Medicaid – Ambulatory Care Payment Reform

Ambulatory Patient Groups (APG)

BACKGROUND

- **Former Medicaid Clinic Reimbursement Method:**
  - Formerly hospital outpatient departments (Article 28 clinics) were reimbursed by Medicaid at an all-inclusive, threshold visit clinic rate. Basically, with a few exceptions, the all-inclusive rate included all medically necessary services provided during the visit including ancillary tests (labs, radiology, other diagnostic tests) ordered during the clinic visit regardless of when they were performed.
- **APG Payment Method Starting December 1, 2008:**
  - Under the new APG payment methodology Medicaid will reimburse hospital outpatient departments based on a classification system which places patients and services into clinically coherent groups. Reimbursement is based on patients' conditions and service intensity. (i.e. diagnosis and procedure).

To receive optimal APG reimbursement, it will be imperative to accurately identify: level of service; all procedures performed; correct primary diagnosis; relevant secondary diagnoses.

- Ancillary services performed as part of the visit, or significant procedure, in some cases may increase the reimbursement. In other cases they are "packaged' in the payment for the medical visit or significant procedure. The process for combining services such as labs and radiology with the clinic visit is handled behind the scene by the Patient Accounts Office and relies heavily on matching services by associating the clinic provider with the "ordering provider" of the ancillary services.

Important Coding Points for Outpatient Clinic Providers under APG

- All services and procedures performed during a clinic visit must be entered on the Encounter Form (EF).
- The diagnosis which is PRIMARY for the visit must be identified by the clinic provider on the EF. How the provider will identify which diagnosis is PRIMARY for billing is a clinic decision and can be accomplished many ways; e.g. numbering, circling the letter "P", etc. However, we recommend including billing and or charge entry in the decision.
  - The primary diagnosis describes the diagnosis, condition, problem or other reason for the encounter/visit as supported in the medical record to be chiefly responsible for the services provided. A symptom may be primary when a diagnosis has not been established.

- All relevant diagnoses should be coded on the claim.
    - Secondary diagnoses or additional codes that describe any coexisting conditions treated or which influenced the medical decision making should be coded on the claim and supported in the documentation.
- Code all procedures performed.
- The EF must reflect the accurate evaluation & management (E&M) code level, and or procedure code. All procedure codes and levels of service must be supported in the documentation.
    - All Teaching Physician Supervision Guidelines with the required attestations apply and must be met in order to bill.
- All Immunizations and therapeutic injections provided during the visit must be entered on the EF, including the correlating drug or vaccine and the medically necessary reason (diagnosis code).
- If an E&M service is performed on the same day as a procedure, the modifier 25 guidelines must be applied (E&M must be a separately identifiable service) in order to add modifier 25 to the E&M and bill for both services.