Understanding the Submission and Remittance Process for the Ambulatory Patient Group (APG) Payment System for Family Planning Providers

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

Call-in Number - (866) 232-9440
Participant PIN - 27691841#
Understanding the Submission and Remittance Process for the Ambulatory Patient Group (APG) Payment System for Family Planning Providers

Introduction
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Webinar Objectives

- Understand the basics of submitting a claim to Medicaid using APGs, as well as common nuances in the family planning setting
- Be familiar with common issues relating to the 835 remittance file in the family planning setting
- Recognize frequent causes for claims denials and understand how to manage denied claims
- Learn how to validate claim payments and adjust paid claims
- Gain answers to general questions about validating APG remittances and payments
Understanding the Submission and Remittance Process for the Ambulatory Patient Group (APG) Payment System for Family Planning Providers

**Presenters**
- Ann Finn
- Robert Tompkins
  
  Provider Consulting Solutions, Inc.
Agenda

- Review APG billing concepts
- Submitting claims to Medicaid for typical family planning visits
- Understanding the remittance advice
- Correcting denials
- Adjusting a claim
- Validating claim payment
APG BILLING CONCEPTS
Medicaid Reimbursement: Old vs. New

- **Threshold Payment:**
  - Single payment for multiple services
    - Little incentive to capture and report services accurately

- **APGs - Ambulatory Patient Groups:**
  - Payments based on amount and type of resources used
    - Requires accurate capturing and billing of diagnoses and CPT codes for all services provided
APG Basics

- Patient encounters are described by a list of APGs that correspond to each service provided either by:
  - Procedure Codes
  - Diagnosis Codes

- Multiple APGs can be assigned to a claim based on services rendered

- Not all services are paid as an APG
Multiple Claims for One Visit

- Under APGs, multiple claims may be needed to ensure full reimbursement

**Claim 1**
- APGs – Evaluation and Management (E/M), Significant Procedures, Lab tests, and HIV Counseling and Testing (post July 1, 2011)

**Claim 2**
- Carve-out Services – Billed to the Ordered Ambulatory Fee Schedule – Drugs, Devices, Tests, and Other Carve-out Services: [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)

**Claim 3**
- Other Carve-outs Services – Prior to July 1, 2011 ONLY—these services now are billable as part of the APG claim
Conditional Carve-outs

- Procedures that may be billed to Medicaid as a separate Ordered Ambulatory claim when there is no medical visit or procedure billed as an APG claim 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!
Primary Types of APGs

- **Significant Procedures:** A procedure that constitutes the reason for the visit and dominates the time and resources expended
  - Examples: Colposcopy, SAB, cyrotherapy, mammogram

- **Medical Visits:** A visit during which a patient receives medical treatment, but did not have a significant procedure performed
  - APG assignment is based on the primary diagnosis
    - Examples: GYN annual visit, STI testing and treatment

- **Ancillaries:** Tests and procedures ordered by the primary physician to assist in patient diagnosis or treatment
  - Examples: Immunizations, IUD insertion and removal, lab tests (e.g. gonorrhea), urine pregnancy tests

- **Drugs**

- **Incidentals**
  - Example: Vaccine administrations
APG Payment Factors

- **Consolidation (or Bundling):** Inclusion of payment for a related procedure in 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
      - [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, 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 procedure, and the second procedure will be discounted (generally by 50%)

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

- Starting January 1, 2011, there is new APG Fee Schedule allowing reimbursement of a fixed amount for defined services on the APG claim
- These procedures are not eligible for a blended payment or capital add-on
- Procedures are paid for the lower of the fee schedule or charge amount
  - Example: As of July 1, 2011, urine pregnancy tests are paid on the APG Fee Schedule when billed with an E/M visit
Modifier U5 – HIV Counseling

- After July 1, 2011, HIV Counseling and/or Testing is billed to the APG claim
- Providers can bill for preventive medicine counseling (99401) of at least **8 minutes but less than 15 minutes** in duration;
  - Inclusion of Modifier U5 on the procedure line will indicate a “reduced service” and will result in the payment weight being discounted by 30%
- Providers should not bill for preventive medicine counseling for sessions less than 8 minutes in duration

**NOTE:** The “U5” modifier should not be added to any other preventive medicine service codes (99402, 99403, and 99404)
New Ancillary Billing Policy for DTCs

- Effective July 2011, Diagnostic and Treatment Centers (DTCs) were given two billing options for “ordered” ancillaries:
  - Contract for ALL labs and radiology
    - DTCs bill Medicaid with the U6 Modifier and pay the provider directly
  - OR
  - Have the outside labs and radiology bill Medicaid directly
    - DTCs bill for services (no U6) and receive no payment
    - Packaged services will have a payment reduction
    - In-house ancillaries still require the U6 Modifier for payment

