



OASAS Interim APG Readiness Overview

Presented by:
Millin Associates, LLC
Billing and Consulting
June 30th, 2011



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- The information herein is valid for the date of the presentation only.
- Nothing herein is a specific recommendation about billing or charging of services or ICD-9/CPT/HCPCS codes. All codes selected should be based upon the ACTUAL DOCUMENTATION representing the SERVICES RENDERED by your organization.
- For each claim, you must check with the coding and coverage guidelines for a particular payer.
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Agenda

- Introduction to Millin Associates
- Overview of APGs
- Charge Capture and Billing for APGs
- Clinical Documentation and APGs
- Action Plan & Resources



SECTION I

INTRODUCTION TO MILLIN ASSOCIATES



Millin Associates, LLC

- Millin Associates is a full-service medical billing & consulting firm, in business for 30 years, with an extensive knowledge of the current healthcare environment. We offer complete and effective revenue cycle management solutions to maximize revenue while ensuring compliancy.
- Among the services we offer:
 - claim scrubbing
 - claims submission & payment posting
 - effective follow up on denials
 - financial and clinical reporting
 - chart to bill audits
 - workflow analysis
 - training & education
 - compliance programs
 - cutting edge web-based software
 - IT development & support



Millin Associates, LLC

- The billing process is becoming more cumbersome and the rules and regulations continue to change making this process significantly more complicated to handle internally.
- This is one of many reasons so many facilities have been turning to Millin Associates to manage the billing process for almost 30 years.
- With a staff of 40, we have all the necessary expertise to handle all the continuous changes.
- Our staff consists of certified coders and billers, APG experts, Physician Practice experts, IT professionals, a Compliance Officer, clinical documentation specialists, and of course a strong Management Team.
- We ensure our clients – clinics and physician practices – are ready for any regulatory changes that arise.

www.millinmedical.com



About the Speakers

- ***Nicole Cascio***
 - Director of Client Services
 - Compliance Officer
 - Lead APG Billing Educator
- ***Christine Cox, CCS, CPC-H, FCS, CHI, C-CDI, CCDS, MDS-CT, AHIMA Certified ICD-10 Trainer***
 - Clinical Services Consultant
 - Lead APG Documentation Educator



SECTION II

OVERVIEW OF APGs



APG Overview

- Ambulatory Payment Group (APG) is a payment methodology for clinics and hospitals which serve Medicaid patients.
- These Medicaid claims take the designated outpatient services into account when determining payment.
- The payment is based also on the clinic's DOH assigned base rate, capital add-on existing operating component. The APG algorithm determines this payment.
- **RECOMMENDATION:**
 - There are a great many caveats and specifications for each clinic type. As the information is updated on a consistent basis, Millin suggest saving the links to the OASAS APG site to your browser (Internet Explorer) Favorites for quick viewing on a regular basis



APG Definitions

- **APG Group Category**
 - CPT/HCPCS codes grouped according to procedure and/or diagnosis.
- **Weights**
 - Average cost for each APG visit/average cost for all APG visits.
- **Packaging/Bundling or Discounting**
 - Weight multiplier applied to each APG
- **Base Rate**
 - Established Base Rate



