



Andrew M. Cuomo, Governor



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NYS Office For People With Developmental Disabilities

# Putting People First

## OPWDD POLICY & MEDICAID BILLING GUIDANCE

### APGs and Standards for Article 16 Clinics

## Presentation Outline

- APG Payment Overview
- Article 16 Clinic Services & Practitioners
- Article 16 Clinic Visits
- Article 16 Clinic Claim Coding
- Allowable CPT/HCPCS Codes
- APG Financial Overview
- Article 16 Clinic Service Documentation

## Purpose of Training

- To provide policy & Medicaid billing guidance to OPWDD Article 16 Clinics that submit NYS Medicaid claims for reimbursement under **APG payment methodology**
- The policy & billing guidance included in the training is specific to billing Article 16 Clinic services to the NYS Medicaid program

## APG Payment Overview

## APG Payment Overview

- What is the Ambulatory Patient Group (APG) payment system and why are we changing?
- A high-level view of how APGs work.
- Modifications made to the APG system to better accommodate mental hygiene clinics.
- How payments will be calculated during the APG “phase-in” period.

## What are APGs?

- APG: Ambulatory Patient Groups
- Healthcare payment methodology developed by 3M Health Information Systems, Inc.
- Categorize ambulatory healthcare visits into clinically relevant groupings which predict the amount and type of resources that will be used in care delivery.
  - APGs predict an average pattern of resource use across a group of patients.
  - Procedure and diagnosis codes are the principal claim elements used to assign one or more APGs to a visit.

## Why are we changing?

- Statutory mandate:
  - Chapter 53 of the Laws of 2008 amended the Public Health Law by adding a new section (2-a) that required the use of APGs in most institutional ambulatory care settings.
  - In 2009, Article 2807(2-a) was further amended to require APG payment for services provided in facilities licensed under the Mental Hygiene Law.

## Advantages

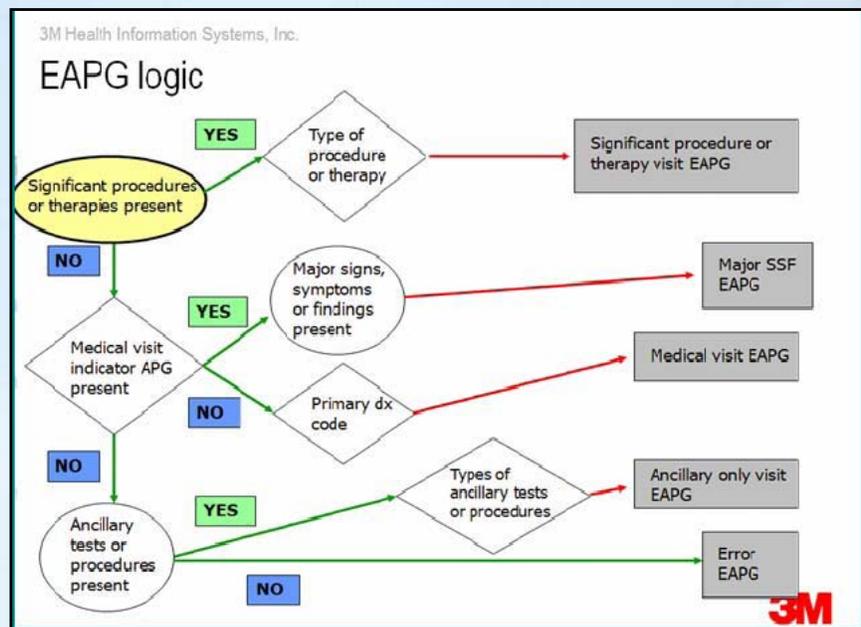
- Make the ambulatory payment system more rational and flexible.
  - Previous system paid a flat rate per visit (Art 28, 31, 32) or visit type (Art 16).
  - APGs reflect the average resources used (staff, time, equipment) for a type of visit and reimburse accordingly.
  - Avoids the complexity of a full scale procedure-based fee schedule.
  - Automatically accommodates changes in a mix of patients and services.

## Payment Methodology Design

- This shift in payment methodology has been carefully designed to be expenditure neutral.
  - On a system-wide basis, the average payment per Article 16 visit following APG implementation should be equivalent to the average payment per Article 16 visit under the current payment system.
  - While expenditure neutral on a system-wide basis, APG payment will modestly redistribute Medicaid revenue among clinics. A multi-year transition period is established to help clinics adjust to the new system.



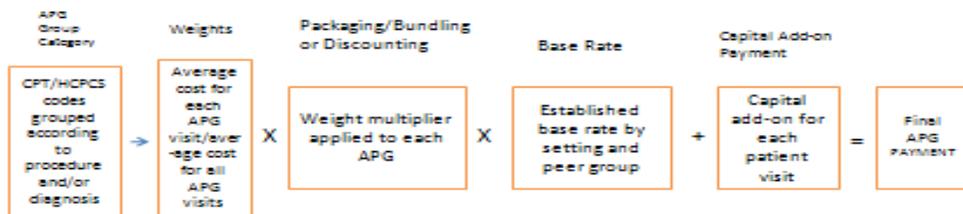
# APG Grouper Logic





# APG Payment Logic

## APG PAYMENT CALCULATION OVERVIEW



### Weight Multiplier (Consolidating or Discounting Logic)

- 100% for primary (highest weighted) APG procedure
- 100% for unrelated ancillaries
- 150% for bilateral procedures
- 50% discounting generally applies (however, a few APGs discount at lower percentage)
- 0% for bundled/consolidated lines (related ancillaries are included in the APG significant procedure payment).

## Service Intensity Weights

- Service Intensity Weight (SIW)
  - A value reflecting the average cost, in terms of provider resources (staff, time, equipment), to deliver a package of services represented by an APG.
  - Each APG is assigned its own SIW.
  - Generally,
    - $\text{APG Payment} = \text{SIW} * \text{Peer Group Base Rate}$

## Consolidation, Packaging, Discounting

- Consolidation (Bundling) – Inclusion of payment for a related procedure in the payment for a more significant procedure delivered within the same visit.
- Packaging – Inclusion of payment for related ancillary services in the payment for a significant procedure.
- Discounting – Discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies. Discounting may also be used as an alternative to consolidation.

## APG Payment Software – 2 Parts

### Grouper

- Groups & categorizes procedures (services) provided during clinic visit in a clinically relevant manner
- Based on clinical concepts that are universal in nature
- Varies little across implementations

### Pricer

- Uses the output of the grouper to determine actual reimbursement
- Determines payment based on reimbursement concepts that may vary significantly by payor
- Customized to the implementation

## Mental Hygiene APG Development

- **Multi-agency effort** involving DOH, OMH, OASAS & OPWDD
- Utilize **standard APG service categories** that group CPT/HCPCS codes to an APG based on logic developed by **3M Health Information Systems**
- **New APG category** created when objective could not be achieved without the new APG category

## Group Modifications for Mental Hygiene Clinics

- **Group Therapy** APGs created for:
  - APG 274: Occupational and Physical Therapy (Group)
  - APG 275: Speech Therapy (Group)
- Substantial restructuring of **Psychotherapy** APGs 315, 316, 317 & 318 based on NYS Mental Hygiene agencies' recommendations

## Pricer Modifications for Mental Hygiene Clinics

- **Reduced packaging:** Most Mental Hygiene series APGs will **NOT** package with a same-day medical visit
- **Multiple same APG discounting:** When multiple procedures group to the same Mental Hygiene APG, **discounting – not consolidation** is typically employed
  - Nutrition, OT, PT & SLP Therapies: 25% discount
  - Psychotherapy, Mental Hygiene Assessment & Developmental & Neuropsychological Testing: 10% discount

## Pricer Modifications for Mental Hygiene Clinics

- **Unit Based Service Intensity Weighting:** The pricer typically ignores CPT/HCPCS timed units of service. Modified for certain mental hygiene APGs (*OT, PT, Nutrition, Individual & Group Education Services*); the claimed number of service units acts as a weight multiplier (up to an allowed limit)
- **Procedure-Specific Weighting:** Typically, procedures within the same APG share the same service intensity weight (SIW); procedure-specific weighting allows the APG to be divided into multiple sub-weighted bands.