- As of October 1, 2011 (retroactive to July 1, 2011), DTCs may contract separately with all labs and/or all radiology
New Ancillary Billing Policy for DTCs

- ALL ancillaries ordered or provided by the DTC on-site 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
- Confirm the service was performed prior to billing
Modifier U6 – “Pay Me”

- DTC’s must include the U6 modifier with each ancillary service HCPCS, including in-house tests
  - Non-contracting DTC’s that perform in-house lab tests and ultrasounds should code Modifier U6 to receive payment
  - For lab tests that package into the E/M, code Modifier U6 to avoid unwanted payment reduction

- Confirm the service was performed prior to billing

NOTE: This has been a common billing error reducing claim payment for family planning providers
SUBMITTING A CLAIM
Timeframe for Submitting the Claim

- Providers have up to 90 days from the date of service to submit an initial claim to Medicaid
  - Delayed claims may be submitted after 90 days (if there is a valid reason for the delay)
  - All claims submitted after 90 days must be submitted within 30 days of the time submission came within the control of the provider
- Submissions must include a valid HIPAA Delay Code

NOTE: Inaccurate reporting of the 90 day indicator has been a subject of recent audits
Valid HIPAA Delay Reasons – 90 Day Indicators

1. **Proof of Eligibility Unknown or Unavailable:** Must be submitted within 30 days from the date of notification of eligibility
2. **Litigation:** Must be submitted within thirty days from the time submission came within the control of the Provider
3. **Authorization Delays:** Delays previously approved by the State - must be submitted within 30 days from the date of notification
4. **Delay in Certifying Provider:** Must be submitted within 30 days from the date of notification of the change in provider’s enrollment status
5. **Delay in Supplying Billing Forms:** Must be submitted within thirty days from the time submission came within the control of the Provider - *reason 5 not accepted for electronic claims*
6. **Delay in Supplying Custom-made Appliances:** *NYS Medicaid does not accept this reason for delay and will deny a code value of “6”*
Valid HIPAA Delay Reasons – 90 Day Indicators

7. **Third Party Processing Delay**: Must be submitted within thirty days from the time submission came within the control of the Provider

8. **Delay in Eligibility Determination**: Must be submitted within thirty days from the date of notification of eligibility

9. **Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules**: Corrected claim must be submitted within 60 days of the date of notification

10. **Administration Delay in the Prior Approval Process**: Must be submitted within 30 days from the date of notification

11. **Other**: This delay reason only applies to adjustments of paid claims and limited situations, which are listed below on the Delay Reason Code form and Provider Manual

**NOTE**: The 30-, 60-, and 90-day submission periods referred to are calendar days
Timeframe for Submitting the Claim

- New claims can be resubmitted as many times as needed within 2 years of the date of service.
- If a claim is NOT paid within 2 years of the date of service, it becomes ineligible for payment except when:

  “the provider can prove in documentation that the delay was due to the DOH, Local Social Services, or Agents of the Department; or if the courts order the department to make payment.”
Types of Claims

- **Institutional Claims**: Submitted as 837i Electronic Submission
- **Professional Claims**: Submitted as 837p Electronic Submission
  - DTCs may not bill for professional services, including physician services, as they are considered part of the APG facility payment
  - For hospitals, physician services are carved-out of the APG payment and may be billed separately
- **Ordered Ambulatory (OA) Claims**: May be included on the 837p/i or billed through ePACES
  - All claims will be returned on the provider’s remittance advice
What is ePACES?

- **Electronic Provider Assisted Claim Entry System (ePACES):** A web-based application that allows providers to request and receive the following:
  - HIPAA-compliant claims (professional, institutional, and dental)
  - Eligibility determinations
  - Claim inquiries
  - Service authorizations
  - Dispensing Validation System (DVS) transactions
- Computer Sciences Corporation (CSC) developed this application on behalf of the NYS DOH

[https://www.emedny.org/selfhelp/epaces/faq.aspx](https://www.emedny.org/selfhelp/epaces/faq.aspx)
Bill Type

- Claims should include a three-digit numeric code which identifies the specific type of bill:
  - **First Digit:**
    - 1 = Hospital
    - 7 = Clinic (free standing)
    - 8 = Special facility (rural primary care facility ONLY)
  - **Second Digit:**
    - 3 = Outpatient
  - **Third Digit:**
    - 1 = New claim (new or add)
    - 7 = Replacement of prior claim (change)
    - 8 = Void/cancel of prior claim (delete)
What Rate Code Should I Use?

- Each claim needs to have a rate code included in order to be paid correctly:
  - **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 requires 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
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
APG 875 Contraceptive Management

- New APG 875 effective July 1, 2011:
  - Significant payment enhancement compared to APG 871
  - E/M service is coded in conjunction with “V25” series primary diagnosis

- Family Planning visit indicator is required:
  - **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
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.

