

How Do APGs Fit Your Facility?

New York State Medicaid has adopted the Ambulatory Patient Groups (APG) payment methodology for outpatient hospital, clinic and dental services.

- Reimbursement and compliant billing are directly affected by correct coding.
- HCPCS/CPT codes are required for all Procedures, Therapies and Ancillaries services. Diagnosis drives Medical Visit reimbursement.
- Service payments discount and consolidate unnecessarily when billed incorrectly on one or more claims.
- Operational Issues such as rate code selection and scheduling can impact payment.
- DOH Grouper errors have caused under and over claim payments which Providers are responsible to resubmit for correction.
- Medicaid Managed Care Plans can be billed under APGs.
- OASAS / OMH services are now transitioning to APGs.



Partner With PCS to Tailor Your Solutions

One size does not fit all. Provider Consulting Solutions is a leading consulting firm in New York State, specializing in Medicaid and Medicare IP/OP reimbursement methodologies. Put PCS' expertise to work with a customized approach to APGs that fits your facility's needs.

- ⇒ Opportunity and Compliance Claim Screening with PCS proprietary edits
- ⇒ Claims Analysis, Payment Validation, Benchmarking, and Reimbursement Modeling
- ⇒ Ongoing Outpatient claim monitoring
- ⇒ Coding and Billing Audits
- ⇒ Operational Assessments and Departmental Review(s)
- ⇒ Education and Training
- ⇒ Regulatory Support

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Medicaid Ambulatory Payment Group (APG) Screen Analysis

Sample Hospital

Claim Date Range: 12/1/2008 - 11/18/2010
Remit Date Range: 12/15/2008 - 11/29/2010

Summary Overview:

	Paid Claims	Remit Payment:
APG:	75,430	\$15,298,530
Fee:	2,673	\$251,804
	Screen Hits:	Estimated Impact:
Revenue:	42,843	\$1,049,834
Compliance:	4,228	(\$18,627)

Category	Screen	Screen Description	Category	Notes	Action	Impact Notes	Screen Hits	Impact
REVENUE								
	AMB100	AMBULATORY SURGERY PROCEDURE BILLED TO CLINIC RATECODE BETWEEN 12/1/2008 AND 6/30/2010	APG-PROCESS	Effective December 1, 2008 – June 30, 2010, an APG visit (or episode) must be billed against an Ambulatory Surgery rate code if the visit includes at least one procedure from the Ambulatory Surgery Procedures List unless performed in the ED. (http://www.nyhealth.gov/health_care/medicaid/rates/APG/docs/ambulatory_surgery_list.pdf)	Resubmit claim as adjustment claim with ASU ratecode for payment correction.	Expected claim payment with ASU ratecode minus Original expected claim payment as Clinic	35	\$17,957
	APG110	APG CLINIC CLAIMS POTENTIAL UNDERPAYMENT (PAYMENT < THRESHOLD BLEND)	APG-PROCESS	Check remittance advice on claim to verify payment was made correctly.	Resubmit Claim as an adjustment claim with all HCPCS	Expected claim payment minus Actual payment	448	\$53,141
	ISADNP102	UNPAID ISADNP WITH PAID APG CLAIM ON EARLIER DATE WITH THE SAME PHYSICIAN	APG-PROCESS	Validate services performed and billed.	If the ISADNP claim is made up of the services that were ordered on another APG claim, void the ISADNP claim, add the HCPCS from the ISADNP Claim to the claim where the services were ordered, and adjust the from and through dates of the ordering claim, changing the dates of the ISADNP services to match the date of the medical visit or significant procedure they are associated to if the ratecode is visit based.		519	\$158,630
							1,002	\$229,728

Medicaid APG Screen Analysis Sample Claim Details

Screen: AMB100

AMBULATORY SURGERY PROCEDURE BILLED TO CLINIC RATECODE BETWEEN 12/1/2008 AND 6/30/2010

Effective December 1, 2008 – June 30, 2010, an APG visit (or episode) must be billed against an Ambulatory Surgery rate code if the visit includes at least one procedure from the Ambulatory Surgery Procedures List unless performed in the ED.