## Other Simplifications for Mental Hygiene Clinics

- **Mental Hygiene Clinics use only the visit-based claiming methodology.** No need to code ancillary and other services related to an initial medical visit to a multi-day “episode of care” claim.
  - However, the existing direction that services are billed only when complete remains. Ex: If a developmental test requires observation over several days, submit a bill for only the final day of face-to-face observation/assessment.
- **The Article 28 ancillary packaging will not be applied to mental hygiene clinics, at least not initially.**

## Mental Hygiene APG Payment

- Methodology mirrors standard APG payment calculation used by DOH
- In general, greater reimbursement for higher intensity services and relatively less reimbursement for lower intensity services
- Links payment to procedures/services provided
- Allows for greater payment homogeneity across outpatient clinic settings for comparable services  
*(including Article 16/Article 28 Clinics)*

## APG Payment Will Be Phased-In!

14 NYCRR 679.9 (a) *New*

$$\begin{aligned}
 & \textit{Payment During Transition Period} \\
 &= (\textit{APG \%} \times \textit{APG Pymt Amt}) \\
 &+ (\textit{Legacy \%} \times \textit{Legacy Pymt Amt}) \\
 &+ \textit{Capital Add On}
 \end{aligned}$$

| APG Phase-In Schedule   |                   |                |
|-------------------------|-------------------|----------------|
| Phase-In Period         | Legacy Phase-In % | APG Phase-In % |
| 07/01/2011 - 06/30/2012 | 75%               | 25%            |
| 07/01/2012 - 06/30/2013 | 50%               | 50%            |
| 07/01/2013 - 12/31/201  | 25%               | 75%            |
| 01/01/2014 and after    | 0%                | 100%           |

## Average Legacy Fee

14 NYCRR 679.9 (b) **New**

- The average operating component payment under the pre-existing reimbursement method during the period: April 1, 2009 to March 31, 2010.
  - Operating component = Full Fee – Capital (Property) Component
  - This is a weighted average & will be dependent upon your clinic's particular mix of visit types (i.e., rate codes) billed during the base period.

## Average Legacy Fee

14 NYCRR 679.9 (b) **New**

- OPWDD may adjust results of the legacy fee calculations **to prevent** a clinic from incurring a decrease or an increase in **Medicaid reimbursement disproportionate** to that of the other clinics within its peer group.



## Illustration of an Average Legacy Fee Calculation

| Rate Code         | Paid Visits   | Full Fee | Capital Comp | Operational Comp | Total Operational Payment |
|-------------------|---------------|----------|--------------|------------------|---------------------------|
| 4140 – Regular    | 5,709         | \$118.54 | \$6.16       | \$112.38         | \$641,577.42              |
| 4141 – Brief      | 1,229         | \$59.57  | \$3.08       | \$56.49          | \$69,426.21               |
| 4142 – Group      | 180           | \$31.81  | \$2.05       | \$29.76          | \$5,356.80                |
| 4143 – Collateral | 62            | \$118.54 | \$6.16       | \$112.38         | \$6,967.56                |
| 4144 – Intake     | 32            | \$118.54 | \$6.16       | \$112.38         | \$3,596.16                |
| 4145 – D & E      | 4             | \$355.62 | \$18.48      | \$337.14         | \$1,348.56                |
| 4150 – Regular    | 4,313         | \$118.54 | \$6.16       | \$112.38         | \$484,694.94              |
| 4151 – Brief      | 1,086         | \$59.57  | \$3.08       | \$56.49          | \$61,348.14               |
| 4152 – Group      | 459           | \$31.81  | \$2.05       | \$29.76          | \$13,659.84               |
| 4153 – Collateral | 1             | \$118.54 | \$6.16       | \$112.38         | \$112.38                  |
| 4154 – Intake     | 34            | \$118.54 | \$6.16       | \$112.38         | \$3,820.92                |
| 4155 – D & E      | 37            | \$355.62 | \$18.48      | \$337.14         | \$12,474.18               |
| <b>Totals</b>     | <b>13,146</b> |          |              |                  | <b>\$1,304,383.11</b>     |

**Average Legacy Fee = \$1,304,383.11 / 13,146 = \$99.22**

## Key Changes - The Current System

- Discrete visit types (regular, brief, group, etc.) are defined by OPWDD regulations.
- OPWDD assigns a fee to each visit type.
- Each visit type assigned a rate code within eMedNY.
- EMedNY pays a fixed fee based on: provider ID, rate code, and service date.
- NYS Medicaid-specific. Similar to institutional/ long-term care reimbursement systems.
- The rate code is the key to correct payment.

## Key Changes – The System Under APGs

- Services defined by CPT/HCPCS procedure codes & ICD-9 CM diagnosis codes.
- Procedure & diagnosis codes are used by eMedNY to assign one or more APG.
- EMedNY computes a payment based on: the assigned APGs, their allowed SIWs, and the base rate of clinic's peer group. Then it adds a fixed, per visit (i.e., per claim) capital add-on.
- More like a standard healthcare payment system.
- **Correct & complete coding of procedures rendered and diagnoses treated is critical to correct payment.**

## Article 16 Clinic Services & Practitioners

## Approved Article 16 Clinic Services

14 NYCRR Part 679.3(j) Revised

### Clinic Intake

- Preliminary clinical interview/assessment of the potential admittee, his/her collateral, and/or the referral source for the purpose of determining the appropriateness of admission to the Article 16 Clinic

## Approved Article 16 Clinic Services

14 NYCRR Part 679.3(j) Revised

### Rehabilitation/ Habilitation

- occupational therapy
- physical therapy
- psychology
- rehabilitation counseling
- speech & language pathology
- social work

### Health Care

- dietetics & nutrition
- nursing
- audiology
- podiatry

### Medical/Dental

- medicine (& specialties such as psychiatry & physiatry)
- dental (& dental hygiene)

## Services to Collateral

14 NYCRR Part 679.1 (d)

- Primary service recipient (**person with developmental disability**) must be admitted to Article 16 Clinic
- Collateral service must be provided to address the needs of the primary service recipient
- Collateral must be identified in the TX plan of the primary service recipient
- Collateral service must be documented in the primary service recipient's file

## Definition of Collateral

14 NYCRR Part 679.99(f)

- Member of the family, defined as biological/ adoptive family, guardian, foster care parent, or family care provider; **or**
- Non-related party, who has a long-term care-giving relationship with the admitted person with a developmental disability, as long as they are not being paid to provide clinical or direct care-giving services to that person

## Approved Practitioners

- Appropriately licensed/certified NY State Education Department (SED) practitioner
- Person with NY SED Limited Permit or an exempt person completing **NYS SED required** supervised experience
- Appropriately supervised student-in-training from accredited & SED approved program
- Qualified non-licensed staff defined in 14 NYCRR Part 679
  - Applied Behavioral Sciences Specialist (ABSS)
  - Rehabilitation Counselor
  - Treatment Coordinator

## Applied Behavioral Sciences Specialist

(ABSS) 14 NYCRR Part 679.99(t)

- Someone having a master's degree in a clinical &/or treatment field of psychology from an accredited institution, who has training in assessment techniques & behavioral program development & who functions **under the supervision of a NYS licensed psychologist**

## Rehabilitation Counselor

14 NYCRR Part 679.99(q)

- **Master's degree** in rehabilitation counseling from an accredited institution whose program includes **supervised clinical experience** in a vocational setting of **at least six months**; or
- **Bachelor's degree** in a human services discipline from an accredited institution & **three years supervised experience** in providing rehabilitation services in a vocational setting

## Treatment Coordinator

14 NYCRR Part 679.99(h)

- **Bachelor's degree** or a license as a **registered nurse** (RN)
- Designated for each person receiving Article 16 Clinic services to coordinate all treatments, activities, experiences or therapies as prescribed through the clinic's admission process & by treating professionals in person's TX plans

## Clinic Plan of Staff Supervision

14 NYCRR Part 679.4(e)

- All services must be delivered by or under the direct supervision of appropriately licensed/certified practitioners or by appropriately supervised & authorized parties, including:
  - Unlicensed Clinical Staff (**ABSS**)
  - Dependent Clinicians
  - Students-in-Training
  - Contract Clinicians

