

Accessing the Enhanced Medicaid Ambulatory Patient Group (APG) Payment for Family Planning Providers

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

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Accessing the Enhanced Medicaid Ambulatory Patient Group (APG) Payment for Family Planning Providers

Welcome

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Introduction

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Webinar Objectives

- Explain the rationale for the creation of APG 875 for Contraceptive Management
- Review policies for the use of APG 875, including special circumstances and exceptions
- Provide concrete examples on the use of APG 875 in various family planning settings, and illustrate how the appropriate use of APG 875 for each example will result in increased revenue
- Answer your questions on the use of APG 875



Accessing the Enhanced Medicaid Ambulatory Patient Group (APG) Payment for Family Planning Providers

Presenter

- **Alan R. Maughan**

Chairperson, Bureau of Strategic Planning and Data Analysis
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New York State Department of Health



What is APG 875 for Contraceptive Management?

- Effective July 1, 2011, the APG reimbursement system includes a new APG for **contraceptive management**, which will be assigned if an appropriate Evaluation and Management (E/M) service is coded in conjunction with a “V25” series ICD-9 code as the primary diagnosis for a visit
- APG 875 was developed for the purpose of implementing the Medicaid Redesign Team (MRT) Initiative #1454, which shifts a portion of family planning grants to Medicaid
- There is a significant payment enhancement associated with this APG as compared to APG 871, to which a family planning medical visit previously would have been mapped



How Does APG 875 Work?

- In order for an E/M to qualify for APG 875, a V25 series primary diagnosis (UB-04 Form: Field 67; 837I Form: Loop 2300 & Segment HIO1-2) must appear on the claim header
 - Additionally, the appropriate family planning condition code or “Y” indicator must be coded in the “Family Planning Visit” indicator field
 - For all other family planning-related procedures (non-E/Ms) performed in a family planning context, a V25 series diagnosis can be the primary or secondary diagnosis
 - 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



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 (*assuming necessary system work can be completed*)



APG 875 - Qualifying V25 Primary Diagnoses

V25 Diagnosis - Potentially Eligible for Enhanced Medicaid Payment

DX general format	Description
V2501	Prescrip-oral contracept
V2502	Initiate contracept NEC
V2503	Contracept mgmt-emergency
V2504	Natrl fam pln-avoid preg
V2509	Contraceptive mangmt NEC
V2511	Insertion of iud
V2512	Removal of iud
V2513	Remove/insert iud
V252	Sterilization
V252	Sterilization
V253	Menstrual extraction
V2540	Contracept surveill NOS
V2541	Contracept pill surveill
V2542	Iud surveillance
V2543	Srvl mplt sbdrm cntncep
V2549	Contracept surveill NEC
V255	Nsrt mplt sbdrm cntncep
V258	Contraceptive mangmt NEC
V259	Contraceptive mangmt NOS

Source: http://www.health.ny.gov/health_care/medicaid/rates/apg/#updates



Payments for APG 875 vs. APG 871

- APG 875 - CONTRACEPTIVE MANAGEMENT** will pay approximately 40-50% 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



Utilization of APG 875 By Family Planning Providers

APG 875 Claims

DOS 7/1/2011-9/26/2011 (Excludes Managed Care and Duals)

Provider Type	Total Claims	Percentage of Claims	Gross Medicaid Spending	Percentage of Spending
Family Planning Providers	7,333	73%	\$ 1,168,346	70%
Non FP Providers	2,669	27%	\$ 512,216	30%

NOTE: APG 875 was implemented 7/1/2011



Utilization of APG 875 By Family Planning Providers

APG 875 Claims

DOS 7/1/2011-9/26/2011 (Excludes Managed Care and Duals)

Provider Type	Total APG 875 and 871 Claims	APG 875 Claims	Percentage of Claims Billed with APG 875	Gross Medicaid Spending (APG 871 and 875)	APG 875 Gross Medicaid Spending	Percentage of Spending Billed with APG 875
Family Planning Providers						
DTC	10,282	6,683	65%	\$1,466,762	\$1,038,491	71%
Hospital	5,821	650	11%	\$ 920,388	\$ 129,855	14%
Non FP Providers						
DTC	8,409	1,297	15%	\$1,244,896	\$ 236,207	19%
Hospital	22,220	1,372	6%	\$3,216,597	\$ 276,008	9%

