

# Introduction to Medicaid Billing Using Ambulatory Patient Groups (APG) for Family Planning Providers

*Presented by the New York State Center of Excellence for Family Planning and Reproductive Health Services*

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# Introduction to Medicaid Billing Using Ambulatory Patient Groups (APG) for Family Planning Providers

## Introduction

### **Colleen Foreman**

Director, Community Based Health Unit,  
Bureau of Maternal and Child Health,  
New York State Department of Health

### **Elizabeth Jones**

Director, New York State Center of Excellence for Family Planning  
and Reproductive Health Services,  
Cicatelli Associates Inc.



# Webinar Objectives

- Review general payment and policy rules for the APG payment methodology
- Illustrate how family planning providers appropriately bill Medicaid using APGs for the most common family planning visits
- Review special payment rules and issues of special interest to family planning providers, providing concrete examples to illustrate appropriate use
- Answer your questions on APGs



# Introduction to Medicaid Billing Using Ambulatory Patient Groups (APG) for Family Planning Providers

## Presenters

**Ann Finn**

Provider Consulting Solutions, Inc.

**Stephen MacCormack**

Provider Consulting Solutions, Inc.



# Medicaid Reimbursement: Old vs. New

- **Threshold Payment**
  - A single payment for multiple services
  - Little incentive to capture and report services accurately
- **APGs - Ambulatory Patient Groups**
  - Payments based on the amount and type of resources used
  - Requires accurate capture and billing of diagnoses and CPT codes for **all** services provided
- **This shift impacts daily operations and billing processes**



# Tackling APGs: What are the Common Challenges?

- Many providers find it difficult to validate whether they receive appropriate payments
- Billing complexities increase concerns about potential compliance issues
- Internal processes do not always capture APG nuances
- Staff can be overwhelmed



# APG Basics

- A patient encounter is described by a list of APGs that corresponds to each service provided either by:
  - Procedure Codes
  - Diagnosis Codes
- Multiple APGs can be assigned to a claim based on the procedures performed
- Not all services are paid as an APG



# What Impacts APG Payment?

- Base Rates
- Weights
- Transition Blend – *Until 2012*
- APG Payment Adjustments
  - Packaging, Consolidation, and Discounting



# Base Rates

- Base rates depend on:
  - Peer group – Type of provider and service
    - Examples: Freestanding Diagnostic and Treatment Center (DTC), Hospital Outpatient Department, Hospital Emergency Room, Hospital Ambulatory Surgery, Freestanding Ambulatory Surgery
  - Region – Downstate , Upstate, or Statewide
  - Case mix, visit volume, existing payment, and targeted investment



# APG Base Rates

Service	Base Region	Jul-09	Dec-09	Jan-10	Jul-10
OPD	Downstate	\$258.90	\$199.18	\$206.48	\$204.33
OPD	Upstate	\$199.00	\$153.11	\$158.71	\$157.07
Hosp. ASU	Downstate	\$156.91	\$156.91	\$228.00	\$215.50
Hosp. ASU	Upstate	\$122.25	\$122.25	\$176.13	\$166.47
DTC	Downstate	\$212.07	\$158.78	\$156.76	\$156.76
DTC	Upstate	\$174.74	\$129.14	\$131.35	\$131.35

Source: [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/#rates](http://www.health.state.ny.us/health_care/medicaid/rates/apg/#rates).



## Statewide Base Rate

- Starting January 1, 2011, the APGs for common family planning services with minimal regional cost variations began paying using new statewide base rate

APG	APG Description	Date added to list
286	MAMMOGRAPHY	1/1/2011
291	BONE DENSITOMETRY	1/1/2011
390	LEVEL I PATHOLOGY	1/1/2011
391	LEVEL II PATHOLOGY	1/1/2011
392	PAP SMEARS	1/1/2011
393	BLOOD AND TISSUE TYPING	1/1/2011
394	LEVEL I IMMUNOLOGY TESTS	1/1/2011
395	LEVEL II IMMUNOLOGY TESTS	1/1/2011

- Current 2011 Statewide Base Rate = **\$165.00**;  
Estimated 2012 Statewide Base Rate = **\$160.00**



# What Rate Code Should I Use?

- Clinic Visit-Based:
  - Hospitals: **1400** (effective 12/1/2008)
  - DTCs: **1407** (effective 9/1/2009)
- Clinic Episodic-Based:
  - Hospitals: **1432** (effective 7/1/2009)
  - DTCs: **1422** (effective 7/1/2011)
- Ambulatory Surgery:
  - Hospitals: **1401** (effective 12/1/2008)
  - Freestanding: **1408** (effective 9/1/2009)
- Ordered Ambulatory Fee-for-Service
  - No rate code on claim



## Visit-Based Rate Codes

- Recognize each date of service as a separate encounter
- In order to be paid correctly, NYS DOH required providers to change the date of service for ancillary services provided subsequent to the clinic visit to the same date as the clinic visit when they were ordered, including:
  - Lab/radiology services provided by the DTC
  - Lab/radiology services referred to outside ancillary providers
- Visit-based rate codes were problematic for providers and led to the creation of episodic-based rate codes



# Episodic-Based Rate Codes

- Episodic-based rate codes cover the entire episode of care:
  - “An episode is defined as all medical visits and/or significant procedures that occur on a single date of service, as well as any associated ancillaries that occurred on or after the date of the medical visit and/or significant procedure”
- Regardless of reported dates of service, all procedures on a claim will be considered part of the same visit
- If significant procedures and/or medical visits from different dates of service are reported on the same claim, unwarranted discounting or consolidation may occur, resulting in underpayment