## Supervision

14 NYCRR Part 679.99(u) & <http://www.op.nysed.gov/>

- Procedural guidance by professional within his/her scope of practice (**sphere of competence**) as defined by SED
- Initial direction & periodic inspection of actual act of accomplishing job activities
- Licensed professionals who provide supervision are engaged in practice of their profession
- Supervisors may be held accountable &/or charged with professional misconduct for misconduct of a supervisee (**including students-in-training**)
- Supervisory records provide documentation & verify required supervision of staff

## Dependent Clinicians

- Supervision must be provided in accordance with NY SED Office of the Professions  
<http://www.op.nysed.gov/>
  - Licensed Practical Nurse (LPN)
  - Occupational Therapy Assistant (OTA)
  - Physical Therapy Assistant (PTA)
  - Physician Assistant (PA)



## Students-in-Training

14 NYCRR Part 679.3(l)

- Must be in a training program operated by an institution of higher learning that is accredited in the applicable service area (**discipline**)
- Must have completed the majority of classroom requirements
- Purpose of placement is part of an approved & required internship or clinical training aspect of degree program



## Students-in-Training

14 NYCRR Part 679.3(l)

- Service recipient & his/her correspondent or referral agent must be notified prior to service provision that service will be provided by a student (non-licensed/credentialed party) under supervision
- Service recipient must be advised that he/she may reject services provided by non-licensed/credentialed party at any time without prejudice or loss of entitlement to service

## Supervision of Students-in-Training

14 NYCRR Part 679.(l)

- Must have written plan of supervision
- Must provide **on-site** supervision when & where the clinic service is delivered
- Supervisor must be licensed/credentialed appropriate to the student's clinical area
- Must include face-to-face contact with student for review of performance, as well as periodic observation of student's contact with admitted persons &/or collateral

## Contract Clinicians

- Subject to control & oversight by the agency holding the Article 16 operating certificate
- All referrals & recommendations for Article 16 Clinic services must be reviewed & approved by the clinic medical director or other designated physician/dentist
- Oversight should be documented by the agency that holds the Article 16 Clinic operating certificate

## Plan of Contract Clinician Oversight

- Monitoring reports that detail the type, frequency & location of clinical services
- Review of “sign-in” and “sign-out” logs & visits to actual service delivery locations by staff directly employed by Article 16 Clinic
- Certified agency must retain final authority to decide what services will be delivered to each person & the amount, frequency & length of time services will be provided; may not delegate final decision-making responsibility for these decisions

| Approved Article 16 Services<br>Clinic Intake  | Approved Practitioners  |
|--|---|
| Preliminary clinical interview/assessment of potential admittee (new referral), his/her collateral &/or referral source for purpose of determining appropriateness of admission to the Article 16 Clinic | NY SED licensed/certified practitioner, limited permit holder, exempt person completing SED required supervised experience, student-in-training or authorized qualified non-licensed staff: <ul style="list-style-type: none"> <li>• ABSS</li> <li>• Rehabilitation Counselor</li> <li>• Treatment Coordinator</li> </ul> |

| Approved Article 16 Services<br>Rehabilitation/Habilitation | Approved Practitioners  |
|---|---|
| Occupational Therapy  | Licensed Occupational Therapist or Certified OTA                              |
| Physical Therapy  | Licensed Physical Therapist or Licensed PTA                                   |
| Psychology  | Licensed Psychologist or an appropriately supervised ABSS staff per 679.99(q) |
| Rehabilitation Counseling                                   | Rehabilitation Counselor per 679.99(q)  |
| Speech & Language Pathology                                 | Licensed Speech & Language Pathologist  |
| Social Work   | LCSW or appropriately supervised LMSW   |

| Approved Article 16 Services<br>Health Care | Approved Practitioners                                    |
|---|---|
| Nutrition (and Dietetics)                   | Certified Dietitian/Certified Nutritionist                |
| Nursing                                     | RN, Nurse Practitioner or an appropriately supervised LPN |
| Audiology                                   | Licensed Audiologist                                      |
| Podiatry                                    | Licensed Podiatrist-Doctor of Podiatric Medicine (DPM)    |

| <b>Approved Article 16 Services<br/>Medical/Dental</b>         | <b>Approved Practitioners</b>  |
|--|--|
| Medicine, including specialties such as psychiatry & physiatry | Licensed Physician, Physician with 3-year limited license, Physician Assistant, Specialist Assistant or Nurse Practitioner |
| Dentistry  | Licensed Dentist, Dental Hygienist or Certified Dental Assistant   |

## Article 16 Clinic Visits

## Former Article 16 Clinic Visit Types

- The former six types of Article 16 Clinic visits; **intake, full, brief, group, collateral and comprehensive diagnostic & evaluation visits** and the corresponding rate codes **NO** longer exist and do **NOT** apply under APG payment methodology

## Definition of Article 16 Clinic Visit

14 NYCRR Part 679.5(b) Revised

- Defined as **all** the approved clinical services provided for a person, his/her collateral or potential admittee on a **common date of service** by approved practitioners except as follows:
  - If a diagnostic and evaluation service (**in any discipline**) is conducted over more than one day, the date of service for claiming purposes is the last day the service is provided
  - If an on-site clinic visit is provided & claimed for reimbursement on the same day as an off-site clinic visit, reimbursement for each visit is considered a separate clinic visit (**Must use separate rate codes for on-site & off-site services**)

## Article 16 Clinic Visit

14 NYCRR Part 679.5(c) Revised

- Must include **face-to-face service** as defined by allowable Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) and/or Current Dental Terminology (CDT) codes; face-to-face service may include **associated observation**

## Face-to-Face Service

- Does **NOT** include the time the person or party spends getting ready to begin, resting, toileting, waiting for equipment **or** independently using equipment **or** the authorized party's **pre & post delivery services/encounter time**

## Pre & Post Delivery Services/Encounter Time

- Reviewing records & tests
- Arranging for additional services
- Communicating with other professionals or service providers in any manner, such as in person, through written reports or telephone or electronic contact
- Communicating with person, collateral or others through written reports or telephone contact
- Documenting face-to-face service in clinical record

## Article 16 Clinic Claim Coding

## Reimbursement Under APGs

- Critical coding elements under APGs:
  - Clinic NPI and Zip+4
  - Rate Code
  - Procedure Code
  - Procedure Code Modifier (where applicable)
  - Service Units (where applicable)
  - Diagnosis Code
  - Clinician NPI
- NCCI Edits
- Medicaid Edits

## Provider & Location (NPI & Zip+4)

- Each certified location on your Article 16 operating certificate should be linked to a:
  - distinct service location in your Medicaid provider file, or
  - distinct Medicaid provider enrollment (a distinct NPI).
- In order for eMedNY to properly assign a claim to the location where service was rendered, a zip+4 code **must** be included in the service address field.
  - Under HIPAA, location codes are not longer used.

## Offsite Services Provider & Location (NPI & Zip+4)

- The “service address” for offsite services is the certified location (main or satellite) where patient records are kept. Do not enter the actual location of offsite services on the claim.
  - Again, include the zip+4 code in the service address field.
- Do not use the offsite service option as a means avoid the certification process. If:
  - (a) services are rendered at a particular “offsite” location on a continuing basis, and
  - (b) if physical space has essentially, if not officially, been “dedicated” to clinic services,
  - (c) the persons receiving the Article 16 Clinic services are only at the location to receive clinic services, i.e., the person does not attend the day hab program or other program that is also located at that site
  - Then you are may be operating a “satellite” clinic location and should seek proper certification as such.

## Rate Codes Under APGs

- Still differentiates between on-site (**clinic**) and off-site (**rehab line**) services.
- Signals eMedNY to access the special APG Grouper-Pricer logic to compute claim payment. The rate code itself no longer prices the claim.
- Also used to differentiate claims among state licensing agencies, clinic type, peer group, and may invoke special processing logic.

## Rate Codes

| Type of Article 16 Clinic | On-Site Services Rate Code | Off-site Services Rate Code |
|---------------------------|----------------------------|-----------------------------|
| Free-standing             | 1546                       | 1549                        |
| Hospital                  | N/A                        | 1537                        |

## Procedure Codes

- Use AMA CPT, ADA CDT, or authorized HCPCS codes. Other procedure code schemes are **not** authorized.
- To receive proper reimbursement under APGs, you must code all procedures rendered during a visit.
  - If your current billing system limits you to one procedure per claim, you need to modify or replace it by July 1, 2011.