NOTE: APG 875 was implemented 7/1/2011



Impact of APG 875 on Family Planning Providers

- To compensate for the loss of grant revenue, providers will receive enhanced reimbursement through APG 875
- Once sufficient claims data is collected and analyzed, the New York State Department of Health will readjust the grant awards so that every effort is made to hold providers harmless



Sample Case 1: Medical Visit - Non-APG 875 Qualifying Primary Diagnosis

Family Planning Visit (DOS 7/1/2011) - Medical Visit With Non-APG 875 Qualifying Diagnosis

Date of Service:		7/1/2011	Family Planning Indicator:		Y							
APG Base Rate:		\$156.76	Rate Code:		1407 DTC General Clinic							
Existing Payment for Blend:		\$138.02	Region:		Iownstate							
Blend Percentage (APG):		75%	Primary Dx Code (Description):		V2681	Fertility preserv proc						
Px Code	Procedure Description	APG	APG Description	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
99213	Office/outpatient visit est	871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Full payment	1	100%	0.7459	\$116.93	\$ 87.70	\$ 34.51	\$ 6.05	\$ 128.26
TOTALS							0.7459	\$116.93	\$87.70	\$34.51	\$6.05	\$128.26



Sample Case 2: Medical Visit - APG 875-Qualifying Primary Diagnosis

Family Planning Visit (DOS 7/1/2011) - Medical Visit With APG 875 Qualifying Visit

Date of Service:		7/1/2011	Family Planning Indicator:		Y							
APG Base Rate:		\$157.76	Rate Code:		1407 DTC General Clinic							
Existing Payment for Blend:		\$138.02	Region:		Downstate							
Blend Percentage (APG):		75%	Primary Dx Code (Description):		V2509		Contraceptive mangmt NEC					
Px Code	Procedure Description	APG	APG Description	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT	Full payment	1	100%	1.1189	\$175.40	\$ 131.55	\$ 34.51	\$ 6.05	\$ 172.11
TOTALS							1.1189	\$175.40	\$131.55	\$34.51	\$6.05	\$172.11



Sample Case 3: Medical Visit - APG 875-Qualifying Primary Diagnosis - Full Phase

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:		\$157.76	Rate Code:		1407 DTC General Clinic							
Existing Payment for Blend:		---	Region:		Downstate							
Blend Percentage (APG):		100%	Primary Dx Code (Description):		V2509		Contraceptive mangmt NEC					
Px Code	Procedure Description	APG	APG Description	Payment Action	Units	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
99213	Office/outpatient visit est	875	CONTRACEPTIVE MANAGEMENT	Full payment	1	100%	1.1189	\$175.40	\$175.40	\$ -	\$ 6.05	\$ 181.45
TOTALS							1.1189	\$175.40	\$175.40	\$0.00	\$6.05	\$181.45



New Family Planning Payment Policy: Conditional “Carve-out” Procedures

- The following CPT codes can be billed to the Ordered Ambulatory Fee Schedule when an APG visit is not billed for the clinic patient on the same date of service

Procedure Code	Procedure Description	APG	APG Description	Date added to carve-out list
J1055	Medroxyprogester acetate inj	435	CLASS I PHARMACOTHERAPY	9/1/2009
86580	TB intradermal test	394	LEVEL I IMMUNOLOGY TESTS	4/1/2010
81025	Urine pregnancy test	410	URINALYSIS	9/1/2009

- Procedure codes 86580 and 81025 recently were added to the APG Fee Schedule and will pay on a line basis as “stand alone” procedures even if there are no other procedures coded



Accessing the Enhanced Medicaid Ambulatory Patient Group (APG) Payment for Family Planning Providers

Presenters

- **Ann Finn**
Provider Consulting Solutions, Inc
-
- **Lana MacCormack**
Provider Consulting Solutions, Inc.



