



APG Implementation

Ambulatory Patient Groups (APGs) and Laboratory Services

March 18, 2009

Objectives

- Provide overview of APG payment methodology and implementation schedule
- Review general APG payment and policy
- Review policy and billing guidance specific to laboratory services
- Review payment examples
- Identify resources to help you
- Answer your questions



Webinar Ground Rules

- Place Phone on Mute During Presentations
- Do Not Put Conference Call on Hold
- Please Hold Questions Until the Q and A Period

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Goals of Reform Efforts

- Improve patient care
- Encourage care in the right setting
- Achieve better value for health care spending
- Ensure Medicaid rates
 - *Are straightforward and transparent*
 - *Buy high quality, cost effective care*
 - *Reinforce health planning and policy priorities*
 - *Are updated frequently*

Building a Sound Primary Care Infrastructure

- ❑ **The 2008-09 Budget Began Ambulatory Care Reform**
 - ❑ New outpatient payment method (APG) replaces per-visit payment system
 - ❑ \$178 million invested in hospital clinics, ambulatory surgery and ER
 - ❑ Additional investments in community clinics and physicians
 - ❑ Enhancements for weekend/evening hours, and diabetes/asthma educators
- ❑ **The 2009-10 Budget Builds on these Reforms**
 - ❑ Increases investment in hospital and community clinic rates
 - ✓ Medicaid will cover approximately 90% of average hospital clinic costs
 - ✓ Medicaid will cover approximately 90% of average D&TC costs
 - ❑ Increases investment in physician fees
 - ✓ Payments to physicians will increase by 80% over 2007 levels
 - ❑ Increases investment in mental health and chemical dependence clinics
 - ❑ Enhances payments for providers that meet medical home standards
 - ❑ Coverage for smoking cessation, cardiac rehabilitation, and screening and counseling for substance abuse patients in ER

Total Ambulatory Care Reform Package

(Gross \$ in Millions)	<u>SFY 08/09 Budget</u> <u>(Approved)</u>	Proposed Additional 09/10	Proposed Additional 10/11	<u>Total Investment</u> <u>(Full Annual)</u>
Hospital Programs	\$178.0	\$59.2	\$92.0	\$270.0
Outpatient Clinic	\$88.0	\$59.2	\$92.0	\$180.0
Ambulatory Surgery	\$40.0	\$0.0	\$0.0	\$40.0
Emergency Room	\$50.0	\$0.0	\$0.0	\$50.0
Freestanding Programs	\$12.5	\$22.9	\$37.5	\$50.0
Primary Care Investments	\$38.0	\$18.1	\$90.1	\$128.1
Asthma and Diabetes Education (08/09 Enacted)				
Expanded "After Hours" Access (08/09 Enacted)				
Social Worker Counseling (08/09 Enacted)				
Smoking Cessation (08/09 Enacted)				
Cardiac Rehabilitation (09/10 Proposed)				
SBIRT (09/10 Proposed)				
Smoking Cessation (09/10 Proposed)				
Primary Care Standards/Medical Home (09/10 Proposed)				
Adirondack Medical Home (09/10 Proposed)				
Physicians	\$120.0	\$14.2	\$68.0	\$188.0
Mental Hygiene Enhancements	N/A	\$31.2	\$32.7	\$32.7
Psychiatric Services Reform				
Detoxification Services Reform				
Office of Mental Health Initiatives				
OASAS Initiatives				
TOTAL	\$348.5	\$145.6	\$320.3	\$668.8

Status of 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 will be implemented in free standing diagnostic and treatment center clinics and ambulatory surgery centers upon CMS approval, retroactive to March 1, 2009.