- 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
Expanding the Family Planning Enhancement

- January 1, 2012 payment for a family planning E/M will be enhanced if the **primary** or **first secondary diagnosis** is in the V25 series
  - APG 871 may get a 50% weight-bump when a V25 diagnosis code is in the first secondary diagnosis field
- 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](http://www.cicatelli.org/titlex/Webinars.htm)
Example – Typical Family Planning Visit

- **What happened at this encounter?**
  - Patient presents for an IUD insertion
  - Patient has not been using contraception method consistently and is worried about HIV
  - Patient requests a breast check
  - Services provided:
    - GYN / General exam
    - IUD insertion
    - HIV counseling (documented for > 9 minutes)
    - Labs (Urine pregnancy test; HIV, chlamydia, and gonorrhea testing)
  - IUD Device
  - Time of appointment: Saturday at 10 AM
  - All services are clearly documented and coding guidelines are followed
What Goes on the Bill?

- **Diagnoses Reported:**
  - V25.11 (Insertion of Intrauterine Contraceptive Device)
  - V72.31 (Routine GYN Exam)
  - V73.89 (HIV Test), V74.5 (STI Screening), V65.44 (HIV Counseling)

- **Procedures Reported:**
  - 58300 IUD Insertion
  - 99213 -25 - E/M
  - 99401-U5 - HIV counsel 8-15 min
  - 81025 - UPT - in house
  - 87491 - Chlamydia - send out
  - 87591 - Gonorrhea - send out
  - 86703 - HIV Test - in house
  - 99051 - Weekends and Nights

- **Devices:**
  - J7300 - IUD

**NOTE:** DTCs must include Modifier U6 to receive reimbursement for labs
About the IUD Insertion and Device...

- IUD Device is **carved-out**
  - IUD device billed separately at cost to the Ordered Ambulatory Fee Schedule (J7300 or J7302)
- Although the IUD insertion is an ancillary service, it is not subject to the U6 Ancillary policy and does not need a U6 modifier


Failure to report devices may result in a significant loss of revenue!
Submitting the Visit... Non-Contracting

APG Claim: Distinct E/M with IUD Insert (DOS 1/1/2012 - Phase 4)

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<th>APG Description</th>
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TOTALS | 2.3430 | $265.23 | $0.00 | $10.00 | $275.23 |
# Contracting

**APG Claim: Distinct E/M with IUD Insert (DOS 1/1/2012 - Phase 4)**

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**TOTALS** |     | 2.3430 | $314.01 | $0.00 | $10.00 | $324.01

New York State Center of Excellence for Family Planning and Reproductive Health Services
Billing the IUD Device

Ordered Ambulatory Claim: The IUD Device

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**TOTALS**  
$250.00
Correct NDC Code Format

- Medicaid requires an 11-digit NDC Code for most drugs to be paid

- Traditionally, NDC is a 10-digit code; however, CMS created an 11-digit NDC derivative with a standard fixed length 5-4-2 configuration
  - For example: 1234-5678-90, 12345-678-90, and 12345-6789-0 could all be entirely different products with the same 10-digit barcode 1234567890
  - The 11-digit codes would be 01234-5678-90, 12345-0678-90, and 12345-6789-00
UNDERSTANDING THE REMITTANCE ADVICE
The Remittance Advice (835)

- A remittance advice is a record of claim transactions that assists providers in identifying and correcting billing errors
  - Plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues
- The remittance advise include the following information:
  - Listing of all claims entered into the computerized processing system during the corresponding cycle
  - Status of each claim (deny/paid/pend) after processing
  - eMedNY edits (errors) failed by pending or denied claims
  - Subtotals and grand totals of claims and dollar amounts
  - Other financial information (e.g. recoupments, negative balances)

Detailed information on the remittance advice available at:
https://www.emedny.org/hipaa/emedny_transactions/transactions.aspx
Formats – Electronic vs. Paper

- Providers may receive remittance advice information in only one of these three formats:
  - **Electronic HIPAA 835/820 Transaction File:** Raw text file includes all remittance information for claim
  - **Paper Report:** Filtered down information per claim mailed to providers
  - **PDF Report:** Same as paper, but transmitted quicker to providers
- The format depends on the billing department/company and software setup
- An institution’s remittance file format can be changed at: 
  [http://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20 Forms/Electronic%20Remittance%20Request%20Form.pdf](http://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/Electronic%20Remittance%20Request%20Form.pdf)
Many providers receive a text file that looks like this:

This file contains codes and symbols that identify different data elements within the file.
Some providers receive a text file from their billing company that looks like this:

The data within this file is spaced consistently and can be read from the “image” by the location of certain fields.
Some providers receive a PDF file that looks like the paper file, but is transmitted more quickly to providers.