# Weights and Blend

- **Weights:** Adjusted periodically as NYS DOH collects new provider data, becoming more stable
  - Reweighting last took place in July 2011
- **Transition Blend:** The Medicaid payment for a visit includes a percentage of the APG payment and a complementary percentage of the average threshold rate in 2007:
  - Phase 1: (2008/2009) 25% APG / 75% Threshold Blend
  - Phase 2: (2010) 50% / 50%
  - Phase 3: (2011) 75% / 25%
  - Phase 4: (2012) 100% APG Payment



# Primary Types of APGs

- **Significant Procedures:** A procedure that constitutes the reason for the visit and dominates the time and resources expended
  - Examples : Colposcopy, Surgical Abortion, Cyrotherapy, Mammogram
- **Medical Visits:** A visit during which a patient receives medical treatment (normally denoted by an Emergency and Management code), but did not have a significant procedure performed
  - APG assignment is based on the primary diagnosis
    - Examples include: GYN Annual Visit, STI Testing and Treatment



## Primary Types of APGs (continued)

- **Ancillaries:** Tests and procedures ordered by the primary physician to assist in patient diagnosis or treatment
  - Examples : Immunizations, IUD Insertion and Removal, Lab Tests such as Gonorrhea, and Urine Pregnancy Tests
- **Drugs**
- **Incidentals**
  - Example: Vaccine Administrations



# Significant Procedure Subtypes

- New in January 2011, significant procedures were divided into subtypes
- Discounting happens within a subtype only

0	No Subtype
1	Per Diem
2	Significant Procedure
21	Physical Therapy & Rehabilitation
22	Mental Health & Counseling
23	Dental Procedure
24	Radiologic Procedure
25	Other Diagnostic Procedure



# APG Payment Factors

- **Consolidation (or Bundling):** 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:** 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
    - Examples: Pharmacotherapy, Lab Tests, Radiology
  - For the full Uniform Packaging List, go to:  
[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/apg\\_uniform\\_packaging.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_uniform_packaging.pdf)



# APG Payment Factors

- **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%)
- **If Stand Alone Do Not Pay (ISADNP):** Certain lab and radiology tests will only be paid if billed on the same claim as the **medical visit** or **significant procedure** APG that occurred when the ISADNP test was ordered



# What is a Carve-out?

- **Carve-out:** A service not reimbursable under APGs
  - Examples: Devices such as IUDs and Implanon, Monoclonal Antibodies and other drugs, certain vaccines
- Bill device and drug carve-outs at cost to the Medicaid Ordered Ambulatory Fee Schedule as separate claim with no rate code
- For a complete list of APG carves-outs, go to:  
[http://nyhealth.gov/health\\_care/medicaid/rates/apg/docs/apg\\_carve\\_outs.pdf](http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_carve_outs.pdf)



## Conditional Carve-outs

- Procedures that may be billed to Medicaid as ordered ambulatory services when an APG claim is not billed for the clinic patient on the same date of service:
  - **J1055:** Depo-Provera injection
  - **81025:** Urine pregnancy test
  - **86580:** TB Intradermal test
- **Report cost—the service will be reimbursed for the lower of the fee schedule payment or charge amount!**



## Carve-outs



- When a carve-out is not billed or billed in error to an APG claim and not to the Ordered Ambulatory Fee Schedule, the claim will receive a \$0 payment
- Carve-outs can be billed using your 837i or ePACES



# New 2011 APG Fee Schedule

- Starting January 1, 2011, the new fee schedule allows reimbursement of a fixed amount for defined services on the APG claim
  - Example: Beginning July 1, 2011 the UPT will pay \$3.19 on the APG Fee Schedule when billed with an E/M on an APG claim
- These procedures are not be eligible for a blended payment or capital add-on
- Procedures are paid for the lower of the fee schedule or charge amount



## Remember: Multiple Claims May be Billed for One Visit



- **Claim 1 - APG rate codes** – Evaluation and Management (E/M), Significant Procedures, and Lab tests
- **Claim 2 – Ordered Ambulatory Fee Schedule** – Drugs, Devices, Tests, and Other Carve-out Services



## New Ancillary Billing Policy for DTCs

- Effective July 2011, DTCs **only** were given two billing options for “ordered” ancillaries:
    - Contract with outside providers for all their labs and radiology
- OR**
- Have the lab and radiology service providers bill Medicaid directly for ancillaries ordered during the clinic visit



## New Ancillary Billing Policy for DTCs

- All ancillaries ordered or provided by the DTC on-site (i.e. point-of-service testing) must be coded on the APG claim along with the medical service(s) provided during the visit
  - Use the episodic rate code (**DTC 1422**) to report multiple dates of service
- Ancillary service should not be reported on a clinic claim until confirmation has been received that the ancillary service was actually performed



## DTC Billing Under the New Policy

- If you are non-contracting and perform in-house lab tests that package into the E/M, you need to code **Modifier U6** to avoid unwanted payment reduction
  - Otherwise, there will be a reduction in payment for the packaged service outside lab is billing for a service

- **Remember: U6 = Pay Me**



# October 1 Changes to Ancillary Billing Policy

- As of October 1, 2011, NYS DOH has reversed its “all or nothing” contracting policy
- Providers no longer are required to contract with outside providers for **ALL** of their lab and radiology services, and may determine whether to contract **separately** with Labs and/or Radiology
- Claims processed prior to October 1, 2011, with a date of service after July 1, 2011, may be resubmitted to NYS DOH for a payment correction
  - The reduction for a packaged service now are calculated using the \$165 State-wide Price



# Key Concepts for Scenarios



# Coding Basics

- “E/M,” “Medical Visit,” and “Evaluation and Management” all stand for **“Evaluation and Management”**
  - Within each type of encounter, there are different levels of care
    - Example: 99214 is a “Level 4” office visit
- “HCPCS” stands for Healthcare Common Procedure Coding System
  - The terms HCPCS, CPT, and Procedure Codes are used interchangeably
  - Level I HCPCS codes are called CPT-4 codes (current procedural terminology)