Ambulatory Patient Groups

Ambulatory Patient Groups (APGs)

- APGs
 - *a patient classification system designed to detail the amount and type of resources used in an ambulatory visit.*
 - *patients in each APG have similar clinical characteristics and similar resource use and costs*
 - *developed by 3M Health Information Systems to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics.*

Three Primary Types of APGs

▪ **SIGNIFICANT PROCEDURE**

- *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.*

▪ **MEDICAL VISIT**

- *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 physician to assist in patient diagnosis or treatment. Examples include: immunizations, plain films, laboratory tests.*

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 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 or ancillary service 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 at 50%.*

Uniform Packaging List

EAPG Description

380 ANESTHESIA
390 LEVEL I PATHOLOGY
394 LEVEL I IMMUNOLOGY TESTS
396 LEVEL I MICROBIOLOGY TESTS
398 LEVEL I ENDOCRINOLOGY TESTS
400 LEVEL I CHEMISTRY TESTS
402 BASIC CHEMISTRY TESTS
406 LEVEL I CLOTTING TESTS
408 LEVEL I HEMATOLOGY TESTS
410 URINALYSIS
411 BLOOD AND URINE DIPSTICK TESTS

EAPG Description

412 SIMPLE PULMONARY FUNCTION TESTS
413 CARDIOGRAM
423 INTRODUCTION OF NEEDLE AND CATHETER
424 DRESSINGS AND OTHER MINOR PROCEDURES
425 OTHER MISCELLANEOUS ANCILLARY PROCEDURES
426 PSYCHOTROPIC MEDICATION MANAGEMENT
427 BIOFEEDBACK AND OTHER TRAINING
435 CLASS I PHARMACOTHERAPY
471 PLAIN FILM

Laboratory Test Categories and 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

Laboratory Test Categories and 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 & 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 & 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



APG Base Rates, Phasing and Blending, and Payment Methodology

Clinic Base Rates

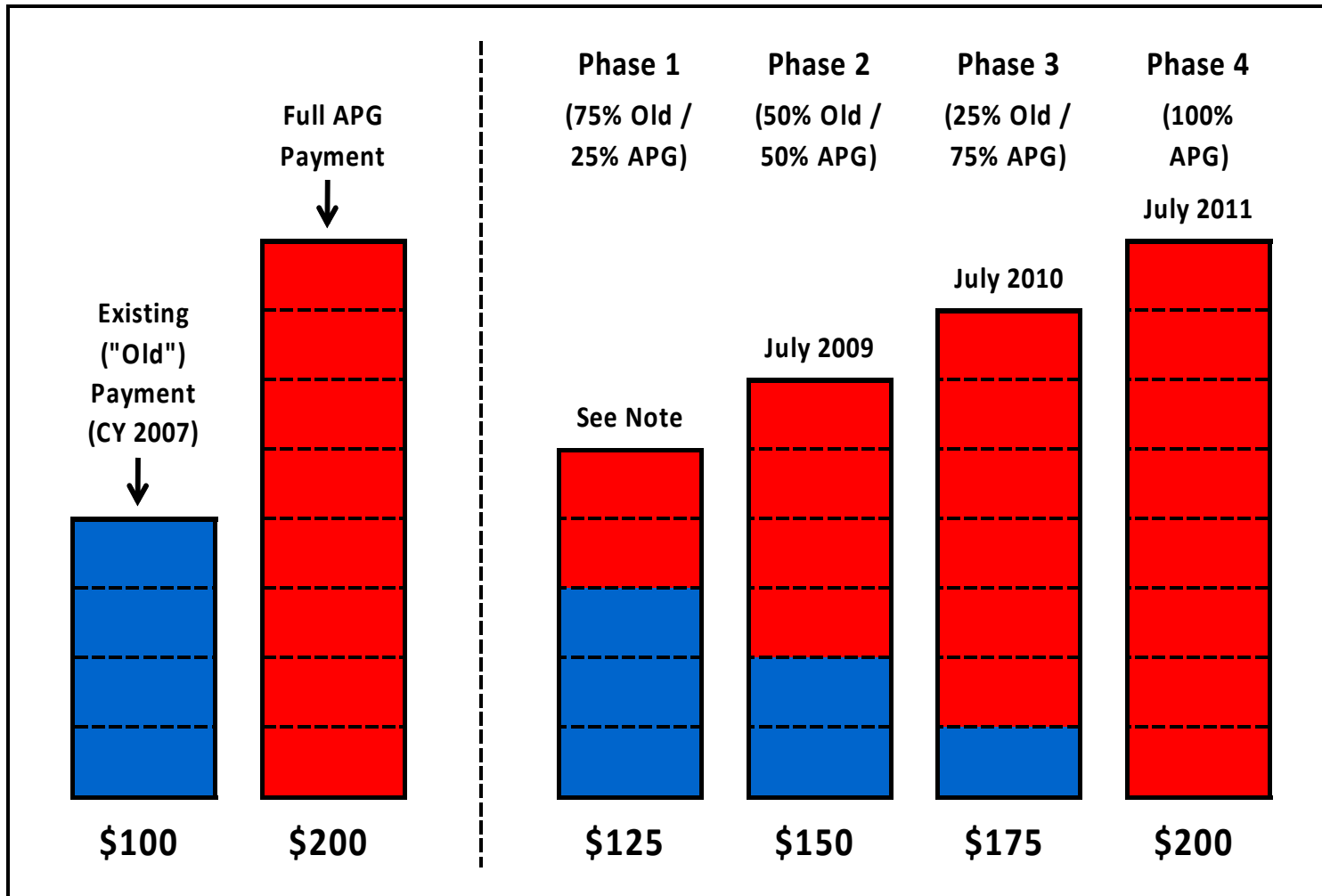
- Base rates are established for peer groups
 - *e.g. DTC, hospital OPD , hospital ED, free standing ambulatory surgery centers, etc.*
- Within each peer group there are downstate and upstate regions that have differing rates.
- Peer group base rates are calculated based on case mix, visit volume, cost, and targeted investment.
- Base rates are multiplied by APG weights on a claim to arrive at the APG payment amount.