Like the Text Image, the data within this file is spaced consistently and can be read from the “image” by the location of certain fields.
There are many variations to the standard formats we have reviewed.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Subscriber Name</th>
<th>Provider Name</th>
<th>MARY SMITH</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID</td>
<td>Payer Claim ID</td>
<td>Provider Claim ID</td>
<td>DEXXXXX</td>
<td>999999999999</td>
<td>9999</td>
</tr>
<tr>
<td>Claim Status</td>
<td>Claim Amount</td>
<td>Paid Amount</td>
<td>1</td>
<td>$235.00</td>
<td>$146.23</td>
</tr>
<tr>
<td></td>
<td>Pt. Responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claim Status Description: Processed as Primary

<table>
<thead>
<tr>
<th>Serv Date</th>
<th>Units</th>
<th>Serv Code</th>
<th>Billed</th>
<th>Paid</th>
<th>Allowed Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/09/2011</td>
<td>1</td>
<td>HC&lt;99395</td>
<td>$181.00</td>
<td>$146.23</td>
<td>$146.23 CD-94: $11.69, CD-45: $45.45</td>
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<tr>
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<td></td>
<td>HC&lt;97210</td>
<td>$30.00</td>
<td>$0.00</td>
<td>- CD-45: $36.00</td>
</tr>
<tr>
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<td></td>
<td>HC&lt;99900</td>
<td>$25.00</td>
<td>$0.00</td>
<td>- CD-96: $25.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>REM: M77</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Remittance Advice (835) Structure

Header:
- Contains transmission information, provider identification numbers, payment method, total payment for the entire transmission, control totals for the transmission

Detail:
- Contains a series of claims with claim and patient identifiers, and adjudication information at the line- and claim-levels

Summary:
- Contains adjustments made to the entire transmission (e.g. advanced payments, balances forwarded, IRS withholdings, and late filing reductions)
Remittance Advice (835) Structure

- **Payment Information**: Service-level payment and payment adjustment codes
  - Critical for reconciling what was expected verses what was paid
- **Transaction Control Number (TCN)**: Unique number assigned to every claim submission and is needed to adjust a claim
  - When adjusting a claim, both the original and the new TCN are returned
- **Reason and Remark Codes**: National Uniform Billing Committee Codes to explain payment decisions by NYS DOH
- **DOH APG Assignment and Weight**: Show whether HCPCS and primary diagnosis are mapping to the expected APG and weight
- **Payer Information**: Indicate the claim’s status
Reason and Remark Codes

- Reason and Remark Codes explain payment/non-payment decisions by NYS DOH and help providers identify necessary changes needed for claim correction.

- Line-level adjustment codes may also identify potential reimbursement opportunity and/or compliance exposure.
  - Examples: MUEs, medical necessity, CCI edits, modifiers.

- Resources on Reason and Remark Codes:
## Common Reason and Remark Codes

### Adjustment Group Codes
- CO: Contractual Obligations
- OA: Other adjustments
- PR: Patient Responsibility

### Adjustment Reason Codes
- **3**: Co-payment Amount
- **16**: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 7/1/2010: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- **18**: Duplicate claim/service.
- **22**: This care may be covered by another payer per coordination of benefits.
- **24**: Charges are covered under a capitation agreement/managed care plan.
- **45**: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- **94**: Processed in Excess of charges.
- **96**: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 7/1/2010: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **97**: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. This change to be effective 7/1/2010: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **125**: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDPReject Reason Code.) This change to be effective 7/1/2010: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Common Code Definitions

- **Common Claim Status Codes:**
  1. Processed as Primary
  2. Processed as Secondary
  3. Processed as Tertiary
  4. Denied
  5. Pended
  22. Reversal of Previous Payment

- **Adjustment Group Codes:**
  - CO - Contractual Obligation (provider is financially liable)
  - CR - Correction and Reversal
  - OA - Other Adjustment (no financial liability)
  - PR - Patient Responsibility (patient is financially liable)
Reading the Remit

**Transaction control number:** 9999999999999999
**Rate code billed:** 1432

**Service Information:**
- **HCPCS:** 99392
- **Modifier:** None
- **Line Charge:** $171.00
- **Line Payment:** $117.76
- **Revenue Code:** None
- **Units:** 1
- **Service date:** 05/05/2011

**Reason Codes and Amounts:**
- 94 – Processed in Excess of charges: $-7.98 (Capital) + $-86 (APG Payment Amount) = $-93.98
- 45 – Charge Exceeds Fee Max: $147.22

**Service Line Balancing:**
$171.00 (Charge) – $147.22 – ($-93.98) = $117.76

**APG Assignment:**
APG 871, payment $117.76 the APG payment portion is $86.51 the blend used is $23.27 weight of 0.7343 discount percent 100%

**Payment:**
$86.51 (APG) + $23.27 (Blend) + $7.98 (Capital) = 117.76

New York State Center of Excellence for Family Planning and Reproductive Health Services 52
Let’s Try the Same Exercise with a Different Report Format...

