

New York State Department of Health

Ambulatory Patient Groups (APG)

KNOWN ISSUES LIST

As of
January 29, 2009

The Ambulatory Patient Group (APG) Known Issues List is designed to keep providers and other interested parties informed of new issues related to the implementation of the APG payment methodology. The document includes important announcements, new issues, active issues and recently closed issues.

This document will be posted on http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm (SDOH APG Website) and on www.nyhipaadesk.com (Issues of eMedNY) and will be updated as issues are corrected and/or new issues, identified. Please visit these sites periodically for updates. If you do not understand the technical terminology in this document, please consult with your technical staff or email us at: nyhipaadesk@csc.com or at: apg@health.state.ny.us.

ANNOUNCEMENTS

Issuance of Preliminary Diagnostic and Treatment Center Base Rates, and Provider-Specific Capital Add-On Amounts and Existing Payment Amounts for Purposes of the Blend

The Department of Health has issued preliminary base rates, provider-specific capital add-on amounts, and provider-specific existing average clinic payments for purposes of the blend. Once approved by the State Division of Budget, these data elements will be posted on the Department's website at:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm

In the interim, these data elements and the facility-specific impacts of the new APG rates are being mailed to each D&TC.

APG Testing

The Department (eMedNY) has been ready to accept test claims from hospital providers since September 8 and is now ready to accept test claims from D&TC providers. This end-to-end test facility permits providers to submit test claims (batches of up to 50 claims) and to receive test remittance advice. It is important for hospitals and D&TCs to take advantage of this opportunity for testing. We believe that testing will help to ensure a smooth implementation of APGs and urge providers to submit test claims as soon as possible. Testing will provide first-hand experience with the APG claiming process.

Extension of Date by Which Hospitals Must Use New APG Rate Codes

Previously the Department announced that APG rate codes would be required for claims for dates of service on or after January 1, 2009 for all applicable hospital outpatient department (clinic), ambulatory surgery and emergency department claims in order to receive payment. To avoid potential cash flow issues (since some hospitals had not yet submitted claims using APG rate codes), this deadline was extended to January 26, 2009. Most claims for dates of service post APG implementation, received prior to January 26, will automatically be reprocessed by eMedNY using the appropriate APG rate code so providers will not have to resubmit claims. Ambulatory surgery claims previously billed using two PAS rate codes for multiple procedures will require providers to rebill these claims using the new ambulatory surgery rate code. Please note that rate codes used prior to APGs will be end-dated as of January 26, 2009 retroactive to December 1, 2008 for hospital OPD and ambulatory surgery unit claims, and retroactive to January 1, 2009, for emergency department claims. **After January 25, 2009 failure to bill using APG rate codes will result in a denial of Medicaid claims for rate codes now included under APGs.**

APG Remittance (835) Correction Notice – Capital Add On Amount

This is a correction to information that was published in PowerPoint presentations used for various APG trainings. Training slides listed capital add-on amounts were to be denoted by CAS OA94. This information is incorrect. CAS OA94 in Loop 2110 denotes charges bundled from another paid zero line and is returned on the claim line with the highest final APG weight.

Capital add-on amounts are denoted by CAS CO94 as provided in Loop 2110.

(Reference page 129 of slides at
http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_presentation.pdf)

NEW ISSUES

EAPG Grouper Returning Inappropriate Error Code for Claims with Revenue Code Line Item and no HCPCS Procedure Code in 3M Core Grouping Software (CGS) and 3M Grouper Plus System (GPS) (1-23-09)

When GPS processes a claim containing a line item with a revenue code and no HCPCS procedure code, the EAPG grouper returns correct grouping results and the following inappropriate error return code: rcEapgsInvalidNumberOfLineItems .

When CGS processes a claim containing a line item with a revenue code and no HCPCS procedure code, the EAPG grouper returns correct grouping results but an inappropriate error is displayed in the error log.

This issue will be fixed in the January 30, 2009 releases of the GPS and CGS. Until then, you may ignore the error return code.

ACTIVE ISSUES

Never Pay APG Coded with a Medical Visit APG

When an APG visit consists solely of a "never pay APG" and a "medical visit APG", the 3M APG grouper/pricer software, as now constructed, packages the medical visit APG with the never pay APG with a resulting payment of zero (because all never pay APGs have weights of zero). In cases where no other visit on the claim pays greater than zero, the payment action for the never pay APG combined with the medical visit APG will actually result in a denied claim, rather than a payment of zero.

Zero payment (or a claim denial) is not an issue if the coding for the visit (date of service) also includes a "significant procedure APG" that is not a never pay APG. In that case, the medical visit APG will package with the payable significant procedure APG and a payment will be made for the visit.

3M will revise its software so that a medical visit APG will no longer package with a never pay APG, but instead the medical visit APG will receive line level payment (unless it is packaging with a payable significant procedure APG). This revision will be included in the April 1, 2009 release of the updated EAPG Grouper/Pricer software to licensed providers and billing vendors.

In the mean time, providers should continue to code all HCPCS codes on their claims. Once the software revision has been completed, CSC will retroactively identify the claims that were denied or zero paid inappropriately and re-processes those claims for payment using the modified software retroactive to December 1, 2008 for OPD clinic and ambulatory surgery claims, or to January 1 for emergency department claims.

Newborn Screening

Previously, DOH issued guidance indicating that rate codes for newborn screening, 3138 and 3139, would be subsumed within APGs and would not be billable once APGs became effective. That policy has been changed. Rate codes 3138 and 3139 will be carved-out of APGs and hospitals should continue to bill for newborn screening services as they have in the past. Use of these rate codes will bypass the billing system edit that prevents services that are not episode-based from being billed during the same time period as a patient's inpatient stay.

CLOSED ISSUES

None