Phasing and Blending

- Phasing: APG payments will be phased-in over time through blending.
- Blending: The Medicaid payment for a visit will include a percentage of the payment amount based on APGs and a complementary percentage of the payment amount based on the average facility clinic rate in 2007 as defined by DOH.

Hospital OPD and DTC Transition and “Blend”

(Dates Reflect Changes Proposed in 09/10 State Budget)

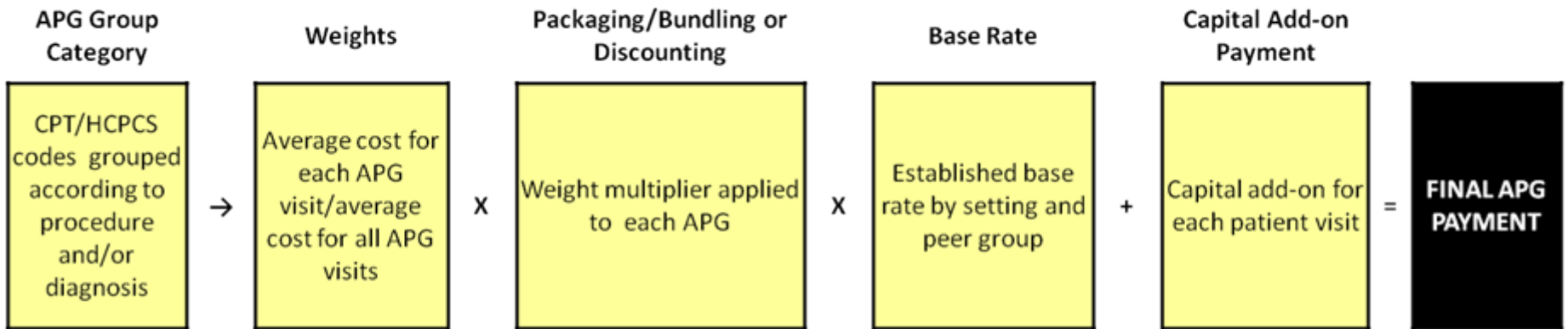


Note: Blend goes into effect on 12/1/08 for Hospital OPDs and 3/1/09 for Free-Standing Clinics and Ambulatory Surgery upon CMS approval.

Clinic APG Payment Methodology

(Hosp OPD, D&TC, Amb Surg, ER)

APG PAYMENT CALCULATION OVERVIEW



Weight Multiplier (Consolidating or Discounting Logic)