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MARY SMITH</th>
<th>Patient ID</th>
<th>DEXXXXX</th>
<th>Claim Status</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Subscriber Name</td>
<td>-</td>
<td>Payer Claim ID</td>
<td>999999999999</td>
<td>Claim Amount</td>
<td>$235.00</td>
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<tr>
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<td>-</td>
<td>Provider Claim ID</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pt. Responsibility</td>
<td>-</td>
</tr>
</tbody>
</table>

Claim Status Description: Processed as Primary

<table>
<thead>
<tr>
<th>Serv Date</th>
<th>Units</th>
<th>Serv Code</th>
<th>Billed</th>
<th>Paid</th>
<th>Allowed Adjustments</th>
</tr>
</thead>
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<td>07/28/2011</td>
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<td>$146.23 CO-94: $-11.69, CO-45: $45.46</td>
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<td>HC&lt;87210</td>
<td>$30.00</td>
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<td>- CO-45: $30.00</td>
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<tr>
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<td></td>
<td>HC&lt;99000</td>
<td>$25.00</td>
<td>$0.00</td>
<td>- CO-95: $25.00</td>
</tr>
<tr>
<td>07/29/2011</td>
<td></td>
<td>REM: M77</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Missing information:
- Transaction Control Number
- Ratecode, Modifier
- Blend information
- APG assignment, APG Weight

We know the HCPCS, units, charge adjustments, and line payment.

**HCPCS: 99395**
- 94 - $-11.69
- 45 – $45.46

This would make validation and adjusting this claim very hard.
DENIALS
Denied Claim Resubmission Timeframe

- **1 - 90 days after Date of Service:** Resubmit as an initial claim to replace denial
- **90 days to 2 years after Date of Service:** Claims must be resubmitted within:
  - 30 days for Litigation, Medicare/Insurance delay, Medicaid Eligibility
  - 60 days for Original Claim denied for non-90 day reason, NYS DOH Delay, IPRO Denial/reversal, and Interrupted Maternity Care

**NOTE:** When submitting claims beyond 90 days, use the appropriate HIPAA Delay Reason Code (90-day indicator)
Common Easy to Repair Denials

- There are many denial reasons that are easy to repair, including:
  - Duplicate claim or service (18)
  - Submission billing error (125)
  - Missing/incomplete/invalid principal diagnosis (MA63)
  - Missing/incomplete/invalid gender (MA39)

NOTE: When correcting denied claims, there may be multiple denial reason codes
18 – Duplicate Claim or Service

- This is an example of a claim denied as a duplicate
- This adjustment claim was incorrectly submitted without a reference TCN, and was processed as an initial claim and denied as a duplicate
- Note: The “Duplicate Claim or Service (18)” reason code may also be used when individual line items are denied
125 – Submission Billing Error

This is an example of a claim denied for a 125 billing submission error.

- There is only one line on the claim and the NYS DOH assigned APG 490 – Incidental (Non-Paying).
- If all lines on a claim pay $0 then the claim is denied with reason code 125.
- There also is a remark code N19, a common remark code describing discounting but not the reason for the denial.
MA63 – Missing/Incomplete/Invalid Primary Diagnosis

- The reason code for denial is a general code (16 – Missing or invalid information); the remark (MA63) tells which specific item is missing or invalid
- Diagnosis codes are not returned in the remittance file; a quick look at the patient’s record showed that the diagnosis code was 590.8 which requires a 5th digit
- With a correct diagnosis code (590.80 or 590.81), this claim would have paid $132.67
MA39 – Missing/ Incomplete/ Invalid Gender

- This is an example of a claim denied for a missing or invalid gender
- A quick look at the submitted claim shows that the improper gender was submitted which did not match what Medicaid had on file
- Gender must be M or F, a U is invalid—missing / invalid gender on a claim will cause the entire claim to deny!
2011 Medicaid NCCI Edits

- Medicaid has Implemented Federal National Correct Coding Initiative (NCCI) edits
- NCCI includes two types of edits:
  - NCCI Procedure-to-Procedure (PTP) edits and
  - Medically Unlikely Edits (MUE)
- Implemented on a “pay and report” basis post-January 1, 2011, and began denying claims after April 1, 2011
- Use of Modifier 59 (distinct procedure) or Modifier 25 (separately identifiable E/M) will override NCCI edit, but must comply with AMA guidelines -- *Use with caution*

[Link](http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/ncci_edits_applied_apgclaims.pdf)
ADJUSTING A CLAIM
Adjusting a Paid Claim

- Although providers have up to 6 years to adjust a paid claim, claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 60 days of the date of notification.
- Providers can add or remove services, and change rate codes.
- To adjust a claim less than 2 years, Patient ID and NPI require a void and new claim submission.