# E/M Code Groups

- **E/M Codes 99201 - 99215:** Services to evaluate patients with a medical problem or chief complaint are codes
  - New patient codes - 99201 - 99205; established patients - 99211 - 99215
  - Used for “sick” visits and problem-focused services
- **E/M Codes 99381 - 99397:** Preventive medicine services
  - Age-specific
  - Meant for the reporting of asymptomatic patients
  - Includes counseling, anticipatory guidance, and risk factor reduction interventions, as well as the ordering of laboratory and diagnostic procedures
  - Used for routine annual exams and other gynecological exams
- **E/M codes should not be reported for a nurse-only visit on the APG claim!**



# Defining Diagnoses

- Primary diagnosis (also called “first-listed” in coding guidelines) is the main condition treated or investigated during the relevant episode of outpatient health care
- Be aware that two or more conditions may all meet the primary or first-listed definition



# ICD-9-CM Coding Guidelines

- “List first the ICD-9 code for the diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record to chiefly responsible for the services provided”
- “Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management”
- “When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, ... any one of the diagnoses may be sequenced first”

**Source:** ICD-9-CM Guidelines for Coding and Reporting.



# What is APG 875 Contraceptive Management?

- Effective July 1, 2011, there is a new APG for **CONTRACEPTIVE MANAGEMENT**, with a significant payment enhancement compared to APG 871 (the former APG paid for contraceptive management medical visits)
  - E/M service is coded in conjunction with a “V25” series primary diagnosis
  - Family Planning visit indicator is present:
    - 837p or ePACES - “Y” must be coded in the Family Planning visit indicator field
    - 837i electronic form - "A4" in one of the condition code fields located in the HI segment of the header of the claim
    - UB-04 Paper form - "A4" as condition code in form fields 18-28



# Expanding the Family Planning Enhancement

- Beginning January 1, 2012, the payment for a family planning E/M will be enhanced if the **primary** or **first secondary diagnosis** is in the V25 series
  - APG 871 will get a 50% weight bump when a V25 diagnosis code is in the first secondary diagnosis field
  - The weight for APG 875 will not decrease in January—it should remain the same or increase
- For detailed guidance on general family planning billing policies, go to:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/docs/billing\\_family\\_services.pdf](http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/billing_family_services.pdf)
- For details on APG 875, access the October 5 Webinar at:  
<http://www.cicatelli.org/titlex/Webinars.htm>



# Payments for APG 875 vs. APG 871

- **APG 875 - CONTRACEPTIVE MANAGEMENT** will pay ~50% more than a general medical visit that maps to **APG 871 - SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS**

APG	APG Description	Est. Jan 2012 APG Weight	DTC Gen Clinic		Hospital OPD	
			Downstate	Upstate	Downstate	Upstate
			Base Rates * >			
			\$ 156.76	\$ 131.35	\$ 204.33	\$ 157.07
871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	0.7459	\$116.93	\$ 97.98	\$152.42	\$117.17
875	CONTRACEPTIVE MANAGEMENT	1.1189	\$175.40	\$146.97	\$228.63	\$175.75
Percentage Increase ->			50%	50%	50%	50%

NOTE: Estimated Phase 4 APG Base Rates effective Jan 1, 2012



# Scenario #1 – Contraceptive Management Visit with an Exam



# Scenario #1 – Contraceptive Management Visit with an Exam

- **What happened at this encounter?**
  - 20 year-old female in for birth control and a GYN exam
  - Patient selects the NuvaRing as her contraceptive method
  - NP performed an exam and lab tests
  - Script given for NuvaRing with instructions



## Scenario #1 – Key Questions to Ask: Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
  - Yes—Report 99395
- Was Contraceptive Management provided?
  - Yes
- What diagnoses are reported?
  - V72.31 (Routine GYN Exam) and V25.02 (Initiation of Other Contraceptive Measure)
- Can I code V25x as a primary diagnosis?
  - Yes—the birth control method required an exam (as supported by documentation) and, therefore, meets the “chiefly responsible” coding criteria



# Scenario #1 – Contraceptive Management Visit with an Exam

- **What's important under APGs?**
  - APG assignment and reimbursement is driven by the primary diagnosis for the E/M
  - Each lab test is billed separately, mapped to an Ancillary APG , and includes the U6 modifier, when appropriate
  - Determining whether the birth control method is billable under APGs, as a carve-out under the Ordered Ambulatory Fee Schedule, or not billable (i.e. prescription)



# Scenario #1 – Contraceptive Management Visit with an Exam

Family Planning Visit (DOS 1/1/2012 - Phase 4) - Medical Visit With APG 875 Qualifying Visit

Date of Service:		1/1/2012		Family Planning Indicator:		Y						
APG Base Rate:		\$156.76		Rate Code:		1422 DTC General Clinic						
Existing Payment for Blend:		NA		Region:		Downstate						
Blend Percentage (APG):		100%		Primary Dx Code (Description):		V2502		Initiation of Other Contract Measure				
Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT		Full payment	1	100%	1.1189	\$175.40	\$0.00	\$6.00	\$181.40
87491	CHYLM D TRACH, DNA, AMP PROBE	394	LEVEL I IMMUNOLOGY TESTS	U6	Packaged	1	0%	0.0982	\$0.00	\$0.00		\$0.00
87591	N.GONORRHOEAE, DNA, AMP PROB	397	LEVEL II MICROBIOLOGY TESTS	U6	Full payment	1	100%	0.2175	\$34.10	\$0.00		\$34.10
<b>TOTALS</b>								1.4346	\$209.50	\$0.00	\$6.00	\$215.50