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



Laboratory Payment Examples

DTC Laboratory Payment Example #1

Annual Adult Medical Checkup Visit, Female										
HCPCS	HCPCS Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Average DTC Base Rate	Average Paid Amount
94620	Pulmonary stress test/simple	60	Pulmonary Tests	Significant Procedure	Full Payment	1.0413	100%	1.0413	\$ 149	\$ 155
83890	Molecule isolate	395	Level II Immunology Tests	Ancillary	Full Payment	0.3007	100%	0.3007	\$ 149	\$ 45
83894	Molecule gel electrophor	395	Level II Immunology Tests	Ancillary	Discounted	0.3007	50%	0.1504	\$ 149	\$ 22
83896	Molecular diagnostics	395	Level II Immunology Tests	Ancillary	Discounted	0.3007	50%	0.1504	\$ 149	\$ 22
83898	Molecule nucleic ampli, each	395	Level II Immunology Tests	Ancillary	Discounted	0.3007	50%	0.1504	\$ 149	\$ 22
83912	Genetic examination	401	Level II Chemistry Tests	Ancillary	Full Payment	0.2411	100%	0.2411	\$ 149	\$ 36
99213	Office/outpatient visit, est	491	Medical Visit Indicator	Incidental	Packaged	0.0000	0%	0.0000	\$ 149	\$ -
94014	Patient recorded spirometry	412	Simple Pulmonary Function Tests	Ancillary	Packaged	0.2771	0%	0.0000	\$ 149	\$ -
94760	Measure blood oxygen level	490	Incidental To Medical, Significant	Incidental	Packaged	0.0000	0%	0.0000	\$ 149	\$ -
82803	Blood gases: pH, pO2 & pCO2	400	Level I Chemistry Tests	Ancillary	Packaged	0.1102	0%	0.0000	\$ 149	\$ -
	Calculated APG Operating Payment					2.8726		2.0343		\$ 303
	Existing Operating Payment (Including Outside Ancillaries)									\$ 125
	Blended Operating Payment (25%/75%)									\$ 170
	Net Difference (Blended Payment- Existing Payment)									\$ 45
	Percentage Difference									36%

NOTE:

Diagnosis of 277.00 (Cystic fibros w/o ileus) was used.

DTC Laboratory Payment Example #2

Annual Adult Medical Checkup Visit, Female										
HCPCS	HCPCS Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Average DTC Base Rate	Average Paid Amount
99215	Office/outpatient visit, est	765	Other Antepartum Diagnoses	Medical Visit	Full Payment	1.0761	100%	1.0761	\$ 149	\$ 160
76801	Ob us < 14 wks, single fetus	470	Obstetrical Ultrasound	Ancillary	Full Payment	0.9504	100%	0.9504	\$ 149	\$ 142
82677	Assay of estriol	399	Level II Endocrinology Tests	Ancillary	Full Payment	0.2470	100%	0.2470	\$ 149	\$ 37
82105	Alpha-fetoprotein, serum	401	Level II Chemistry Tests	Ancillary	Full Payment	0.2411	100%	0.2411	\$ 149	\$ 36
90384	Rh ig, full-dose, im	415	Level II Immunization	Ancillary	Full Payment	0.2358	100%	0.2358	\$ 149	\$ 35
87653	Strep b, dna, amp probe	397	Level II Microbiology Tests	Ancillary	Full Payment	0.2270	100%	0.2270	\$ 149	\$ 34
82731	Assay of fetal fibronectin	401	Level II Chemistry Tests	Ancillary	Discounted	0.2411	50%	0.1206	\$ 149	\$ 18
82951	Glucose tolerance test (GTT)	400	Level I Chemistry Tests	Ancillary	Packaged	0.1102	0%	0.0000	\$ 149	\$ -
82947	Assay, glucose, blood quant	402	Basic Chemistry Tests	Ancillary	Packaged	0.0838	0%	0.0000	\$ 149	\$ -
85025	Complete cbc w/auto diff wbc	408	Level I Hematology Tests	Ancillary	Packaged	0.0857	0%	0.0000	\$ 149	\$ -
87880	Strep a assay w/optic	396	Level I Microbiology Tests	Ancillary	Packaged	0.1687	0%	0.0000	\$ 149	\$ -
Calculated APG Operating Payment						3.6670		3.0981		\$ 462
Existing Operating Payment (Including Outside Ancillaries)										\$ 125
Blended Operating Payment (25%/75%)										\$ 209
Net Difference (Blended Payment- Existing Payment)										\$ 84
Percentage Difference										67%

NOTE:

Procedure code 99386 will group to APG 765 with an associated diagnosis of 643.83 (Pregnancy complicated NEC Antepart)