NOTE: After 2 years, do not submit a void with a new replacement claim as the new claim will be ineligible for payment. **Always submit the claim as an adjustment instead.**
Adjusting a Paid Claim

- When adjusting a claim, it is important to include:
  - **Transaction Control Number:** The TCN of the most recent paid version of the claim being adjusted serves as the reference TCN
    - Missing or invalid reference TCNs will result in a denial
  - **HCPCS:** All original HCPCS and additions must be submitted together as a new adjustment claim
    - Submitting HCPCS separately as a “late charge” will override the original claim or be denied as a duplicate and may result in revenue loss
  - **Bill Type:** The third digit should = 7 (adjustment)
  - **Referring Physician:** The Referring Physician ID is required on the new Ordered Ambulatory claim when a service was billed in error as an APG
Example – Adding a Service to a Paid Claim

- The patient had an ultrasound that was not captured on the initial claim.
- How would you add that service to the previously paid claim?
  - Add the ultrasound HCPCS to the list of original HCPCS on the claim.
  - Submit an adjustment claims (bill type xx7) with the Reference TCN of the previously paid claim.
  - The reprocessed claim receives a new TCN that is used to make any further adjustments.
Example – Correcting a Denial

- A claim was denied due to an invalid gender on the claim
- How would you correct that denial and resubmit for payment?
  - Correct the gender on the claim according to what the NYS DOH has on file for the patient
    - If the claim was originally paid, submit an adjustment claim (bill type xx7) with the Reference TCN of the previous paid claim
    - If the claim is an initial claim denial, resubmit the corrected claim as an initial claim
  - Validate that the claim was paid once the remittance file is received
Example – Carve-out Billed in Error as APG

- An IUD was billed in error to an APG claim and not paid because it is a carve-out
- How would you correct this claim to receive payment for the IUD?
  - Submit a new Ordered Ambulatory claim for the IUD
  - Place correct Physician NPI in the referring physician ID field
  - Validate that the line has the appropriate charge and modifier
  - Add the appropriate HIPAA Delay reason code to the claim if over 90 days old
  - Submit an adjustment claim (bill type xx7) with the Reference TCN of the previous paid APG claim without the IUD HCPCS to remove that service
Example – Depo-Provera Improperly Billed as Ordered Ambulatory Service with an E/M

- Since Depo-Provera is a conditional carve-out, it should not be billed separately to the Ordered Ambulatory Fee Schedule when administered with a billable medical service (E/M or SP)
- How do we correct the Depo-Provera overpayment in this scenario?
  - If the Depo-Provera and administration are the only services on the claim, submit a void claim (bill type xx8) referencing the TCN of the incorrectly paid Ordered Ambulatory claim
  - If there are other services on claim, submit an adjustment claim (bill type xx7) without the Depo-Provera and admin referencing the TCN of the incorrectly billed Ordered Ambulatory claim
  - Adjust the paid APG claim to include the Depo-Provera and administration
VALIDATING CLAIM PAYMENT
What Impacts APG Payment?

- Base Rates
- Weights
- Transition Blend – Until 2012
- APG Payment Adjustments
  - Packaging, Consolidation, and Discounting
  - NCCI Edits
# APG Regional Base Rates

<table>
<thead>
<tr>
<th>Service</th>
<th>Base Region</th>
<th>Jul-09</th>
<th>Dec-09</th>
<th>Jan-10</th>
<th>Jul-10</th>
</tr>
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<tbody>
<tr>
<td>OPD</td>
<td>Downstate</td>
<td>$258.90</td>
<td>$199.18</td>
<td>$206.48</td>
<td>$204.33</td>
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<tr>
<td>OPD</td>
<td>Upstate</td>
<td>$199.00</td>
<td>$153.11</td>
<td>$158.71</td>
<td>$157.07</td>
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<tr>
<td>Hosp. ASU</td>
<td>Downstate</td>
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<td>$156.91</td>
<td>$228.00</td>
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<td>Hosp. ASU</td>
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<td>$122.25</td>
<td>$176.13</td>
<td>$166.47</td>
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<tr>
<td>DTC</td>
<td>Downstate</td>
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<td>$158.78</td>
<td>$156.76</td>
<td>$156.76</td>
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<tr>
<td>DTC</td>
<td>Upstate</td>
<td>$174.74</td>
<td>$129.14</td>
<td>$131.35</td>
<td>$131.35</td>
</tr>
</tbody>
</table>