# Scenario #1 – Contraceptive Management Visit with an Exam

*What happens if I don't include Modifier U6?*

Family Planning Visit (DOS 1/1/2012 - Phase 4) - Medical Visit With APG 875 Qualifying Visit

Date of Service:	1/1/2012	Family Planning Indicator:	Y
APG Base Rate:	\$156.76	Rate Code:	1422 DTC General Clinic
Existing Payment for Blend:	NA	Region:	Downstate
Blend Percentage (APG):	100%	Primary Dx Code (Description):	V2502 Initiation of Other Contract Measure

Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT		Full payment	1	100%	1.1189	\$175.40	\$0.00	\$6.00	\$181.40
87491	CHYLMD TRACH, DNA, AMP PROBE	394	LEVEL I IMMUNOLOGY TESTS		Packaged	1	0%	0.0982	(\$15.39)	\$0.00		(\$15.39)
87591	N.GONORRHOEAE, DNA, AMP PROB	397	LEVEL II MICROBIOLOGY TESTS		Full payment	1	0%	0.2175	\$0.00	\$0.00		\$0.00
<b>TOTALS</b>								1.4346	\$160.01	\$0.00	\$6.00	\$166.01

■ Not including U6—a difference in payment ~\$50!



## Be Careful...

- If a payment is made for a family planning procedure (based on a V25 series diagnosis) and the claim does not include a "Y" or "A4" in the Family Planning box, some or all of the payment for the claim may be subject to recovery under audit
- Inappropriate use of a V25 diagnosis could also result in an audit-based recovery
- Providers should follow all appropriate guidelines with respect to using a diagnosis from the V25 series

Source:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/docs/billing\\_family\\_services.pdf](http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/billing_family_services.pdf)



## Scenario #2 – Depo-Provera: Physician/Nurse Practitioner Visit



## Scenario #2 – Depo-Provera: Physician/Nurse Practitioner Visit

- **What happened at this encounter?**
  - Patient comes in to start Depo-Provera as her contraceptive method
  - Patient protocol requires an exam and counseling
  - Services provided: Depo 150mm IM; patient to return in 11-12 weeks for repeat Depo



## Scenario #2 – Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
  - Yes—Report 99213 for the exam
- Was Contraceptive Management provided?
  - Yes
- What diagnoses are reported?
  - V72.31 (Routine GYN Exam) and V25.02 (Initiation of Other Contraceptive Measure)
- Can I code V25x as a primary diagnosis?
  - Yes



## Scenario #2 – Depo-Provera: Physician/Nurse Practitioner Visit

- **What about the Depo-Provera?**
  - Depo-Provera is considered a **conditional carve-out**
  - When administered during a billable E/M encounter, the Depo-Provera and injection are billed to the APG claim and package into the E/M
  - No additional payment received



# Scenario #2 – Depo-Provera: Physician/Nurse Practitioner Visit

Family Planning Visit (DOS 1/1/2012 - Phase 4) - Medical Visit With APG 875 Qualifying Visit

Date of Service:		1/1/2012	Family Planning Indicator:		Y							
APG Base Rate:		\$156.76	Rate Code:		1422 DTC General Clinic							
Existing Payment for Blend:		NA	Region:		Downstate							
Blend Percentage (APG):		100%	Primary Dx Code (Description):		V2502	Initiation of Other Contract Measure						

Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT		Full payment	1	100%	1.1189	\$175.40	\$ -	\$ 6.00	\$ 181.40
J1055	Depo Provera	435	CLASS I PHARMACOTHERAPY		Packaged	1	0%	0.1879	\$0.00	\$ -		\$ -
96372	Ther/proph/diag inj sc/im	490	INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT		Full payment	1	0%	0.0000	\$0.00	\$ -		\$ -
<b>TOTALS</b>								1.3068	\$175.40	\$0.00	\$6.00	\$181.40



## Scenario #2 – Depo-Provera: Follow-up Injections

- When a patient comes in for follow-up Depo-Provera injections every three months and there is not a billable E/M service, bill the injection and the Depo-Provera at cost to the Ordered Ambulatory Fee Schedule



## Billing Conditional Carve-outs

- Bill using APGs when administered by a Physician or NP during a billable E/M
  - Bill an APG claim with E/M with J1055 for the Depo-Provera, and 81025 for the Urine Pregnancy Test
    - Depo-Provera will package into the E/M and no additional payment is received
    - As of July 1, 2011, Urine Pregnancy Tests will pay \$3.19
- There is no APG claim when administered by a Physician or NP, but a full E/M is not provided
  - Bill to Ordered Ambulatory Fee Schedule as you would for a RN or LPN



# Billing Conditional Carve-outs

- Bill Ordered Ambulatory Fee Schedules when administered by an RN or LPN within their scope of practice; there is a patient-specific order from a licensed physician, NP, or nurse midwife; AND an APG visit is not billed
  - Bill 96372 for the Depo-Provera administration and J1055 at cost for the Depo-Provera, and 81025 for the Urine Pregnancy Test
    - Depo-Provera will pay \$13.23, J1055 will pay at cost, and the Urine Pregnancy Test will pay at \$2.00



## Scenario #3 – Scheduled Contraceptive Implant



## Scenario #3 – Scheduled Contraceptive Implant

- **What happened at this encounter?**
  - Patient comes in for a scheduled contraceptive implant (Implanon)
  - Patient does not speak English and requires an interpreter
  - The decision to get this method was made at a prior visit
  - The physician asks a few questions and provides information regarding the benefits and risks of Implanon
  - Implanon is inserted



## Scenario #3 – Is this a Contraceptive Management Visit?

- **Is it appropriate to report an E/M for this encounter?**
  - No—services are related to insertion procedure only
  - Report 11975 (Insertion Implantable Contraceptive Cap)
- **Was Contraceptive Management provided?**
  - Yes
- **What diagnoses are reported?**
  - V255 (Insertion of Implantable Subdermal Contraceptive)
- **Can I code V25x as a primary diagnosis?**
  - Yes