DTC Laboratory Payment Example #3

Annual Adult Medical Checkup Visit, Female										
HCPCS	HCPCS Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Average DTC Base Rate	Average Paid Amount
99215	Office/outpatient visit, est	713	Diabetes Without Complications	Medical Visit	Full Payment	0.6435	100%	0.6435	\$ 149	\$ 96
76801	Ob us < 14 wks, single fetus	470	Obstetrical Ultrasound	Ancillary	Full Payment	0.9504	100%	0.9504	\$ 149	\$ 142
82677	Assay of estriol	399	Level II Endocrinology Tests	Ancillary	Full Payment	0.2470	100%	0.2470	\$ 149	\$ 37
82105	Alpha-fetoprotein, serum	401	Level II Chemistry Tests	Ancillary	Full Payment	0.2411	100%	0.2411	\$ 149	\$ 36
90384	Rh ig, full-dose, im	415	Level II Immunization	Ancillary	Full Payment	0.2358	100%	0.2358	\$ 149	\$ 35
87653	Strep b, dna, amp probe	397	Level II Microbiology Tests	Ancillary	Full Payment	0.2270	100%	0.2270	\$ 149	\$ 34
82731	Assay of fetal fibronectin	401	Level II Chemistry Tests	Ancillary	Discounted	0.2411	50%	0.1206	\$ 149	\$ 18
83036	Glycosylated hemoglobin test	400	Level I Chemistry Tests	Ancillary	Packaged	0.1102	0%	0.0000	\$ 149	\$ -
85025	Complete cbc w/auto diff wbc	408	Level I Hematology Tests	Ancillary	Packaged	0.0857	0%	0.0000	\$ 149	\$ -
87880	Strep a assay w/optic	396	Level I Microbiology Tests	Ancillary	Packaged	0.1687	0%	0.0000	\$ 149	\$ -
Calculated APG Operating Payment						3.1506		2.6655		\$ 397
Existing Operating Payment (Including Outside Ancillaries)										\$ 125
Blended Operating Payment (25%/75%)										\$ 193
Net Difference (Blended Payment- Existing Payment)										\$ 68
Percentage Difference										54%

NOTE:
 Procedure code 99215 will group to APG 713 with an associated diagnosis of 250.00 Diabetes-(DM II wo cmp nt st uncntr).

DTC Laboratory Payment Example #4

Annual Adult Medical Checkup Visit, Male										
HCPCS	HCPCS Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Average DTC Base Rate	Average Paid Amount
99386	Prev visit, new, age 40-64 *	801	Lymphoma, Myeloma & Non-Acute Leukemia	Medical Visit	Full Payment	2.0890	100%	2.0890	\$ 149	\$ 311
80061	Lipid panel	403	Organ Or Disease Oriented Panels	Ancillary	Full Payment	0.3618	100%	0.3618	\$ 149	\$ 54
86694	Herpes simplex test	395	Level II Immunology Tests	Ancillary	Full Payment	0.3007	100%	0.3007	\$ 149	\$ 45
87535	Hiv-1, dna, amp probe	397	Level II Microbiology Tests	Ancillary	Full Payment	0.2270	100%	0.2270	\$ 149	\$ 34
36415	Routine venipuncture	457	Venipuncture	Ancillary	Full Payment	0.0675	100%	0.0675	\$ 149	\$ 10
87081	Culture screen only	396	Level I Microbiology Tests	Ancillary	Packaged	0.1687	0%	0.0000	\$ 149	\$ -
86592	Blood serology, qualitative	394	Level I Immunology Tests	Ancillary	Packaged	0.1688	0%	0.0000	\$ 149	\$ -
86580	TB intradermal test	394	Level I Immunology Tests	Ancillary	Packaged	0.1688	0%	0.0000	\$ 149	\$ -
85025	Complete cbc w/auto diff wbc	408	Level I Hematology Tests	Ancillary	Packaged	0.0857	0%	0.0000	\$ 149	\$ -
81002	Urinalysis nonauto w/o scope	411	Blood And Urine Dipstick Tests	Ancillary	Packaged	0.1899	0%	0.0000	\$ 149	\$ -
Calculated APG Operating Payment						3.8279		3.0460		\$ 454
Existing Operating Payment (Including Outside Ancillaries)										\$ 125
Blended Operating Payment (25%/75%)										\$ 207
Net Difference (Blended Payment- Existing Payment)										\$ 82
Percentage Difference										66%