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, APGs will have a new statewide base rate feature to reimburse providers for certain APGs (Drugs, Radiology, Lab, Devices) comprised of procedures that have minimal regional cost variation
  - Current 2011 Statewide Base Rate = $165.00
  - Estimated 2012 Statewide Base Rate = $160.00

A few impacted APGs that pertain to family planning:

<table>
<thead>
<tr>
<th>APG</th>
<th>APG Description</th>
<th>Date added to list</th>
</tr>
</thead>
<tbody>
<tr>
<td>286</td>
<td>MAMMOGRAPHY</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>291</td>
<td>BONE DENSITOMETRY</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>390</td>
<td>LEVEL I PATHOLOGY</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>391</td>
<td>LEVEL II PATHOLOGY</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>392</td>
<td>PAP SMEARS</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>393</td>
<td>BLOOD AND TISSUE TYPING</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>394</td>
<td>LEVEL I IMMUNOLOGY TESTS</td>
<td>1/1/2011</td>
</tr>
<tr>
<td>395</td>
<td>LEVEL II IMMUNOLOGY TESTS</td>
<td>1/1/2011</td>
</tr>
</tbody>
</table>
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
Validating Claim Payment – 100% APGs

Steps:
1. For each HCPCS on the claim payable by weight, multiply:
   Base Rate x APG Weight x Payment Discount x Units
2. Add Payments for HCPCS paid on APG Fee Schedule
3. Add Capital

NOTE: Don’t forget there are 2 base rates: regional and statewide
Validating Claim Payment – APG / Threshold Blend

Steps:
1. APG/threshold blend through 2011
2. For each HCPCS on the claim payable by weight, multiply:
   \[
   \text{APG Blend} \times \text{Base Rate} \times (\text{APG or Procedure Weight}) \times \text{Payment Discount} \times \text{Units (if applicable)}
   \]
   \[
   + \quad (1 - \text{APG Blend}) \times \text{Threshold Blended Rate} \times (\text{APG or Procedure Weight}) / (\text{Visit / Episode Weight for All Paying Lines})
   \]
   - The threshold payment is spread across these paying services
3. Add Payments for HCPCS paid on APG Fee Schedule
4. Add Capital
Understanding the Payment – 100% APG

APG Claim: Distinct E/M with IUD Insert (DOS 1/1/2012 - Phase 4)

Date of Service: 1/1/2012
APG Base Rate: $131.35
Statewide Base Rate: $165.00
Existing Payment for Blend: $100.00
Blend Percentage (APG): 100%

<table>
<thead>
<tr>
<th>Px Code</th>
<th>Procedure Description</th>
<th>APG</th>
<th>APG Description</th>
<th>Modifier</th>
<th>Payment Action</th>
<th>Units</th>
<th>Payment Percent</th>
<th>Allowed Weight</th>
<th>Full APG Payment</th>
<th>Existing Payment of Blend</th>
<th>Capital - sample</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office/outpatient visit est</td>
<td>875</td>
<td>CONTRACEPTIVE MANAGEMENT</td>
<td>25</td>
<td>Full payment</td>
<td>1</td>
<td>100%</td>
<td>1.1189</td>
<td>$146.97</td>
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<tr>
<td>58300</td>
<td>Insert IUD</td>
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<td>MINOR REPRODUCTIVE SERVICES</td>
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<td>Full payment</td>
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<tr>
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<td>Preventive counseling indiv</td>
<td>490</td>
<td>INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT</td>
<td>U5</td>
<td>Partial Payment</td>
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<td>70%</td>
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<td>$15.85</td>
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<tr>
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<td>HIV-1/HIV-2, single assay</td>
<td>394</td>
<td>LEVEL I IMMUNOLOGY TESTS</td>
<td>U6 - inhouse</td>
<td>APG Fee payment</td>
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<td>100%</td>
<td>Fee</td>
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<td>Urine pregnancy test</td>
<td>410</td>
<td>URINALYSIS</td>
<td>U6 - inhouse</td>
<td>APG Fee payment</td>
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<td>100%</td>
<td>Fee</td>
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<td>CHYLMĐ TRACH, DNA, AMP PROBE</td>
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</tbody>
</table>

**TOTALS** 2,3430 $265.23 $0.00 $10.00 $275.23

New York State Center of Excellence for Family Planning and Reproductive Health Services
## 75% APG / 25% Threshold Payment

### APG Claim: Distinct E/M with IUD Insert (DOS 11/1/2011 - Phase 3 75% APG)

- **Date of Service:** 1/1/2012
- **APG Base Rate:** $131.35
- **Statewide Base Rate:** $165.00
- **Existing Payment for Blend:** $100.00
- **Blend Percentage (APG):** 75%
- **Rate Code:** 1422 DTC General Clinic
- **Region:** Upstate

