab Tests Carved out of APGS
 - Lead screen
 - HIV viral load test
 - HIV drug resistance tests
 - Hep C virus, genotype tests
- All genetic laboratory tests
- These tests may be continued to be billed to eMedNY by the testing laboratory using the laboratory fee schedule.
- A complete list of carve outs is available at;

http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf

APG Carve Outs

- All laboratory tests are included in the clinic payment (i.e., not fee billable by labs) for rate codes 1695 and 2983 - with the exception of the following HCPCS codes;
 - 86701- *HIV-1*
 - 86702- *HIV-2*
 - 86703- *HIV-1 and HIV-2, single assay*
- Beginning on January 1, 2011, rate codes 1695 and 2983 will be eliminated (i.e., carved into APGs) and lab tests associated with these services will be billable FFS for non-contracting labs.



Medicare / Medicaid Dual Eligibles

- Medicaid will continue to pay clinics the full annual deductible as well as the full 20% Medicare Part B coinsurance amount for all APG Medicare / Medicaid “crossover” claims.
- For MA/MC crossover claims-if the lab provider is required to bill Medicare directly, the ancillary provider should do so and the claim will be automatically crossed over to Medicaid for any balance due. The clinic should not report these lab tests on their APG claim since they will not be paying the laboratory provider.
- For MA/MC crossover claims, when a lab bills Medicare directly, Medicare generally pays 100% of the lab claim.

Pre and Post Surgery Testing

- **Pre-Surgical Testing:** Pre-surgical testing for ambulatory surgery ordered by an OPD or DTC clinic practitioner for a clinic patient during an APG reimbursable clinic visit should be billed using an APG rate code.
 - Pre-surgical testing ordered by a hospital ambulatory surgery unit or ambulatory surgery center practitioner for a patient referred to the ambulatory surgery facility should be billed by the ancillary provider on an ordered ambulatory basis using the Medicaid fee schedule.
- **Post-surgical Testing (e.g., pathology):** All post-surgical tests ordered by the hospital ambulatory surgery unit or ambulatory surgery center practitioner should be billed by the ancillary provider on an ordered ambulatory basis using the Medicaid fee schedule.

FQHCs

- Ancillary lab APG billing and payment policy applies to FQHCs that have opted into APGs.
 - But, like other providers, they will have the ability to opt out of the contracting aspect of the ancillary policy
- If an FQHC has not opted into APGs and continues to be reimbursed under the prospective payment system (PPS):
 - In general, lab is carved out of the PPS rate and may be billed to Medicaid by the testing lab using the laboratory fee schedule.



Additional Laboratory Specific Issues



Can DTC Clinics Opt Out of APGs?

- DTC clinics can not opt out of APGs.
- Only FQHCs can opt out of APGs.
 - FQHCs must notify DOH by November 1 any change of status to opt in or out of APGs for the following calendar year.



What if a Clinic does not pay for Laboratory Tests provided by a contract lab?

- Non-payment by a clinic to a laboratory for services provided may constitute an unacceptable practice under Social Service Regulation 18NYCRR 515.2 (b)(4).
- Non-payment may cause the clinic to be subject to OMIG action/audit.



How is Laboratory Reference Testing Billed?

- In most cases, the reference lab should bill the referring lab, and the referring lab should bill the clinic (or the fee schedule).
- If a lab refers more than 30% of its work to a reference lab, the reference lab should bill the clinic directly.



How are Drug Screens Covered by Medicaid in MMTP Clinics?

- MMTP clinics currently are not subject to APGs.
- Reimbursement for laboratory drug screen tests is included in the MMTP rate and the lab should bill the clinic.

Can Labs Get Paid for Venipuncture Under APGs?

- A clinic can bill Medicaid for venipuncture as part of a medical visit or significant procedure.
- Blood draw/venipuncture is not a uniform packaged ancillary.
 - Separate line item payment is made to the clinic under APGs for venipuncture when billed with an E&M and/or significant procedure.
 - However, if venipuncture is billed without an E&M and/or significant procedure, no clinic payment is made.



How Will Medicaid Reimburse for New Lab Tests under APGs?

- The APG grouper/pricer is updated at least once year to include new services covered by Medicaid.
- Medicaid will only reimburse the clinics for lab tests that are included in the APG grouper.



Laboratory Utilization Threshold Limits and Co-payments

- Utilization Thresholds will apply to clinic visits paid thru APGs, but will not specifically apply to laboratory services within those visits.
- Similarly, Medicaid co-payments will apply to the clinic visit paid thru APGs, but will not specifically apply to laboratory services within those visits.



Supporting Materials and Contact Information

Supporting Materials

- The following is available on the DOH website
 - (http://www.nyhealth.gov/health_care/medicaid/rates/apg/)
 - *Provider Manual- updated June 2010*
 - (http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual)
 - *PowerPoint Presentations*
 - *APG Documentation*
 - *APG Types, APG Categories, APG Consolidation Logic*
 - *Revised Rate Code Lists*
 - *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 (currently under revision)*
 - *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*