## Article 16 Clinic Crosswalk

- For nutrition/dietetics, psychotherapy, rehab counseling, OT, PT & SLP services: limit procedure codes to those specifically authorized in the Article 16 Clinic crosswalk handout.
  - Note that rehabilitation counseling services are billed to the physical medicine series, not the psychotherapy series.
  - CPT E&M Codes (99XXX) are limited to medical disciplines. Do not use for the disciplines listed above.
  - Contact OPWDD Central Office if you believe you must bill a procedure code that is not in the Art 16 crosswalk.

## Other APG Procedure Codes

- Procedures codes for most services rendered by audiologists, medical practitioners (physicians, physician assistants, nurse practitioners, nurses), dental practitioners, and DPMs are not listed in the Article 16 crosswalk.
  - Follow instructions provided to Article 28 clinics when billing these services. Refer to the DOH APG Provider Manual and DOH's APG website.
  - Most medical services will code to E&M series. Under APGs, this invokes the "medical visit" logic in the grouper which will assign the final APG based on primary diagnosis.

## Not Authorized Procedure Codes

- The “after hours add-on” procedure codes listed below are **NOT AUTHORIZED** for use by Article 16 clinics. Their use will result in recovery action.
  - 99050 – Service provided in the office at times other than regularly scheduled office hours, or days when the office is usually closed, in addition to basic service.
  - 99051 – Service provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

## Procedure Code Modifiers

- If your current billing software does not support modifiers, you will need to modify or replace it.
- The APG grouper-pricer recognizes several CPT procedure code modifiers. Explanations of their proper use and affect on payment are given in the DOH APG Provider Manual. Most of the modifiers are mainly applicable to medical services.
- There are also several additional **special modifiers** whose use is limited to specific subsets of clinics. We will cover the “special modifiers” that should and should not be used by Article 16 clinics.

## Required Procedure Code Modifiers

- **All** Rehabilitation Counseling services **must** be accompanied by one of the following two modifiers:
  - **HN** – Bachelors degree level
  - **HO** – Masters degree level
  - Payment Action: Imposes 25% discount on payment.
  - Do not use these modifiers for services other than rehabilitation counseling. The discount will be imposed.
- SLP treatment services **billed to procedure codes in the physical medicine series (97XXX)**, must include modifier **GN** to avoid failing the OT/PT prior approval edit.

## Recommended Procedure Code Modifiers

- Use of the following therapy modifiers is recommended when appropriate, but not required:
  - **GN**: Services delivered under an outpatient speech language pathology plan of care.
    - However, as previously described, GN is required when billing an allowed physical medicine procedure rendered by an SLP.
  - **GO**: Services delivered under an outpatient occupational therapy plan of care.
  - **GP**: Services delivered under an outpatient physical therapy plan of care.
- No impact on payment (except for the special GN case).

## Modifier 59

- Modifiers 59 may be required on some claims to avoid rejection based on an NCCI edit.
  - More on NCCI later in the presentation.
  - The use of modifier 59 should involve human choice. OPWDD does not recommend using software logic to automatically insert modifier 59 on all claims.

## Not Authorized Procedure Code Modifiers

- The following modifiers are **NOT AUTHORIZED** for use by Article 16 clinics. Their use will result in recovery action.
  - AF: Service rendered by a specialty physician.
  - AG: Service rendered by a primary physician.
  - SA: Service rendered by a nurse practitioner.
  - U4: Language other than English.

## Procedure Code Service Units

- Take action now if your billing system does not permit entry and submission of procedure code service units.
- Where their use is allowed, service units have the effect of multiplying a procedure's SIW.
- "Payable maximums" have been established for procedure codes that permit use of service units.
  - See mental hygiene crosswalk.
  - EMedNY pays the lower of: (a) submitted units, or (b) payable maximum. You can submit the units actually delivered, but eMedNY will only pay the maximum allowed.
  - Impact of submitting units above the "payable maximums" on OT/PT prior approval system is not yet known.

## Diagnosis Codes

- As with procedure codes, policy on proper diagnosis coding has not changed. However, compliance with policy is now critical to insure proper payment – especially with respect to physician E&M services.
- Use ICD-9 CM diagnosis codes.
  - Get ready for ICD-10.

## Diagnosis Codes

- The primary (first) diagnosis code entered on the claim should reflect the primary condition treated during the clinic visit (i.e., **reflect the primary reason for the visit**).
- You have a problem if:
  - Your system hard codes all claims with the same diagnosis (e.g., mental retardation).
  - Your system codes diagnosis based on a data element in a consumer profile record instead of a data element in the visit/treatment record.
  - Defaults to a standard diagnosis code when it is absent in a treatment record.

## Clinician Identification

14 NYCRR Part 679.7(a) **Section Change & Revision**

- OPWDD Article 16 Clinic regulations (**Billing Standards**) require inclusion of the clinician NPI (or, in some instances, the clinician supervising service delivery), as a condition of reimbursement.

## Clinician ID: Licensed/Certified Professionals

- If the Article 16 clinic services was delivered by a licensed professional, report the clinician's NPI on the claim.
- Medicaid cross-references the clinician NPI to ensure:
  - Clinician is officially registered as practicing at your clinic.
  - Clinician license is active and no administrative sanctions or exclusions are in effect.

## Clinician ID: Unlicensed Professionals

- Students-in-training:
  - If the clinician holds a "limited license," use his or her NPI.
  - Otherwise, use the NPI of the **supervising** clinician.
- Applied Behavioral Sciences Specialists:
  - Use the NPI of the **supervising** licensed **psychologist**.
  - Reminder: Mental Health Counselors are not authorized parties in Article 16 Clinics. Mental Health Counselors meeting OPWDD regulatory requirements for ABSS, may practice (and bill) as an ABSS.
    - **DO NOT send the NPI of a MHC. If practicing as an ABSS, send the supervising psychologist's NPI.**

## Clinician ID: Unlicensed Professionals

- Rehabilitation Counselors:
  - Use the Article 16 bypass code for unlicensed clinicians (02249136).
  - Even if your rehabilitation counselor has managed to get an NPI, do not send it. Use the bypass code for all rehabilitation counselor services.

## Clinician ID: Intake Visits

- When an intake visit is delivered by a licensed professional, send the clinician NPI.
- When an intake visit is delivered by an unlicensed professional, use the Article 16 bypass code: 02249136.

## Clinician ID: Bypass Code

- Bypass codes have also been established for unlicensed professionals employed by OMH & OASAS clinics.
  - Use only the OPWDD bypass code for Article 16 services.
  - You will be required to re-bill any Article 16 services billed with OMH or OASAS bypass codes.
- Do NOT use the bypass code when claiming services delivered by students-in-training or ABSS.
- OTA's and PTA's are certified in NYS and eligible for their own NPI's. Use the OTA's or PTA's own NPI when billing their services. Do NOT use their supervisor's NPI or the bypass code.

## Multiple Clinicians on Same Service Date

- EMedNY currently reads the attending clinician field only at the document level.
- Generally, we recommend that you use the NPI of the practitioner who had the greatest amount of face-to-face time with the patient.

## NCCI Edits

- NCCI: National Correct Coding Initiative
  - The Patient Protection and Affordable Care Act requires State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems by October 1, 2010.
    - **EMedNY Implementation Starts April 1, 2011.**
  - CMS originally developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payments in Medicare Part B claims.
  - The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported.

## NCCI Edits

- NCCI edits consist of two types of edits:
  - NCCI procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
  - Medically Unlikely Edits (MUE), units-of-service edits, that define for each HCPCS / CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas).

## NCCI Edits

- Assuming the edits have been well designed, most combinations initially rejected by NCCI will be true errors.
  - However, it is understood that many of the combinations can also sometimes result from legitimate, payable services.
  - Generally, modifier 59 will allow payment as separate, distinct services.
  - Modifier 59 will generate a discount under APG's, but typically this is the same discount invoked in normal APG claim processing of the same combinations.