Ambulatory Patient Group (APG) Basics

- The encounter is described by a list of APGs that correspond to each service provided to the patient either by:
 - **Procedure Codes**
 - **Diagnosis Codes**
- Multiple APGs can be assigned to a claim based on the procedures performed



Defining the “Visit”

- “E/M,” “Medical Visit,” and “Evaluation and Management” all stand for **“Evaluation and Management”**
 - E/M coding is the process by which patient encounters with physicians and nurse practitioners (NP) are translated into five digit CPT codes to facilitate billing
 - There are different E/M codes for different types of encounters
 - Within each type of encounter, there are different levels of care
 - Example: 99214 is a “Level 4” office visit



E/M Code Groups

- Preventive medicine services are represented in E/M codes **99381 - 99397**
 - 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 Code Groups

- Services to evaluate patients with a medical problem or chief complaint are codes 99201 - 99215
 - New patient codes are 99201 - 99205
 - Established patients are 99211 - 99215
 - Used for “sick” visits and problem-focused services



Patient Encounters with RNs and LPNs

- Generally, these visits are not reimbursable under Medicaid. Exceptions include when an RN or LPN:
 - Administers an immunization (non-carve-out)
 - Performs an ordered Urine Pregnancy Test
 - Administers ordered Depo-Provera
 - Administers ordered allergy injections
- **An E/M code should not be reported for a nurse only visit on the APG claim!**



Defining “Procedure Codes”

- Healthcare Common Procedure Coding System (HCPCS)
 - Level I HCPCS codes are called CPT-4 codes (current procedural terminology). Every procedure has its own individual CPT code
 - Example: 58300 - Insertion of IUD
 - Level II HCPCS codes identify products, supplies, materials, and services which are not included in the CPT-4 code
 - Example: J7300 - IUD Device



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 / 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.



APG 875: New York State-posted Guidelines

- In order for an E/M procedure code to qualify for the new APG 875, a primary diagnosis from the V25 series must appear in the header of the claim
- When other family planning-related procedures are **performed in a family planning context**, a diagnosis in the V25 series must appear on the claim; this diagnosis does not need to be the primary diagnosis

Source:

http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/billing_family_services.pdf



APG 875: New York State-posted Guidelines

- If a payment is made for a family planning procedure (based on a V25 series diagnosis) and the claim does not include a "Y" in the Family Planning box, some or all of the payment for the claim may be subject to recovery under audit
- The 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



Scenario #1 - Contraceptive Management Visit

- **What happened at this encounter?**
 - Female patient missed some pills and also complains of some stomach cramping and spotting
 - Requires a script refill
 - Seen by a NP and exam declined
 - Given a prescription for Ortho-Cyclen



Scenario #1 - Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
 - Yes—Report a low-level E/M (99212) for the medical visit
- Was Contraceptive Management provided?
 - Yes
- What diagnoses are reported?
 - V25.41 (Surveillance of Previously Prescribed Birth Control Medicine - Contraceptive Pill)
- Can I code V25x as a primary diagnosis?
 - Yes—APG 875 paid



Scenario #1 - Contraceptive Management Visit

Don't Forget:

1. An E/M code must be reported with a primary diagnosis from the V25 series to qualify for the new APG 875
2. Always apply coding guidelines



Scenario #2 - Contraceptive Management Visit with an Annual 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
 - The NP performed an exam and lab tests, and provides condoms with instructions
 - Script given for NuvaRing with instructions



Scenario #2 - 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)



Scenario #2 - Is this a Contraceptive Management Visit? (continued)

- 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
 - DOH to provide additional guidance



Scenario #2 - Contraceptive Management Visit with an Annual Exam

- When two diagnoses are reported (V72.31 and V25.02), apply the ICD coding guidelines:
 - Primary Diagnosis – “The diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided”
- OR**
- Primary Diagnosis – “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”



Scenario #3 - Annual Exam, Condition, and Contraceptive Management

- **What happened at this encounter?**
 - Patient seen for an annual exam
 - Patient selects the NuvaRing as her contraceptive method
 - Complains of urinary frequency
 - Services provided: Routine labs (Pap, Chlamydia/Gonorrhea), script for NuvaRing, urine culture and sensitivity (C/S) test, and script for 150mg of Diflucan