NOTE:
 Procedure code 99386 will group to APG 801 with an associated diagnosis of 159.1 (Malignant neo spleen NEC)

DTC Laboratory Payment Example #5

Annual Adult Medical Checkup Visit, Male										
HCPCS	HCPCS Description	APG	APG Description	Payment Element	Payment Action	Full APG Weight	Pct. Paid	Allowed APG Weight	Average DTC Base Rate	Average Paid Amount
92552	Pure tone audiometry, air	257	Audiometry	Significant Procedure	Full Payment	0.5955	100%	0.5955	\$ 149	\$ 89
99386	Prev visit, new, age 40-64	491	Medical Visit Indicator	Incidental	Packaged	1.1276	0%	0.0000	\$ 149	\$ -
92081	Visual field examination(s)	491	Medical Visit Indicator	Incidental	Packaged	1.1276	0%	0.0000	\$ 149	\$ -
87535	Hiv-1, dna, amp probe	397	Level II Microbiology Tests	Ancillary	Full Payment	0.2270	100%	0.2270	\$ 149	\$ 34
80061	Lipid panel	403	Organ Or Disease Oriented Panels	Ancillary	Full Payment	0.3618	100%	0.3618	\$ 149	\$ 54
86694	Herpes simplex test	395	Level II Immunology Tests	Ancillary	Full Payment	0.3007	100%	0.3007	\$ 149	\$ 45
36415	Routine venipuncture	457	Venipuncture	Ancillary	Full Payment	0.0675	100%	0.0675	\$ 149	\$ 10
87206	Smear, fluorescent/acid stai	396	Level I Microbiology Tests	Ancillary	Packaged	0.1687	0%	0.0000	\$ 149	\$ -
87081	Culture screen only	396	Level I Microbiology Tests	Ancillary	Packaged	0.1687	0%	0.0000	\$ 149	\$ -
86592	Blood serology, qualitative	394	Level I Immunology Tests	Ancillary	Packaged	0.1688	0%	0.0000	\$ 149	\$ -
86580	TB intradermal test	394	Level I Immunology Tests	Ancillary	Packaged	0.1688	0%	0.0000	\$ 149	\$ -
85025	Complete cbc w/auto diff wbc	408	Level I Hematology Tests	Ancillary	Packaged	0.0857	0%	0.0000	\$ 149	\$ -
81002	Urinalysis nonauto w/o scope	411	Blood And Urine Dipstick Tests	Ancillary	Packaged	0.1899	0%	0.0000	\$ 149	\$ -
Calculated APG Operating Payment						4.7582		1.5525		\$ 231
Existing Operating Payment (Including Outside Ancillaries)										\$ 125
Blended Operating Payment (25%/75%)										\$ 152
Net Difference (Blended Payment- Existing Payment)										\$ 27
Percentage Difference										21%

NOTE:

Diagnosis of V700 (Physical Exam) was used.



APG Payment Policy for Laboratory Services

Payment and Billing Policy

- 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 bill eMedNY for lab services, once results are reported, using appropriate CPT codes.
- Lab providers may not bill eMedNY directly for lab services related to an APG reimbursed clinic visit.

Example #1

- Clinic practitioner orders lab test for clinic patient.
- Patient goes to laboratory patient service center for lab test.
- Upon receipt of lab test results, clinic bills eMedNY for the lab service.
- Clinic pays laboratory for services rendered to the clinic patient.

Example #2

- Clinic practitioner draws blood from clinic patient for analysis.
- Clinic sends specimen to laboratory for analysis.
- Upon receipt of lab test results from laboratory, clinic bills eMedNY for the lab service.
- Clinic pays laboratory for services rendered on behalf of clinic patient.

General Rule

- Payment for lab services for clinic patients are included in the APG payment to clinics.
- Labs should not bill eMedNY for lab services provided to clinic patients.
- Clinics are obligated to provide or arrange for medically necessary lab services for clinic patients.
- Clinics are required to pay labs for services rendered to clinic patients.