## NCCI Edits

| CPT   | Description              | CPT   | Description                   | Mod Ind |
|-------|--------------------------|-------|-------------------------------|---------|
| 90804 | Psytx, office, 20-30 min | 90801 | Psy dx interview              | 1       |
| 90804 | Psytx, office, 20-30 min | 90802 | Intact psy dx interview       | 1       |
| 90804 | Psytx, office, 20-30 min | 90810 | Intact psytx, off, 20-30 min  | 1       |
| 90804 | Psytx, office, 20-30 min | 90811 | Intact psytx, 20-30, w/e&m    | 1       |
| 90804 | Psytx, office, 20-30 min | 90812 | Intact psytx, off, 45-50 min  | 1       |
| 90804 | Psytx, office, 20-30 min | 90813 | Intact psytx, 45-50 min w/e&m | 1       |
| 90804 | Psytx, office, 20-30 min | 90814 | Intact psytx, off, 75-80 min  | 1       |
| 90804 | Psytx, office, 20-30 min | 90815 | Intact psytx, 75-80 w/e&m     | 1       |



## NCCI Edits

| CPT   | Description              | CPT   | Description                               | Mod Ind |
|-------|--------------------------|-------|---|---------|
| 90804 | Psytx, office, 20-30 min | 90845 | Psychoanalysis                            | 1       |
| 90804 | Psytx, office, 20-30 min | 90862 | Medication management                     | 1       |
| 90804 | Psytx, office, 20-30 min | 96116 | Neurobehavioral status exam               | 1       |
| 90804 | Psytx, office, 20-30 min | 97802 | Medical nutrition, indiv, each 15 min     | 1       |
| 90804 | Psytx, office, 20-30 min | 97803 | Med nutrition, indiv, subseq, each 15 min | 1       |
| 90804 | Psytx, office, 20-30 min | 97804 | Medical nutrition, group, each 30 min     | 1       |
| 90804 | Psytx, office, 20-30 min | G0270 | MNT subs tx for change dx, each 15 min    | 1       |
| 90804 | Psytx, office, 20-30 min | G0271 | Group MNT 2 or more 30 mins               | 1       |
| 90804 | Psytx, office, 20-30 min | M0064 | Visit for drug monitoring                 | 1       |



## NCCI Edits

| CPT   | Description      | CPT   | Description                               | Mod Ind |
|-------|------------------|-------|---|---------|
| 97002 | Pt re-evaluation | 96101 | Psycho testing by psych/phys              | 1       |
| 97002 | Pt re-evaluation | 96102 | Psycho testing by technician              | 1       |
| 97002 | Pt re-evaluation | 96105 | Assessment of aphasia                     | 1       |
| 97002 | Pt re-evaluation | 96118 | Neuropsych tst by psych/phys              | 1       |
| 97002 | Pt re-evaluation | 96119 | Neuropsych testing by tec                 | 1       |
| 97002 | Pt re-evaluation | 96125 | Cognitive test by hc pro                  | 1       |
| 97002 | Pt re-evaluation | 97001 | Pt evaluation                             | 0       |
| 97002 | Pt re-evaluation | 97750 | Physical performance test, 15 min         | 0       |
| 97002 | Pt re-evaluation | 97755 | Assistive technology assess, 15 min       | 0       |
| 97002 | Pt re-evaluation | 97762 | C/o for orthotic/prosth use, 15 min       | 0       |
| 97002 | Pt re-evaluation | 97802 | Medical nutrition, indiv, each 15 min     | 1       |
| 97002 | Pt re-evaluation | 97803 | Med nutrition, indiv, subseq, each 15 min | 1       |
| 97002 | Pt re-evaluation | 97804 | Medical nutrition, group, each 30 min     | 1       |

## NCCI Edits

- Resources:
  - CMS Webpage:  
<https://www.cms.gov/MedicaidNCCICoding/>
  - Modifier 59 and NCCI Edits:  
<https://www.cms.gov/MedicaidNCCICoding/05/Modifier%2059%20Article.asp#TopOfPage>

## Medicaid (eMedNY) Edits

- Most existing Medicaid clinic edits remain.
  - Edits preventing payment of more than one Article 16 clinic visit per day per patient will be relaxed.
  - If clear abuse emerges, these will be re-established.
- In addition, there are some new edits for APG's. These are described in the DOH APG Provider Manual.
  - ***Claim Payer Pd Amt Not Equal to Sum of Line Payer Pd Amt***
  - ***Rate Code Invalid for Clinic PAC/PAS***
  - ***All APG Lines Paid Zero***
  - ***Recipient Ineligible on Date of Service***
  - DOH APG Provider Manual:  
[http://www.nyhealth.gov/health\\_care/medicaid/rates/apg/docs/apg\\_provider\\_manual.pdf](http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual.pdf)

## Allowable CPT/HCPCS Codes

## Mental Hygiene APG Categories

- Long term therapies such as **OT, PT**, (including **rehabilitation counseling**) & **SLP**
- Behavioral health services such as **psychology, social work & pharmacologic management** (by appropriate medical practitioners)
- **Nutrition/dietetics & education & collateral services**

| APG Category   | Allowable CPT/HCPSC Codes   |
|--|---|
| 270 Occupational Therapy<br>(Rehabilitation Counseling may only use 97003, 97004, 97532, 97535, 97537) | 97003, 97004, 97532 - 97537, 97542  |
| 271 Physical Therapy<br>(Rehabilitation Counseling may only use 97530)                                 | 97001, 97002, 97012, 97016 - 97039, 97110 - 97140, 97530, 97545, 97546, 97750, 97755, 97760 – 97762 |
| 274 Physical Therapy Group<br>(includes OT & Rehabilitation Counseling Group)                          | 97150   |

## OT/PT

- Practitioners may utilize CPT codes from APG 270, 271 or 274 even if the CPT code is mapped to an APG that reflects a “different discipline”
- **Must** use current CMS Local Coverage Determination (LCD) **guidelines for timed CPT codes** for Outpatient PT & OT Services to determine number of units to bill

## Rehabilitation Counseling

- Practitioners may **ONLY** use the following seven CPT codes from APG 270, APG 271 and APG 274:

|       |       |               |
|-------|-------|---------------|
| 97003 | 97004 | 97150 (Group) |
| 97530 | 97532 |               |
| 97535 | 97537 |               |

## Rehabilitation Counseling

- MUST include **license-level modifier** on the claim that indicates the educational level of the rehabilitation counselor
  - **HN-Bachelors**
  - **HO-Masters**
- Unit of service must be the full time indicated per unit by the allowable CPT code

| APG Category                  | Allowable CPT/HCPSC Codes  |
|-------------------------------|--|
| 272 Speech Language Pathology | 92506, S9152, 92507, 92526, 92597, 92605 - 92610, 92626, 92630, 92633, 92640 |
| 275 Speech Therapy Group      | 92508  |

## Speech & Language Pathology

- **MUST** include **therapy modifier GN** on the claim to identify services as being delivered under an outpatient SLP treatment plan
- Do **not** need **therapy modifier GN** on the claims for SLP evaluations &/or testing
- A person who is exempt from licensure while completing SED required supervised experience; **clinical fellowship year (CFY)** may provide Article 16 Clinic SLP services

## Developmental & Neuropsychological Testing

| CPT Code | APG 310 Type of Test            | NY SED Licensed/Certified Practitioner/14 NYCRR Part 679 Authorized Professional<br>Examples of Tests associated with CPT code  |
|----------|---------------------------------|---|
| 96101    | Psychological Testing           | <u>ONLY</u> Licensed Psychologist, Physician (including Psychiatrist) or LCSW; e.g. MMPI, Rorschach, WAIS, ADOS, ADI-R  |
| 96102    | Psychological Testing           | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. MMPI, WAIS, ADOS, ADI-R  |
| 96105    | Assessment of Aphasia           | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. Boston Diagnostic Aphasia Examination                                    |
| 96110    | Developmental Testing, Limited  | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. Developmental Screening Test II, Early Language Milestone Screen         |
| 96111    | Developmental Testing, Extended | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. Adaptive Behavior Assessment System or Vineland Adaptive Behavior Scales |