Scenario #3 - Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
 - Yes—Report 99395 for the comprehensive preventive medicine E/M
- Was Contraceptive Management provided?
 - Yes
- What diagnoses are reported?
 - V72.31 (Routine GYN Exam), V74.5 (Screening for Venereal Disease), 112.1 (Candidiasis Infection - Vaginal), and V25.02 (Initiation of Other Contraceptive Measure)



Scenario #3 - Is this a Contraceptive Management Visit? (continued)

- Can I code V25x as a primary diagnosis?
 - The birth control method requires an exam; however, the condition required additional testing and medical decision-making, resulting in a prescription
 - The clinician would need to decide whether 112.1 (Candidiasis Infection - Vaginal) or V25.02 (Initiation of Other Contraceptive Measure) was “chiefly responsible”
 - DOH to provide additional guidance



Scenario #4 - Depo-Provera: Physician/NP 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 #4 - 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 #5 - Depo-Provera: Physician/NP Visit

- What happens if patient also has a condition?
 - The patient complains of white vaginal discharge and slight itching
 - She is due for return Depo-Provera injection
 - Patient receives a problem-focused exam
 - Services provided: Depo 150mm IM, STI screening, Gonorrhea and Chlamydia wet prep, script for Clindamycin 300 mg twice daily for 7 days, and instructions; patient to return in 11-12 weeks for repeat Depo



Scenario #5 - Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
 - Yes—Report 99213 for the physician encounter
- Was Contraceptive Management provided?
 - Yes
- What diagnoses are reported?
 - V72.31 (Routine GYN Exam), V25.02 (Initiation of Other Contraceptive Measure), V72.41, V74.5, V73.89 (Laboratory Tests, UPT, etc), and 616.10 (Vaginitis)



Scenario #5 - Is this a Contraceptive Management Visit? (continued)

- Can I code V25x as a primary diagnosis?
 - No—services “chiefly responsible” are related to Vaginitis



Scenarios #4 and #5 - Depo-Provera: Physician / NP 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



What is a “Carve Out”?

- Carve-outs are services not reimbursable under the APG system, and include the following:
 - Depo-Provera
 - Devices such as IUDs and Implanon
 - Monoclonal antibody therapies
 - Certain vaccines
- When billed in error as part of an APG claim, you will receive a \$0 payment



Conditional Carve Outs

- “Conditional” carve-outs are procedures that may be billed to Medicaid as ordered ambulatory services* when an APG claim is not billed for the clinic patient:
 - J1055 - Depo-Provera
 - 81025 - Urine Pregnancy Test
 - 86580 - TB Intradermal test

* When administered by an RN or LPN within their scope of practice, there is a patient-specific order from a licensed physician, nurse practitioner, or nurse midwife, and an APG visit is not billed



Scenario #6 - Depo-Provera: RN / LPN Visit

- **What happened at this encounter?**
 - Patient comes for a follow-up Depo-Provera injection
 - The injection is given by a RN or LPN
 - There is an order from a physician or NP
 - No other service is provided



Scenario #6 - Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
 - No
- Was Contraceptive Management provided?
 - Yes
- What diagnoses are reported?
 - V25.49 (Surveillance of Previously Prescribed Contraceptive Method)
- Can I code V25x as a primary diagnosis?
 - Yes, but no APG claim—no APG 875



Scenario #6 - Depo-Provera: RN / LPN Visit

- Then how do I get reimbursed?
 - Bill the Depo-Provera (J1055) at cost and for the injection (96372) on a separate claim to the Ordered Ambulatory Fee Schedule



Let's Review:

Billing for Conditional Carve Outs

- When administered by a physician or NP during a billable E/M:
 - Bill an APG claim with E/M for the Depo-Provera (J1055) and injection (96372), or a Urine Pregnancy Test (81025)
 - Depo-Provera and injection will be packaged into the E/M; no additional payment is received
 - New as of July 1, 2011, providers receive \$3.19 on their APG claims for Urine Pregnancy Tests



Let's Review:

Billing for Conditional Carve-Outs

- When administered by an RN or LPN within their scope of practice and there is a patient-specific order from a licensed physician, NP, or nurse midwife and an APG visit is not billed:
 - Bill the Ordered Ambulatory Service Fee Schedule for the Depo-Provera administration (96372) and Depo-Provera (J1055) at cost
 - Reimbursement: \$13.23 for 96372; at cost for J1055
 - Bill the Laboratory Fee Schedule for the Urine Pregnancy Test (81025)
 - Reimbursement: ~\$2.00 for 81025