## Scenario #3 – Scheduled Contraceptive Implant

- **APG 875 paid?**
  - No –because 11975 is considered a significant procedure (Weight = 2.959) and maps to APG 4 regardless of the primary diagnosis
  - Significant procedures do not map to APG 875
- **What about the implant?**
  - J7307 (Implanon Implant System) is a carve-out and should be billed separately to the Ordered Ambulatory Fee Schedule at cost



## Scenario #3 – Scheduled Contraceptive Implant

*Don't forget to bill for the interpreter services*

- New in 2011, interpreter services can be billed to the APG claim
  - An interpreter needs to be present to bill for this service

HCPCS Code	Txt HCPCS	HCPCS Code Description	APG - for reference only	October 2011 Px-Based Weight	July and Oct 2011 Units
T1013	T1013	Sign Lang/Oral Interpreter	490	0.0295	3

- Maps to APG 490 and has a procedure-based weight for payment
- T1013 needs to be billed with a paying E/M or significant procedure because it is an **ISADNP**



# Scenario #3 – Scheduled Contraceptive Implant

## Family Planning Visit (DOS 1/1/2012 - Phase 4) - Medical Visit With APG 875 Qualifying Visit

Date of Service:		1/1/2012		Family Planning Indicator:		Y							
APG Base Rate:		\$156.76		Rate Code:		1422 DTC General Clinic							
Existing Payment for Blend:		NA		Region:		Downstate							
Blend Percentage (APG):		100%		Primary Dx Code (Description):		V255		Insertion of Implantable Subdermal Ctrpt.					
Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment	
11975	Insert contraceptive cap	4	LEVEL II SKIN INCISION AND DRAINAGE		Full payment	1	100%	2.0377	\$319.43	\$ -	\$ 6.00	\$ 325.43	
T1013	Sign language / Oral Interpreter	490	INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT		Full payment	3	100%	0.0295	\$13.87	\$ -		\$ 13.87	
<b>TOTALS</b>								2.0672	\$333.30	\$333.30	\$0.00	\$6.00	\$339.30

- Don't forget to bill a separate Ordered Ambulatory Fee claim in addition to the APG claim for the Implanon device (CPT J7307)



# Scenario #4 – Sick Visit with Multiple Diagnoses



## Scenario #4 – Sick Visit with Multiple Diagnoses

- **What happened at this encounter?**
  - Patient presents for STI treatment
  - Patient tests positive for Chlamydia and Gonorrhea



## Scenario #4 – Sick Visit with Multiple Diagnoses

- Report E/M code 99213 for the visit, and diagnoses codes 098.0 (Gonorrhea Acute), and 079.88 (Other Specified Chlamydial Infection)
- When patients are treated for multiple conditions and neither condition dominates the visit, the concept of co-equal applies
  - Diagnosis codes may be sequenced in the order determined by the clinician, which can impact reimbursement:
    - 098.0 (Gonorrhea Acute, Female) mapped to APG 751 (Weight = **0.8393**)
    - 079.88 (Other Specified Chlamydia Infection) mapped to APG 809 (Weight = **0.7683**)



# Scenario #4 – Sick Visit with Multiple Diagnoses

## Sick Visit (DOS 1/1/2012 - Phase 4)

Date of Service:		1/1/2012		Family Planning Indicator:							
APG Base Rate:		\$156.76		Rate Code: 1422 DTC General Clinic							
Existing Payment for Blend:		NA		Region: Downstate							
Blend Percentage (APG):		100%									
Px Code	PDX	PDX Description	APG	APG Description	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Capital - sample	Total Payment
99213	0980	ACUTE GC INFECT LOWER GU	751	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	Full payment	1	100%	0.8393	\$131.57	\$6.00	\$137.57
99213	07988	OTH SPCF CHLAMYDIAL INFC	809	OTHER INFECTIOUS & PARASITIC DISEASES	Full payment	1	100%	0.7683	\$120.44	\$6.00	\$126.44
<b>DIFFERENCE</b>											\$11.13



# Scenario #4B – Sick Visit with STI Symptoms

- **What happened at this encounter?**
  - Patient presents for STI testing
  - Chlamydia and gonorrhea symptoms



## Scenario #4B – Sick Visit with STI Symptoms

- Report E/M code 99213 for the visit
- Report appropriate Screening Exam diagnosis
  - Even though you are treating the STI condition with antibiotics, many providers choose not to report the STI diagnoses until confirmed
  - Medical visit will be mapped to lower paying APG 871 (Weight = 0.7459)



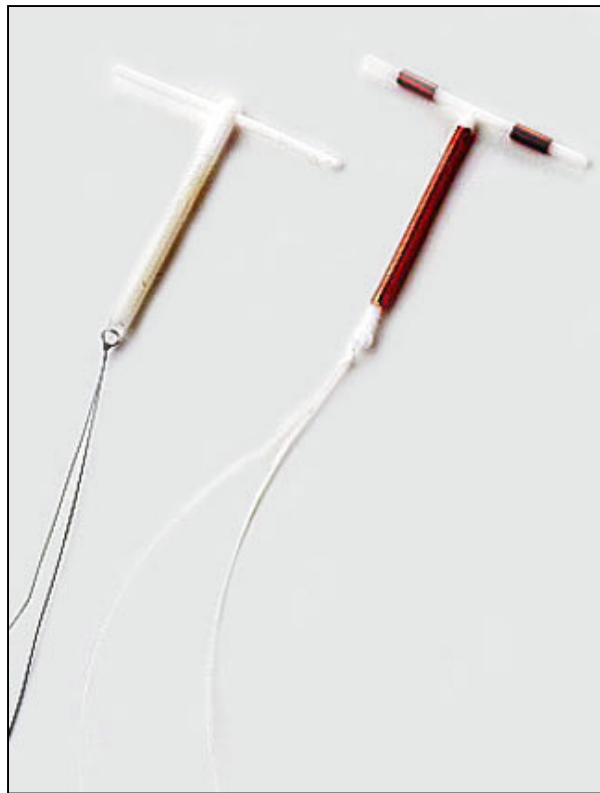
## Primary Diagnoses Makes a Difference



- When there are co-equal diagnoses, you may choose the condition that would realize a higher reimbursement as primary
- Always follow coding guidelines