## Developmental & Neuropsychological Testing

| CPT Code | APG 310 Type of Test          | NY SED Licensed/Certified Practitioner/14 NYCRR Part 679 Authorized Professional<br>Examples of Tests associated with CPT code   |
|----------|-------------------------------|--|
| 96116    | Neurobehavioral Status Exam   | <u>ONLY</u> Licensed Psychologist or Physician (including Psychiatrist); e.g. Neurobehavioral Cognitive Status Examination (NCSE)  |
| 96118    | Neuro-psychological Testing   | <u>ONLY</u> Licensed Psychologist or Physician (and Psychiatrist); e.g. Halstead-Reitan Neuropsychological Battery, D-KEFS, NEPSY  |
| 96119    | Neuro-Psychological Testing   | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. Halstead-Reitan Neuropsychological Battery, D-KEFS, NEPSY |
| 96125    | Cognitive Performance Testing | Appropriately qualified &/or supervised health care professional within the scope of his/her NYS licensure &/or training; e.g. Ross Information Processing Assessment                    |



## Developmental & Neuropsychological Testing

- Sub-weighted bands of procedure-specific weights vary based on CPT descriptions, test content, length of time involved in administration of the test & allowed practitioners who may administer the test
- **Unit maximum of 1** for each CPT code
- Practitioners should record total number of units for each CPT code based on CPT descriptions &/or guidelines even if the total number of units provided is above the unit maximum of one



## Developmental & Neuropsychological Testing

- In addition to NYS licensed psychologists & physicians, appropriately qualified &/or supervised health care professionals within the scope of his/her NYS licensure &/or training may provide some testing services
- An ABSS is considered an appropriately qualified &/or supervised health care professional to provide testing services based on scope of his/her training for CPT codes: **96102, 96110, 96111, 96119, 96125**

| APG Category                                      | Allowable CPT/HCPSC Codes   |
|---|---|
| <b>315 Individual Brief Psychotherapy</b>         | <b>90804, 90805, 90810, 90811</b>   |
| <b>316 Individual Comprehensive Psychotherapy</b> | <b>90806, 90807, 90808, 90809, 90812, 90813, 90814, 90815, 90819, 90845</b> |
| <b>317 Family Psychotherapy</b>                   | <b>90846, 90847</b>   |
| <b>318 Group Psychotherapy</b>                    | <b>90849, 90853, 90857</b>  |

## Psychotherapy

- NY SED licensed/certified practitioner:
  - Psychiatrist (MD/DO)
  - Licensed Psychologist
  - Licensed Clinical Social Worker (LCSW)
  - Psychiatric Nurse Practitioner
- And an appropriately supervised:
  - Physician Assistant
  - Licensed Master Social Worker (LMSW)
  - Applied Behavioral Sciences Specialist (ABSS)

## Psychotherapy

- Select appropriate psychotherapy CPT code
  - type of psychotherapy (insight oriented, behavior modifying &/or supportive vs interactive)
  - length of the face-to-face time spent providing psychotherapy
  - whether medical E&M services are also provided on the same date of service as the psychotherapy
- Family psychotherapy **CPT codes 90846 & 90847** are typically, but are **not** required to be, 45-60 minutes & include services provided to appropriate collateral

| APG Category  | Allowable CPT/HCPSC Codes |
|---|---------------------------|
| <b>323 Mental Hygiene Assessment</b>                                | <b>90801, 90802</b>       |
| <b>324 Brief Assessment</b>   | <b>T1023</b>              |
| <b>426 Psychotropic Medication Management &amp; Drug Monitoring</b> | <b>M0064, 90862</b>       |

## Assessment: Clinical Diagnostic or Evaluative Interview

- **CPT codes 90801 & 90802** Diagnostic or evaluative interviews **MUST** be conducted by Psychiatrist, Licensed Psychologist, LCSW, or appropriately supervised LMSW or ABSS
- **Not generally repeated** for same person for same reason unless clinical justification to do so; clinical record documentation **MUST** support & justify the reason to provide service more than once to same person

## Assessment: Clinical Diagnostic or Evaluative Interview

- Includes history, mental status & disposition
- Information may also be obtained from members of family, educational &/or employment setting; & other relevant health information sources to:
  - complete family, social &/or psychiatric history
  - conduct mental status evaluation
  - establish initial psychiatric diagnosis & TX plan
  - evaluate person's ability &/or capacity to respond to TX

## Brief Assessment

(Clinic Intake)

- NY SED licensed/certified practitioner, Part 679 authorized professional, or Article 16 treatment coordinator may provide clinic intake
- **HCPCS Code T1023** Preliminary clinical interview/ assessment of potential admittee (new referral), his/her collateral &/or the referral source for purpose of determining appropriateness of admission to Article 16 Clinic

## Brief Assessment

(Clinic Intake)

- May include **gathering of information including relevant documentation** of:
  - clinical diagnoses, personal demographics, insurance information, establishment of financial resources/benefits, completion of related clinic program paperwork, **and**
  - the scope & type of services currently received by person outside of Article 16 Clinic to ensure coordination & non-duplication of services

## Brief Assessment

(Clinic Intake)

- **NOT** “repeated” or claimed (billed) to “update” information for the admitted person’s clinical record
- May **NOT** be necessary for a person to receive Article 16 Clinic services if the person is known to the clinic program & if there is appropriate & sufficient documentation of the person’s established developmental disability

## Psychotropic Medication Management & Drug Monitoring

- **MUST** be provided by Physician (MD/DO), including psychiatrist; Nurse Practitioner (NP); or appropriately supervised Physician Assistant (PA)
- If pharmacologic management & psychotherapy with an E&M (90805, 90807, 90809, 90811, 90813 or 90815) are provided on the same date of service, the pharmacologic management is included in the E&M services & 90862 may **NOT** be billed separately for that date of service

## Psychotropic Medication Management & Drug Monitoring

- **CPT code 90862**
  - Prescription, use & review of medication, monitoring medication effects & adjusting dosage
  - Involves relevant interval history, focused mental status, assessment of TX response & ongoing TX formulation
  - Any psychotherapy provided is minimal & usually supportive in nature
- **HCPSC code M0064**
  - Brief office visit for monitoring or changing drug prescriptions
  - Used for lesser level of drug monitoring, such as simple dosage adjustment
  - Time spent is generally less than 10 minutes

| APG Category  | Allowable CPT/HCPSC Codes         |
|---|-----------------------------------|
| 118 Nutrition Therapy   | 97802, 97803, 97804, G0270, G0271 |
| 428 Education - Individual Collateral &/or Diabetes Self Management Training (DSMT) | 98960, G0108                      |
| 429 Education - Group Collateral &/or Diabetes Self Management Training (DSMT)      | 98961, 98962, G0109               |

## Nutrition Therapy

- **MUST ONLY** be provided for clinical signs/symptoms related to:
  - Type 1 & Type 2 diabetes
  - renal disease
  - gastro-intestinal disorders
  - cardio-vascular disease
  - obesity, anorexia &/or bulimia

## Nutrition Therapy

- **MUST** be provided by a NYS certified dietitian/nutritionist; **in addition**, may also be a registered dietitian (RD)
- Unit of service **MUST** be the full time indicated per unit by the allowable CPT/HCPCS code
- If provided to person in OPWDD certified residence &/or family care home, must not be able to be safely addressed by assigned nutrition &/or nursing staff (**within their scope of NYS licensure/training/competence**)

## Education Services

- May be provided to individuals or groups:
  - primary service recipient or group of service recipients
  - person's collateral or group of collateral
- Use standardized curriculum &/or generally accepted community standards of professional practice
- Unit of service **MUST** be the full time indicated per unit by the allowable CPT/HCPCS code
- All requirements for collateral services apply

## Services to Collateral

14 NYCRR Part 679.1 (d)

- Primary service recipient (**person with developmental disability**) must be admitted to Article 16 Clinic
- Collateral service must be provided to address the needs of the primary service recipient
- Collateral must be identified in the TX plan of the primary service recipient
- Collateral service must be documented in the primary service recipient file

## Diabetes Self Management Training (DSMT)

- **MUST** be provided by NYS licensed, registered or certified professional as allowed by DOH, who is **also** a Certified Diabetes Educator (CDE)
- **MUST** be provided to individuals &/or groups of individuals with **new diagnosis** of diabetes or **change in diagnosis** that requires additional training in diabetic care

## Other Allowable CPT/HCPCS Codes

- Standard APG categories; same as DOH Article 28 Clinics:
  - audiology
  - nursing
  - podiatry
  - dentistry
  - medicine, including medical specialties such as psychiatry & psychiatry services (E&M services)