(http://www.nyhealth.gov/health_care/medicaid/rates/APG/docs/ambulatory_surgery_list.pdf)

Claim billed in error to clinic ratecode (50% APG Blend)								
Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Expected Line Payment
3/16/2010	52000*	Cystoscopy	Significant Procedure	NO	NO	3.7694	1	\$486
3/16/2010	99213	Office/outpatient visit, est	Medical Visit	NO	NO	1.1276	0	\$0
Total Reimbursement:								\$486

Corrected Claim - Billed to correct ASU ratecode (100% APG)								
Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Expected Line Payment
3/16/2010	52000*	Cystoscopy	Significant Procedure	NO	NO	3.7694	1	\$975
3/16/2010	99213	Office/outpatient visit, est	Medical Visit	NO	NO	1.1276	0	\$0
Total Reimbursement:								\$975
Increase:								\$489

HCPCS 52000 is an ASU procedure

Clinic payment is based on downstate APG rate of \$206.48, threshold blend rate of \$162.69, capital add-on of \$15.23, billed at 50% APG blend

ASU payment is based on downstate APG rate of \$228.00, capital add-on of \$115.70, billed at 100% APG blend

Medicaid APG Screen Analysis Sample Claim Details

Screen: APG110

APG CLINIC CLAIMS POTENTIAL UNDERPAYMENT (PAYMENT < THRESHOLD BLEND)

Clinic payment under APGs is a blend of Threshold and APG payment calculations. There should not be an instance where a claim receives less than the blend percent of the threshold rate. Below is an example where the claim was paid less than the threshold blend payment.

Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Remit Payment	Expected Payment
1/25/2010	82962	Glucose blood test	Ancillary	YES	YES	0.0838	0	\$0	\$0
1/25/2010	99212	Office/outpatient visit, est	Medical Visit	NO	NO	0.7961	1	\$22	\$129
Total:								\$22	\$129

Threshold Blend Payment (50%)	\$49
Incorrect Remit Claim Payment	\$22
PCS Expected Claim Payment (50% APG Blend)	\$129
Claim Underpayment	\$107

Clinic payment is based on downstate APG rate of \$258.90, threshold blend rate of \$97.59, capital add-on of \$9.32, billed at 50% APG blend

Medicaid APG Screen Analysis Sample Claim Details

Screen: ISADNP102

UNPAID ISADNP WITH PAID APG CLAIM ON EARLIER DATE WITH THE SAME PHYSICIAN

This APG claim has standalone service that does not pay because it is not billed on a claim with a paid medical service. (It is not packaged, is not consolidated, is not a neverpay, is not a carve-out and is not the same APG as another SP). The patient has a related previous paid medical visit claim that if billed together with an episodic ratecode would trigger the standalone to pay.

Claim A - Patient's initial medical visit								
Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Remit Payment
1/25/2010	99212	Office/outpatient visit, est	Medical Visit	NO	NO	0.7961	1	\$126
Claim B - Billed Separately in Error - Patient returns for a standalone test								
Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Remit Payment
1/29/2010	72125	Ct neck spine w/o dye	Significant Ancillary	YES	NO	1.4786	0	\$0
Total Reimbursement:								\$126

Claim correction created by combining the standalone claim with the initial visit claim								
Service Date	HCPCS	HCPCS Description	APG Type	Standalone	Packaged	SIW	Discount	Expected Payment
1/25/2010	99212	Office/outpatient visit, est	Medical Visit	NO	NO	0.7961	1	\$126
1/29/2010	72125	CT Scan Neck Spine w/o Dye	Significant Ancillary	YES	NO	1.4786	1	\$221
Total Reimbursement:								\$347
Increase:								\$221

Clinic payment is based on downstate APG rate of \$206.48, threshold blend rate of \$162.69, capital add-on of \$15.23, billed at 50% APG blend