## Scenario #5 – IUD Insertion



## Scenario #5 – IUD Insertion

- **What happened at this encounter?**
  - Patient returns for a scheduled IUD insertion
  - Services provided: IUD insertion
  - Time of appointment: Saturday at 10 AM



## Scenario #5 – Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
  - No, but likely took place at a prior visit
- Was Contraceptive Management provided?
  - Yes
- What diagnoses are reported?
  - V25.11(Insertion of Intrauterine Contraceptive Device)
- Can I code V25x as a primary diagnosis?
  - Yes, but there is no APG 875



## Scenario #5 – IUD Insertion

- **What about the IUD insertion?**
  - Bill 58300 (APG 417) for the IUD Insertion on your APG claim—the insertion is considered an **ancillary APG** and pays whether or not it is billed with an E/M
  - Because the IUD Device is a **carve-out**, bill the IUD device (J7300 or J7302) separately to the Ordered Ambulatory Fee Schedule at cost
  - **Failure to report this device will result in a significant loss of revenue!**



## Scenario #5 – IUD Insertion: After Hours Access

- Add-on payment available for visits that are scheduled and occur on evenings (after 6:00 PM), weekends, and holidays
  - Maps to APG 448 (Weight = 0.0759) for a ~\$12.00 add-on
  - Not payable if only the CPT is listed on the claim
  - Reimbursement only occurs when accompanied by a valid CPT code that represents a medical service or procedure

CPT	Description
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.



# Scenario #5 – IUD Insertion

## Family Planning Visit (DOS 1/1/2012 - Phase 4) - Medical Visit With APG 875 Qualifying Visit

Date of Service:		1/1/2012	Family Planning Indicator:		Y							
APG Base Rate:		\$156.76	Rate Code:		1422 DTC General Clinic							
Existing Payment for Blend:		NA	Region:		Downstate							
Blend Percentage (APG):		100%	Primary Dx Code (Description):		V25.11	Insertion of IUD						
Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment
58300	Insert IUD	417	MINOR REPRODUCTIVE SERVICES		Full payment	1	100%	0.6601	\$103.48	\$ -		\$ 103.48
99051	Med serv eve/wkend/holiday	448	EXPANDED HOURS ACCESS		Full payment	1	100%	0.0759	\$11.90	\$ -		\$ 11.90
<b>TOTALS</b>								0.7360	\$115.38	\$0.00	\$0.00	\$ 115.38



## A Note About Pap Smears...

- We recommend that you **not** bill the Q0091 code for collection of screening pap smears
  - Maps to APG 392 - Pap Smear
  - Was created for a unique Medicare coverage situation
- The collection of a Pap smear specimen is always part of the E/M or preventive medicine service
- For additional information, go to:

[http://www.acog.org/acog\\_districts/dist\\_notice.cfm?recno=13&bulletin=3862](http://www.acog.org/acog_districts/dist_notice.cfm?recno=13&bulletin=3862);

[http://www.acog.org/departments/dept\\_notice.cfm?recno=6&bulletin=5662](http://www.acog.org/departments/dept_notice.cfm?recno=6&bulletin=5662)



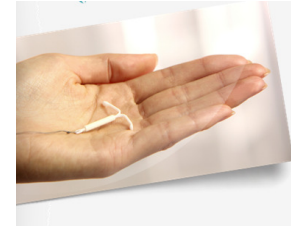
## IUD Inserts and APG 875



- APG 875 is considered a medical visit APG
  - Only E/M codes will map to this APG 875 based on the V25 primary diagnosis
- Ancillary and Significant Procedures APG assignment (e.g. IUD and Implanon insertions and removals) are **NOT** based on the primary diagnosis and **NEVER** map to APG 875



## Scenario #5B – IUD Removal



- **What about the IUD removal?**
  - Coding rules for reporting E/M, laboratory tests, etc. are the same
  - Report 58301 (Removal of Intrauterine Device) in addition to other services provided with diagnosis V25.12 (Encounter for Removal of IUD)
  - Providers have missed capturing for this service resulting in a loss of revenue
  - Maps to APG 417 (Minor Reproductive Procedures)



# Scenario #6 – HPV Vaccine



## Scenario #6 – HPV Vaccine

- **What happened at this encounter?**
  - Patient presents asking for the HPV vaccine
  - Services provided: Annual exam
  - Patient comes back for two follow-up HPV vaccines within 6 months



# HPV Vaccines

- HPV Vaccines are administered to females and males aged 9-26 years old in 3 separate doses:
  - The first dose is administered on an elected date, and the second and third doses are administered 2 and 6 months after, respectively
- Bill Gardasil (CPT code 90649) for the toxoid each time it is administered
- Effective 1/1/2009, Cervarix (CPT code 90650) was added as an HPV vaccine; it is provided to the same population using the same dosing schedule