## Services Provided by RNs & LPNs

RNs & LPNs may only provide services:

- Within their respective scope of practice & competence as defined by the SED
  - e.g., LPN may **NOT** perform a patient assessment
  - Refer to Office of the Professions website for additional information <http://www.op.nysed.gov/nurse.htm>
- When there is patient specific order from licensed physician or nurse practitioner

## Billable Services Provided by RNs & LPNs

- The following services **ARE** billable examples when the person **ONLY** receives service from RN/LPN:
  - Administration/materials for immunization/ vaccination/allergy injections (other than seasonal flu, H1N1 or pneumococcal which are carved out of APGs)
  - TB intradermal test – CPT 86580
  - Health counseling &/or education – maintenance of health, prevention of illness or complications, health procedures, emotional adjustment & adaptation of person/collateral
  - Developmental Testing, Limited (CPT 96110) (within scope of training/competence)

## Non-Billable Services Provided by RNs & LPNs

- Can **NOT** bill E&M code if person **ONLY** receives service from RN/LPN
- Any treatment generally considered:
  - first aid
  - collection of a laboratory specimen (including phlebotomy)
  - routine medication administration
  - nursing services required by OPWDD ADM #2003-01

**NOT** reimbursable Article 16 Clinic services

## APG Financial Overview

## APG Financial Overview

- Article 16 Peer Groups, Bases Rates & Payment Schedule
- Remittance Statements
- APG Discounting
- Psychiatric Services
- Special Services
- Updating the APG Payment System
- Article 16 Clinic Services & Other OPWDD Services
- Resources

## What Will I Get Paid?

- Generally:
  - Payment = APG Operating Payment + Capital Add-on
  - APG Operating Payment =  $(APG_1 \text{ SIW} * \text{Discount \%} * \text{Base Rate}) + (APG_2 \text{ SIW} * \text{Discount \%} * \text{Base Rate}) + (APG_3 \text{ SIW} * \text{Discount \%} * \text{Base Rate}) + \dots$
- During Transition Period:
  - Payment =  $([APG \text{ Phase-In \%}] * [APG \text{ Operating Payment}]) + ([\text{Legacy Phase-In \%}] * [\text{Average Legacy Fee}]) + \text{Capital Add-on}$

## Peer Groups & Base Rates

- **Peer Group A**
  - Basis: Geographic Region (New York City & Long Island)
  - Base Rate: \$180.95
- **Peer Group B**
  - Basis: Geographic Region (Rest of State)
  - Base Rate: \$186.99
- **Peer Group C**
  - Basis: Specialty Clinic affiliated with and serving two major hospitals and linked to Federal designations
  - Base Rate: \$270.50

## Payment Schedule

### ARTICLE 16 APG CROSSWALK - THERAPY, PSYCHOTHERAPY, TESTING & EVALUATION SVCS

| APG | APG Description      | HCPCS Code | HCPCS code description               | Jul 2011 Weight | Jul 2011 Units Limit | Peer Group A Per Unit Pymnt | Peer Group B Per Unit Pymnt |
|-----|----------------------|------------|--------------------------------------|-----------------|----------------------|-----------------------------|-----------------------------|
| 270 | Occupational Therapy | 97003      | OT evaluation                        | 0.8141          | 1                    | \$ 147.31                   | \$ 152.23                   |
|     |                      | 97004      | OT re-evaluation                     | 0.8141          | 1                    | \$ 147.31                   | \$ 152.23                   |
|     |                      | 97532      | Cognitive skills development, 15 min | 0.2414          | 3                    | \$ 43.68                    | \$ 45.14                    |
|     |                      | 97533      | Sensory integration, 15 min          | 0.2414          | 3                    | \$ 43.68                    | \$ 45.14                    |
|     |                      | 97535      | Self care mngment training, 15 min   | 0.2414          | 3                    | \$ 43.68                    | \$ 45.14                    |
|     |                      | 97537      | Community/work reintegr, 15 min      | 0.2414          | 3                    | \$ 43.68                    | \$ 45.14                    |
|     |                      | 97542      | Wheelchair mngment training, 15 min  | 0.2603          | 8                    | \$ 47.10                    | \$ 48.67                    |



NYS Office for People With Developmental Disabilities

Putting People First

# Remittance Info



PAGE 02  
DATE 12/19/2008  
CYCLE 1635

TO: ABC HOSPITAL  
P. O. BOX 999  
ANYTOWN, NEW YORK 11111

ETIN:  
CLINIC-APG  
PROVIDER ID/NPI: 00987654/0123456789  
REMITTANCE NO: 08122200001

| OFFICE ACCOUNT NUMBER<br>CPT | CLIENT NAME<br>APG | CLIENT ID<br>COMBINED WITH CPT | TCN<br>FULL WEIGHT APG AMOUNT | DATE OF SERVICE<br>PCT APG WEIGHT | RATE CODE<br>APG PAID | CHARGED CAPITAL ADD ON | TOTAL PAID<br>EXISTING OPERATING COMPONENT | STATUS | ERRORS |
|------------------------------|--------------------|--------------------------------|-------------------------------|-----------------------------------|-----------------------|------------------------|--|--------|--------|
| 1                            | 2                  | 3                              | 4                             | 5                                 | 6                     | 7                      | 8  |        |        |
| TCN: 08343-000789012-2-0     |                    |                                | TOTAL PAID:                   | 185.50                            |                       |                        |  |        |        |
| 1234567890                   | Bill Smith         | AB12345C                       | 08343-000789012-2-0           | 12/01/2008                        | 1400                  | 1000.00                | 106.02                                     | PAID   |        |
| 99213                        | 00881              |                                | 1.22020                       | 100                               | 45.25                 | 15.00                  | 48.77                                      |        |        |
| 1234567890                   | Bill Smith         | AB12345C                       | 08343-000789012-2-0           | 12/01/2008                        |                       | 800.00                 | 0.00                                       | PAID   |        |
| 85025                        | 00408              | 99213                          | 0.13340                       | 0                                 | 0.00                  | 0.00                   | 0.00                                       |        |        |
| 1234567890                   | Bill Smith         | AB12345C                       | 08343-000789012-2-0           | 12/01/2008                        |                       | 1000.00                | 24.94                                      | PAID   |        |
| 80076                        | 00403              |                                | 0.32690                       | 100                               | 12.00                 | 0.00                   | 12.94                                      |        |        |
| 1234567890                   | Bill Smith         | AB12345C                       | 08343-000789012-2-0           | 12/01/2008                        |                       | 200.00                 | 33.77                                      | PAID   |        |
| 90740                        | 00416              |                                | 0.44200                       | 100                               | 16.25                 | 0.00                   | 17.52                                      |        |        |
| 1234567890                   | Bill Smith         | AB12345C                       | 08343-000789012-2-0           | 12/01/2008                        |                       | 50.00                  | 20.77                                      |        |        |
| 36415                        | 00457              |                                | 0.26740                       | 100                               | 10.00                 | 0.00                   | 10.77                                      |        |        |

The paid amount for the first claim is determined by the sum of the APG Paid \$83.50 (The amounts in column 6 already reduced to 25% in year 1), plus the sum of the Existing Operating Component \$90.00 (The amounts in column 8 that are already reduced to 75% for year 1), plus the Capital Add-on amount in column 7, \$15.00, plus any reductions. = Total Paid TCN \$185.50.

### NEW APG DATA ELEMENTS:

- CPT: Reported procedure code
- APG: APG code assigned by grouper
- Combined With CPT: Pointer to other significant procedure that caused the packaging and therefore zero payment on this line
- Full Weight APG Amount: Assigned grouper weight
- PCT APG Weight: Related to grouper assigned Payment Action Code. This is additional weight factor applied to Full Weight
- APG Paid: APG Paid Amount for outpatient is the amount after the 25%, 50% or 75% is applied over each of the first three years.
- Capital Add-on: Amount added to Claim Payment (line 1).
- Existing Operating Component: Amount added to outpatient payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines.
  - Figure above EOC -Total line payment - includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount.
- Total Paid TCN: Total Claim Payment
- Rate Code: Will appear only on line 1 of claim

## No Capital APGs

- Certain APGs, **when billed alone**, will not generate a capital add-on. Most relevant to Article 16 Clinics:
  - 118 – Nutrition
  - 274 – Physical Therapy, Group
  - 275 – Speech Therapy, Group
  - 426 – Psychotropic Medication Management
  - 428 – Patient Education, Individual
  - 429 – Patient Education, Group
- **This list changes periodically, check the DOH APG website for updates.**

## Discounting

- Most mental hygiene APGs will not package with a medical visit.
- For most mental hygiene APGs, “multiple same APG discounting” replaces consolidation or bundling.