<table>
<thead>
<tr>
<th>Px Code</th>
<th>Procedure Description</th>
<th>APG</th>
<th>APG Description</th>
<th>Modifier</th>
<th>Payment Action</th>
<th>Units</th>
<th>Payment Percent</th>
<th>Allowed Weight</th>
<th>APG Payment</th>
<th>Existing Payment Portion</th>
<th>Capital - sample</th>
<th>Total Payment</th>
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<tr>
<td>99213</td>
<td>Office/outpatient visit est</td>
<td>875</td>
<td>CONTRACEPTIVE MANAGEMENT</td>
<td>25</td>
<td>Full payment</td>
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<td>100%</td>
<td>1.1189</td>
<td>$110.23</td>
<td>$14.33</td>
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<td>58300</td>
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<td>86703</td>
<td>HIV-1/HIV-2, single assay</td>
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<td>LEVEL I IMMUNOLOGY TESTS</td>
<td>U6 - inhouse</td>
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<td>Fee</td>
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<td>URINALYSIS</td>
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<td>EXPANDED HOURS ACCESS</td>
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**TOTALS**

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<td>$205.40</td>
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75% APG / 25% Threshold Payment

APG Claim: Distinct E/M with IUD Insert (DOS 11/1/2011 - Phase 3 75% APG)

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<td>1.1189</td>
<td>$110.23</td>
<td>$15.72</td>
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<tr>
<td>58300</td>
<td>Insert IUD</td>
<td>417</td>
<td>MINOR REPRODUCTIVE SERVICES</td>
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<td>Full payment</td>
<td>1</td>
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<td>0.6601</td>
<td>$65.03</td>
<td>$9.28</td>
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**TOTALS**

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<td></td>
<td>1.7790</td>
<td>$175.25</td>
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<td>$210.25</td>
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New York State Center of Excellence for Family Planning and Reproductive Health Services
Understanding Threshold Blend

- A service, such as a medical visit, may have a different line payment across claims depending on the number of payable services on each claim due to the spread of threshold payment during APG Phases 1-3

  - Threshold Blended Payment is spread across ALL payable services on a claim
  - On the examples above, regardless of the number of HCPCs, the total threshold payment would equal $25
APG Weight Changes and Blending

- If the weight of APG 875 is 1.1189 during 2011, will the payment go down if NYS DOH lowers the payment to 1.08 for 2012?
  - No, due to the fact the APG blend moved from 75% to 100% and the APG base rate is higher than the threshold blended rate

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
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<tbody>
<tr>
<td>APG Base Rate:</td>
<td>$131.35</td>
<td>$131.35</td>
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<tr>
<td>Threshold Blend:</td>
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<tr>
<td>Capital:</td>
<td>$10.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>875 Weight:</td>
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<td>1.08</td>
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<td>APG Blend:</td>
<td>75%</td>
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<tr>
<td>APG Payment:</td>
<td>$145.23</td>
<td>$151.86</td>
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Being Compliance Minded

- “Compliance” is being in accordance with state and federal guidelines, regulations and law
- It is essential to always follow coding guidelines and only code what is contained in the medical record
- It is the providers’ responsibility to ensure proper coding and validate payments received
  - Corrections must be made once an institution is made aware of an issue
Question and Answer Period

Understanding the Submission and Remittance Process for the Ambulatory Patient Group (APG) Payment System for Family Planning Providers

- Ann Finn and Robert Tompkins
  Provider Consulting Solutions, Inc.

- Ronald Bass and Alan Maughan
  Office of Health Insurance Programs
  New York State Department of Health
Resources

- **DOH APG Website:**
  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

- **eMedNY:**
  https://www.emedny.org/

- **EDI:**
  http://www.wpc-edi.com/
Contact Information

- **Grouper / Pricer Software Support**
  - *3M Health Information Systems*
    - Grouper / Pricer Issues  1-800-367-2447
    - Product Support  1-800-435-7776
    - [http://www.3mhis.com](http://www.3mhis.com)

- **Billing Questions**
  - *Computer Sciences Corporation*
    - eMedNY Call Center:  1-800-343-9000
    - Send questions to:  eMedNYProviderRelations@csc.com

- **Policy and Rate Issues**
  - *New York State Department of Health*
    - Office of Health Insurance Programs
    - Div. of Financial Planning and Policy  518-473-2160
    - Send questions to:  apg@health.state.ny.us
A Special Thank You to Our Presenters

- Ann Finn
- Robert Tompkins
- Ronald Bass
- Alan Maughan

New York State Department of Health Office of Health Insurance Programs

New York State Department Bureau of Maternal and Child Health