# HPV Vaccines

- HPV vaccines for patients under age 19 are acquired through the Vaccines for Children Program
  - Clinics should bill for administration fee only using the **-SL** modifier with Vaccine code (90649-SL, 90650-SL)
    - Prior to October 1, 2011, bill the 90649-SL as an Ordered Ambulatory claim
    - Post October 1, 2011, bill 90649-SL to the APG claim instead
    - Do not bill the administration code
  - Report a cost of \$17.85 on either claim
  - Medicaid payment is ~\$17.85 (administration cost)
  - Bill 3 separate claims—one for each administration



# HPV Vaccines

- For patients aged 19 and older:
  - Bill an APG claim each time the vaccine is given with the following CPT codes:
    - E/M – only if appropriate services were provided
    - 90649 or 90650 for the HPV vaccine
    - 90471 - 90472 for adult administration
  - As of January 1, 2010, the administration is considered incidental to the vaccine and no longer pays separately
  - 90649 will map to APG 416 and should be billed three separate times



## HPV Vaccines: Child Turning Adult

- What if patient is 18 years-old when she or he receives the first 2 vaccines and then turns 19 before the last vaccine is given?
  - Bill the first two vaccines through Vaccines for Children Program with 90649-SL
  - Bill the final vaccine as an adult APG claim with toxoid and administration



# HPV Vaccines: Free Vaccines for Adults

- What if patient is an adult and receives a free HPV vaccine?
  - Bill the toxoid with new **-FB** modifier
  - The new modifier is effective October 1, 2011, but may be retroactively billed back to October 1, 2010
  - Prior to October 1, 2011, bill the Ordered Ambulatory Fee Schedule with 90649 -FB at \$13.32; after October 1, 2011, bill 90649 -FB to APG claim with \$13.32 as the cost
  - Bill each of the three times the vaccine is administered
  - Medicaid payment for administration = \$13.32
  - Refer to NYS DOH Modifier policy at:  
[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/#updates](http://www.health.state.ny.us/health_care/medicaid/rates/apg/#updates)



## October 1, 2011 Change: Billing with SL and FB Modifiers

- As of October 1, 2011, administrations through the Vaccines for Children program may be billed to the APG claim using the SL Modifier rather than Ordered Ambulatory fee Schedules
  - Bill the toxoid with SL modifier for children under 19
  - Report a cost of \$17.85
  - Payment = \$17.85
- Adult Free Vaccines may also be billed with the FB modifier



## Scenario #7 – HIV Counseling and Testing



# Scenario #7 – HIV Counseling and Testing

- **What happened at this encounter?**
  - Patient reveals her former partner has recently tested positive for HIV and told her she should get tested
  - The patient and her partner did not consistently use condoms, and the patient has continued to use contraception inconsistently
  - Patient receives GYN Exam, Contraceptive Management, HIV Counseling and HIV Rapid Test, Urine Pregnancy Test, and Chlamydia and Gonorrhea Screening
  - Clinician documents over 8 minutes of counseling provided in patient chart with start and stop times



# HIV Counseling and Testing

- As of July 1, 2011, HIV Counseling and Testing was subsumed by the APG payment methodology, and can no longer be billed as a separate threshold visit
- **Challenges:**
  - Must be documented
  - Distinct HIV counseling (CPT 99401) must last at least 8 minutes—most family planning providers agree this distinct service does not require 8 minutes when part of a larger discussion on sexual risk behaviors
  - Many family planning providers no longer bill for this service, resulting in a loss of revenue



# Scenario #7 – HIV Counseling and Testing

## Exam with HIV C&T Visit (DOS 1/1/2012 - Phase 4)

Date of Service:		1/1/2012	Family Planning Indicator:		Y							
APG Base Rate:		\$156.76	Rate Code:		1422 DTC General Clinic							
Existing Payment for Blend:		NA	Region:		Downstate							
Blend Percentage (APG):		100%	Primary Dx Code (Description):		V2549	CONTRACEPT SURVEILL NEC						
Px Code	Procedure Description	APG	APG Description	Modifier	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	Existing Payment Portion of Blend	Capital - sample	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT		Full payment	1	100%	1.1189	\$175.40	\$ -	\$ 6.00	\$ 181.40
99401	Preventive counseling indiv	490	INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT		Full payment	1	100%	0.1724	\$27.03	\$ -		\$ 27.03
86703	HIV Rapid Test	394	LEVEL I IMMUNOLOGY TESTS	U6 - inhouse	APG Fee payment	1	100%	0.0982	\$15.39	\$ -		\$ 15.39
81025	Urine pregnancy test	410	URINALYSIS	U6 - inhouse	APG Fee payment	1	100%	Fee	\$3.19	\$ -		\$ 3.19
87491	CHYLMD TRACH, DNA, AMP PROBE	394	LEVEL I IMMUNOLOGY TESTS	None - non contracting	No payment	1	0%	0.0982	(\$15.39)	\$ -		(\$15.39)
87591	N.GONORRHOEAE, DNA, AMP PROB	397	LEVEL II MICROBIOLOGY TESTS	None - non contracting	No payment	1	0%	0.2175	\$ -	\$ -		\$0.00



# HIV Counseling and Testing

- HIV Rapid test will pay separately when billed with CPT 86703 (APG 394) and the U6 modifier
- **APG Issue:**
  - HIV Rapid Tests (CPT 86703) with U6 modifier were not paid correctly from July 1 through September 30, 2011, and can be resubmitted for payment correction



## Other Concepts to Think About: Ultrasounds

- Use Obstetric US (HCPCS 76815 / 76817) when the patient is known to be pregnant
  - These codes are for ancillary services (APG 470) and will be paid in full
    - Use for viewing the maternal/fetal structures or when the exam is to confirm pregnancy, regardless of the result
- The non-OB procedure (76830) is a significant procedure (APG 288)
  - Because it is considered a significant ancillary service, the procedure is paid in addition to the medical visit
  - Part of the radiologic subtype group post-2011