Exceptions to the Rule

- Lab Tests Carved out of APGS
 - *Lead screen*
 - *HIV viral load test*
 - *HIV drug resistance tests*
 - *Hep C virus, genotype tests*
- These tests may continue to be billed to eMedNY using the fee-for-service laboratory fee schedule.

Exceptions to the Rule...cont.

- Medical visits for certain HIV services are not billed under APGs
 - *1695 – DTC HIV Counseling and Testing Visit*
 - *1802 – DTC Post-Test HIV Counseling Visit (Positive Result)*
 - *1850 – DTC Day Health Care Service (HIV)*
 - *2961- OPD AIDS Clinic, therapeutic visit*
 - *2983- OPD HIV Counseling and Testing Visit*
 - *3111- OPD Post Test HIV Counseling Visit-positive result*
 - *3109 – DTC and OPD HIV Counseling (No Testing)*

Exceptions to the Rule...cont.

- Federally Qualified Health Centers (FQHCs) that do not participate in the APG payment methodology.
- As with the HIV services mentioned above, lab services ordered by FQHC practitioners may be billed using the fee-for-service laboratory fee schedule as long as the lab service **is not** included in the clinic rate of payment.
- If the clinic rate includes these services then the lab must bill the clinic for these services.

Take Home Message for Labs

- Negotiate or revisit contracts with clinics for lab services for clinic patients,
- Change requisition forms to include indication as to whether patient is a “clinic patient,”
- Report test results timely to ordering practitioner at clinics, and
- Submit claims timely to clinics, including appropriate CPT codes, for services rendered to clinic patients.

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 then bill eMedny 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.



Issues of Special Interest to Laboratories

Ordered Ambulatory Services

- When lab services are ordered by a private practitioner or practitioner group, and are not subject to APG payments, the lab services are considered ordered ambulatory services.
- Ordered ambulatory services are not reimbursed under APGs.
- The testing laboratory may continue to bill Medicaid directly for any lab tests that are provided on an ordered ambulatory basis.



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

- It will not be possible for a lab to identify payment amounts for specific lab tests under APGs in all circumstances.
- In many cases, APG reimbursement to a clinic reflects the average costs of the ancillary services provided.
- Medicaid payment to a clinic for lab tests varies, depending on the weight of the APG, the other services or procedures provided on the same date of service, if any, and the APG grouper pricer logic (e.g. line item, packaged, bundled or discounted payment).

How are Lab Service Payment Amounts to be Determined ?

- Payment amounts will need to be negotiated by clinics and laboratories and set forth in contractual agreements.
- Laboratories are expected to receive a fair market value reimbursement for laboratory testing.

Clinic Non-payment for Laboratory Tests?

- 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.

Are Laboratories Required to Enroll in Medicaid?

- Under the APG payment methodology , laboratories providing services to Medicaid clinic patients are not required to enroll in Medicaid as participating providers.
- However the Laboratory must have a valid NYS Health Department permit.

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.
- If a lab refers more than 30% of its work to a reference lab, the reference lab should bill the clinic directly.



Drug Screens and CPT-4 Code 80101 from 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.*
 - *If billed without an E&M and/or significant procedure, no clinic payment is made.*
- A lab may bill a clinic for venipuncture.

How Will MA Reimburse for New Covered Lab Services?

- The APG grouper/pricer is updated at least twice/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.



Handouts & Contact Information

Supporting Materials

- Available on DOH website
(http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm)
 - *Provider Manual and Implementation Schedule*
 - *APG Final Regulations*
 - *APG Known Issues List*
 - *APG Training Presentations*
 - *Frequently Asked Questions*
 - *APG Types, APG Categories, APG Consolidation Logic*
 - *Payment Examples*
 - *Uniformly Packaged APGs*
 - *Inpatient-Only Procedure List*
 - *Never Pay and If Stand Alone Do Not Pay Lists*
 - *Carve-Outs List*
 - *List of Rate Codes Subsumed in APGs*
 - *Ambulatory Surgery Procedure List*
 - *Hospital Base Rates, Capital Add-Ons, Operating Payment for Blend*
 - *Other Implementation Materials*

Contact Information

- Grouper/Pricer Software Support
 - *3-M Health Information Systems, Inc.*
 - *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*
 - *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*
 - *apg@health.state.ny.us*



Questions?