## Discounting

- Multiple APG discounting takes place when more than one APG within a particular type is billed during the same visit.
  - Therapy and Psychotherapy are separate types. Thus,
    - APG 270 (Occupational Therapy) will not discount in the face of APG 315 (Brief Psychotherapy).
    - APG 270 (Occupational Therapy) will discount in the face of APG 271 (Physical Therapy).

## Discounting

- The standard discount rate within APG's is 50%, but this has been modified for most Art 16 services.
  - Therapies (25%): 270, 271, 272, 274, 275
  - Testing, Assess, Psychotherapy (10%): 310, 315, 316, 317, 318, 322, 323. Note: 323 never discounts.
- Same discounting percentage applied when:
  - discounting is applied in lieu of consolidation
  - multiple APG's are billed within the same type
- **See DOH APG website for a complete list of APG with modified discount rates.**

## Discounting

- Review of Actual Discounting Examples
  - PLEASE REFER TO DISCOUNTING HAND-OUT

## Billing Psychiatric Services

- **If you operate a joint-licensed Article 28 clinic, the expectation is that medical services will be billed under your Article 28 license.**
  - Psychiatry is a medical service.
- **Under APG's psychiatric services can be billed:**
  - Medical Visit (Using E&M and Dx Codes)
  - Medication Management Visit (APG 426)
  - Comprehensive Psychiatric Visit (APG 315, 316)
  - It's **one** of the three above, **not a combination.**

## Special Services

- If you currently deliver TB screening (PPD), Pneumonia and Flu Shots through your Article 16, you can continue to do this.
- Smoking cessation services:
  - May be billed by Article 16 Clinics (if you do not operate an Art 28)
  - Follow the Article 28 Rules

## Special Services

| April 2011 APG "Fee Schedule" Procedures |                               |                                |             |
|--|-------------------------------|--------------------------------|-------------|
| NYS Department of Health                 |                               |                                |             |
| HCPCS Code                               | HCPCS Code Description        | April 2011 Fee Schedule Amount | Units Limit |
| 86580                                    | TB intradermal test           | \$ 5.00                        | 1           |
| G0008                                    | Admin influenza virus vaccine | \$ 13.23                       | 1           |
| 90473                                    | Immune admin oral/nasal       | \$ 8.57                        | 1           |
| G0009                                    | Admin pneumococcal vaccine    | \$ 13.23                       | 1           |
| 90655                                    | Flu vaccine no preserv 6-35m  | \$ 15.45                       | 1           |
| 90656                                    | Flu vaccine no preserv 3 & >  | \$ 12.54                       | 1           |
| 90657                                    | Flu vaccine 3 yrs im          | \$ 5.68                        | 1           |
| 90658                                    | Flu vaccine 3 yrs & > im      | \$ 11.37                       | 1           |
| 90660                                    | Flu vaccine nasal             | \$ 22.32                       | 1           |
| 90669                                    | Pneumococcal vaccine 7 val im | \$ 95.48                       | 1           |
| 90732                                    | Pneumococcal vaccine          | \$ 43.25                       | 1           |

## Updating APG Payment

- **We expect to review peer group base rates annually and updated when appropriate.**
  - Base Rate = Base Year Expenditures / (Visits \* CMI)
- **Service Intensity Weights are also reviewed annually as part of a multi-agency process.**
  - Significant changes to SIW may force a base rate revision.
  - This is your opportunity to provide feedback to the reimbursement process.
  - We need to know about disconnects between payment and actual cost of service delivery.

## Article 16 & Other OWPDD Services

- ICF Residents
- Day Treatment Program Participants
- HCBS Waiver Enrollees
  - Residents of IRA's with Enhanced Clinical Funding
  - Day Hab Programs with Enhanced Clinical Funding

## Resources

- **AMA CPT Handbook**
- **HCPCS Manual**
- **Medicare Local Coverage Decisions**
- **Article 16 Regulations & Clinic Manual**
- **DOH APG Website:**
  - [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/](http://www.health.state.ny.us/health_care/medicaid/rates/apg/)
- **Medicaid Update**
- **CMS NCCI Webpage:**
  - <https://www.cms.gov/MedicaidNCCICoding/>

## Article 16 Clinic Service Documentation

## Article 16 Clinic Service Documentation

- Documentation must support the need for services
- Documentation must provide an accurate clinical picture of the person
- Documentation must clearly paint a picture of the services provided
- Documentation must be consistent with frequency of current treatment plan

## Examples of Article 16 Clinical Record Documentation

- Assessments/ Evaluations/ Examinations
- Clinic Treatment Plans
- Clinic Treatment (Progress) Notes
- Clinic Treatment Reviews
- Annual Physician (Re) Assessment

## Assessments/ Evaluations/ Examinations

- Date conducted (date of service)
- Reason for/presenting problem & history
- Protocol used (standardized instrument)
- Measurable, observable & descriptive test results, including informed clinical opinion
- Diagnosis & need for treatment/not at this time or indication when to be seen again
- Full signature, title & three part date

## Clinic Treatment Plans

- Based on current & written individualized assessment/ evaluation/ examination
- Individually tailored (not cookie cutter)
- Duration of TX plan is **1 year** unless otherwise indicated by Clinic Medical Director
- Full signature & three part date (clinician)
- Full signature & date reviewed by Medical Director or designated physician/dentist **by the end of calendar month in which TX plan is effective or when there are changes to elements of TX plan**

## Elements of Treatment Plan

- **Treatment Diagnosis** related to service provided
- Person's developmental disability or other diagnosis (**medical and/or psychiatric**) that may relate to TX
- Identification of therapy, therapies or specific type or modality of therapeutic intervention
- TX goals; functional & time framed
- Frequency: If range, must **ONLY** be written to include **a plus 1 type order**, i.e., 1-2 or 2-3 times a week
- Location: If service delivery is in OPWDD-certified residence

## Coordination of Clinic Treatment Plans

- Must incorporate all other individualized written plans of services (ISP, IEP, & other Art 16 &/or Art 28 clinic TX plans)
- Must not be in conflict with or duplicate the same clinical service or modality (e.g. gait training) from multiple sources
- **Identification of an Article 16 Clinic service on other individualized plans of service is NOT a billing requirement for the Article 16 Clinic provider**

## Article 16 Clinic Treatment Coordinator

- Must forward written treatment plan recommendations to person's Medicaid Service Coordinator (MSC) or other coordinator outside of Article 16 Clinic when TX plan is **1st developed, at least semi-annually** & whenever clinic **TX plan is changed significantly**

## Treatment (Progress) Notes

- Date of service & location of treatment
- Duration of face-to-face encounter (e.g. 35 minutes – best practice is clock time)
- Description of face-to-face encounter – tasks, activities, procedures; person's progress &/or response – in relation to treatment plan
- Full signature, title & three part date

## Clinic Treatment Reviews

- Type & frequency of clinic services
- Whether TX goals have been met &/or whether new TX goals need to be established
- Specific rather than general; quantifiable (if appropriate) & directly related to the person's clinic TX plan
- Must indicate whether clinic TX is to continue, be changed (next steps) or be discontinued
- Full signature, title & three part date

## Treatment Review Schedule

- TX outcomes &/or course of TX reviewed:
  - as specified by treating physician or dentist for **medical, including medical specialties, or dental treatment**; and/or
  - **at least every 6 months by the end of the calendar month in which clinic treatment review occurs** for all other Article 16 Clinic TX plan services

## Annual Physician (Re) Assessment

- Annual review of the person's TX, evaluative & clinical/medical information
- Type, frequency & length of time provided
- Clinical appropriateness
- Recommendation & brief rationale to continue clinic treatment
- Full signature & date of (re) assessment by Medical Director or designated physician
- No later than **31 days after a full calendar year** since the date of the last physician reassessment

## Questions?

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