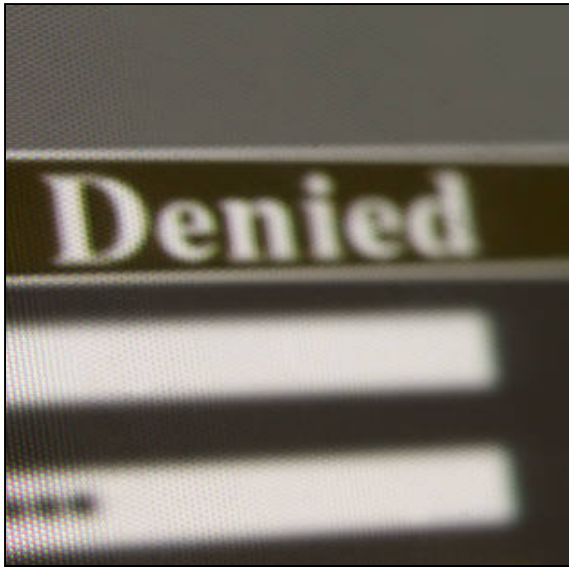


## Other Concepts to Think About: Modifiers

- It is important to code the appropriate modifiers to the APG claim
  - Currently, only certain modifiers impact payment
  - It is an internal decisions regarding who assigns and validates modifiers
- **PCS frequently sees inaccurate use of modifiers on claims**
- For a full list of APG modifiers, go to:  
[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/new\\_york\\_state\\_modifiers.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/new_york_state_modifiers.pdf)



## Other Concepts to Think About: 2011 Medicaid NCCI Edits



- Implementation of the Federal National Correct Coding Initiative (NCCI) edits
- Implemented on a “pay and report” basis post-Jan 1, 2011
- Set to deny claims post-April 1, 2011
- Use of Modifier 59 (distinct procedure) will override NCCI edit
- Use with caution



## Other Concepts to Think About: Physician Services

- **Hospitals:** Physician services are carved-out of the APG payment for all services rendered and may be billed separately
  - Ambulatory Surgery: Carved-out effective 12/1/2008
  - Emergency Department: Carved-out effective 1/1/2009
  - Outpatient Department: Carved-out effective 2/1/2010
- **Diagnostic and Treatment Centers:** Physician services are considered part of the APG facility payment and should not be billed



## Other Concepts to Think About: Fidelis Managed Care and Family Planning

- Providers may bill Medicaid Fee-For-Service for family planning and reproductive health services provided to Fidelis Care New York enrollees
- This applies only to Medicaid Managed Care & Family Health Plus (FHPlus) enrollees of NYS Catholic Health Plan (i.e. Fidelis Care New York) (Plan Code SP)
- For more information, go to:  
[http://www.fideliscare.org/downloads/fid\\_med\\_20110217.pdf](http://www.fideliscare.org/downloads/fid_med_20110217.pdf)



## Steps to Ensure Success: Good Documentation



- **Ask yourself...**
  - Is it complete and accurate?
  - Are orders dated and signed?
  - Are charts reviewed on a regular basis?
  - Are clinicians available to clarify / answer questions pertaining to the billing of visit?



# Steps to Ensure Success: Managing Your Claims

- **Who is providing the service?**
  - Physician, NP, LPN, or RN
- **Are services billable to APGs, Ordered Ambulatory Fee Schedule, or both?**
- **Were other billable services provided?**
  - HIV Counseling and Testing, After Hours, Smoking Cessation, etc.



# Steps to Ensure Success: Managing Your Claims

- **Payments need validation—do you have the right information and tools?**
  - Provider billing errors
  - NYS DOH claim payment errors
- **Denial Management**
  - Some denials are easy to repair
  - You only have 60 days to correct
- **Preparation for ICD-10**
  - Implementation is fast approaching!
- **Resolve Compliance Issues**



## APG Challenges:

# Retroactive Processing and Adjusting Claims

- Due to delays in CMS approval, for 10 months DTC claims were paid at a threshold rate, and then voided and repaid as APGs
  - APG billing mistakes typically carried forward across claims
  - Providers are overwhelmed with validating APG claims
  - **Challenge:** Validating whether proper payment was received or adjusted for a large number of claims
- **Good News:** Providers have up to 6 years to adjust a paid Medicaid claim
- **NYS DOH is working with providers to resolve claim problems, but you must re-bill within 60 days**



# Remittance: Paper vs. Electronic

- Providers often do not have all the remittance data available to help them understand claim issues and payments
- You may elect to receive only one format from eMedNY
  - **835 Text File** – *complete information*
  - **Paper Report** – *filtered down information per claim mailed to providers*
  - **PDF Report** – *same as paper, but transmitted quicker to providers*
- To change your election of remittance file format, go to:  
<http://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/Electronic%20Remittance%20Request%20Form.pdf>



# NYS DOH Resources

- **DOH APG Website:**

[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/](http://www.health.state.ny.us/health_care/medicaid/rates/apg/)

- **APG Provider Manual:**

[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/#apg\\_logic](http://www.health.state.ny.us/health_care/medicaid/rates/apg/#apg_logic)

- **eMedNY:**

<https://www.emedny.org/>



# Question and Answer Period

## Introduction to Medicaid Billing Using Ambulatory Patient Groups (APG) for Family Planning Providers

- **Ann Finn and Stephen MacCormack**  
Provider Consulting Solutions, Inc.
- **Ronald Bass and Alan R. Maughan**  
Office of Health Insurance Programs  
New York State Department of Health



# A Special Thank You to Our Presenters

- Ann Finn
- Stephen MacCormack
- Ronald Bass
- Alan R. Maughan

**New York State Department of Health Office  
of Health Insurance Programs**

**New York State Department Bureau of  
Maternal and Child Health**