Scenario #7 - Scheduled Contraceptive Implant

- **What happened at this encounter?**
 - Patient comes in for a scheduled contraceptive implant (Implanon)
 - The decision to get this method was made at a prior visit
 - Physician / NP asks a few questions and provides information regarding the benefits and risks of Implanon
 - Implanon is inserted



Scenario #7 - 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 #7 - Scheduled Contraceptive Implant

- **APG 875 paid?**
 - No—since 11975 is considered a significant procedure (Weight = 2.959) and maps to APG 4 regardless of 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



Scenario #8 - IUD Insertion

- **What happened at this encounter?**
 - Patient presents for an annual exam and IUD insertion
 - Services provided: Annual exam, Pap test, urine culture and sensitivity (C/S) test, IUD insertion



Scenario #8 - Is this a Contraceptive Management Visit?

- Is it appropriate to report an E/M for this encounter?
 - Yes—report 99395 if the patient’s condition requires a significant, separately identifiable E/ M service above and beyond the IUD procedure and was performed on the same day
- Was Contraceptive Management provided?
 - Yes



Scenario #8 - Is this a Contraceptive Management Visit? (continued)

- **What diagnoses are reported?**
 - V25.11(Insertion of Intrauterine Contraceptive Device), V72.31 (Routine GYN Exam), V72.41, V74.5, and V73.89 (Laboratory Tests, Urine Pregnancy Test, etc)
- **Can I code V25x as a primary diagnosis?**
 - It depends on your documentation



Scenario #8 - IUD Insertion

- **What about the IUD insertion?**
 - Also code 58300 (APG 417) for the IUD Insertion on your APG claim in addition to the E/M
 - The insertion is considered an ancillary APG and both services will be reimbursed
 - 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 #8 - IUD Insertion

- **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)



Reminder: 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



Managing Your Claims: 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?



Managing Your Claims: Billing Services Under APGs

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



Managing Your Claims: Billing the Visit Under APGs

- The Patient Visit may require multiple claims to be reimbursed correctly:
 - **Claim 1:** APG - E/M, significant procedures and certain ancillary services, laboratory tests, and drugs
 - Claim must include the APG claim rate code
 - Diagnostic and Treatment Centers - 1422 Episodic and 1407 Visit-Based
 - Hospital Out-Patient Departments - 1432 Episodic and 1400 Visit-Based



Managing Your Claims: Billing the Visit Under APGs

- The Patient Visit may require multiple claims to be reimbursed correctly:
 - **Claim 2:** Carve-outs - Drugs, devices, tests and other carve-out services billed to Medicaid Fee Schedules
 - Examples: Monoclonal antibody therapies drugs, IUD devices, Nurse-administered Depo-Provera and injections
 - **Claim submitted on 837i or ePACES with NO rate code**



Managing Your Claims: Billing Services Under APGs

- **Who is billing your claims?**
 - In-house staff (staff or certified coders?)
 - Outside billing company?
- **Who is verifying you claims?**
 - Do you know whether what is on the bill matches the medical record?



Managing Your Claims: Payment Validation

- **Payments need validation. Do you have the right information and tools?**
 - Provider billing errors
 - Department of Health claim payment errors
- **Denial Management**
 - Some denials are easy to repair
 - You only have 60 days to correct
- **Compliance issues need to be resolved!**



Question and Answer Period

Accessing the Enhanced Medicaid Ambulatory Patient Group (APG) Payment for Family Planning Providers

- **Alan R. Maughan**
Chairperson, Bureau of Strategic Planning and Data Analysis
Office of Health Insurance Programs
New York State Department of Health
- **Ann Finn and Lana MacCormack**
Provider Consulting Solutions, Inc.



*** Upcoming Webinar ***
**Introduction to Medicaid Billing Using APGs
for Family Planning Providers**

Tuesday, October 18
10:00 AM – 11:30 AM

To Register Click Here

<https://www1.gotomeeting.com/register/497776512>



Question and Answer Period

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- Lana MacCormack

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- Maria Payne
- Stephen MacCormack

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