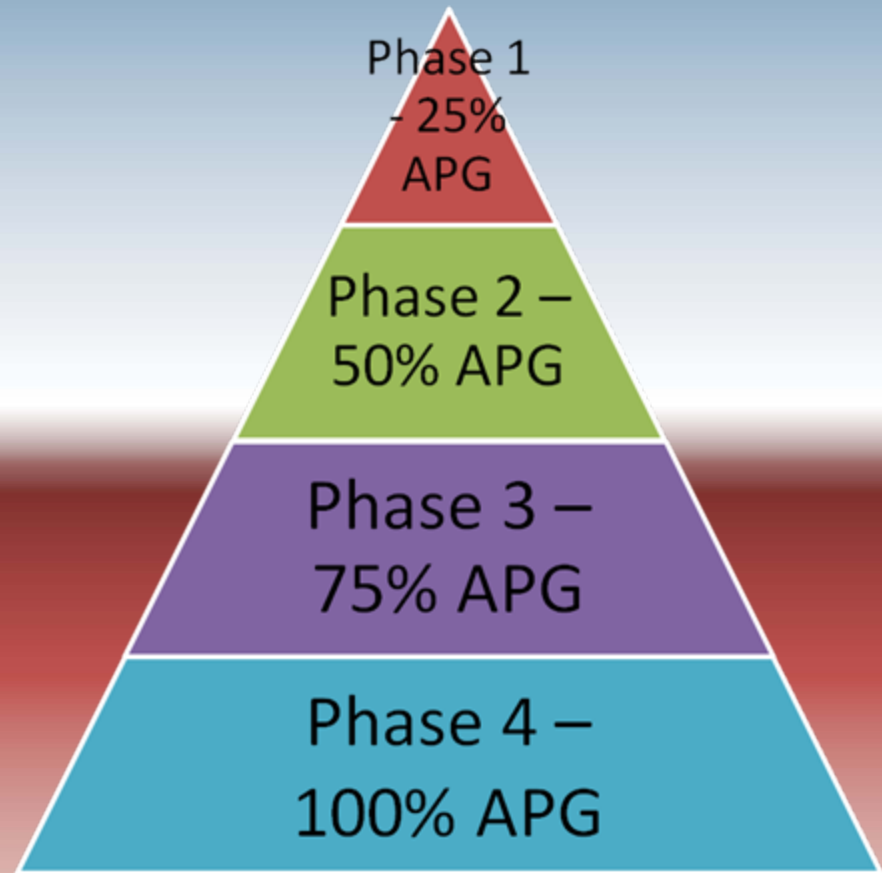
SECTION III

CHARGE CAPTURE AND BILLING FOR APGs



Freestanding Clinic APG Phase In

- Phase 1
 - July 2011 to June 2012
- Phase 2
 - July 2012 to June 2013
- Phase 3
 - July 2013-December 2013
- Phase 4
 - Full APGs begins January 2014





APG Interim Billing

- While OASAS APGs are going into effect for Dates of Service July 1st, 2011, Federal approval has not yet been received.
- OASAS published interim billing guidelines on June 14th, 2011.



RATE CODES

APG Rate Code	Legacy Rate Code	Description
1528	4273, 4274, 4275	Part 822 Hospital (Article 28/32) Chemical Dependence Outpatient Program
1540	4214, 4215, 4216	Part 822 Community (Article 32 Only) Chemical Dependence Outpatient Clinic Program
1543	1671	Part 822 Hospital (Article 28/32) Opiate Treatment Program



Coding Changes

Current System

- Assessment – Code 90801
(Rate code 4214)
- Individual Counseling –
Codes 90804 or 90806 (Rate
code 4215)

APG System

- Assessment - Depending
upon time spent on the
assessment, can use Codes
H0001, H0002, or T1023
(Rate code 1540)
- Individual Counseling –
Codes 90804/90806 for
Medicare, use Codes G0396
or G0397 for Medicaid (Rate
code 1540)



Coding Changes

Current System

- Group Counseling – Codes 90853 or 90849 (Rate code 4216)
- Brief Intervention – No codes
- Medication Management – No codes
- Psychotropic Medication – No codes

APG System

- Group Counseling – Codes 90853/90849 for Medicare, use Codes H0005 or 90849 for Medicaid (Rate code 1540)
- Brief Intervention – H0050
- Medication Management – H0034
- Psychotropic Medication – M0064 (routine) or 90862 (complex)



3M Grouper

- Although other clinic types such as Article 28 and Article 16 are recommended to obtain the 3M Grouper, Substance Abuse clinics DO NOT need to purchase the 3M Grouper.
 - *Generally the payments are based on the procedure codes and not a combination of the procedure and diagnosis codes, except for the Evaluation and Management codes (CPT 9920x, 9921x).*



APG Charge Capture Issues

- PRIOR TO APGs:
 - Time Based
 - Limited Code Set
 - Single service billed on claims
- APG Implementation:
 - Time and Content
 - Expanded Code Set
 - Multiple services billed on claims
 - Discounting for multiple procedures
 - Clinical Collaboration
 - Improved documentation initiatives



APG Billing Issues

- For clinics using a system that does not alert users to multiple services in a single DOS, APG encounters, in general, should be held for as much 48 hours before being billed.
- For regular substance abuse treatment (individual therapy, group therapy, etc. - pretty much everything else on the encounter form), a patient can come in for individual therapy and then come back in the afternoon for group therapy. Those used to go out on two claims; **HOWEVER**, that will change with APG billing.



APG Billing Issues

- Unlike OMH clinics – who could get payment for a regular and a collateral group on the same day on two claims (4301/4304) – OASAS clinics never got paid for 2 services (i.e., regular and group or regular and assessment). One would always deny.
- With APGs, a regular and group therapy, for example, should show up on the same claim.
 - Does your system roll these multiple services into a single claim for that DOS?



Methadone Episodic Billing

<u>On the 837</u>	<u>Code</u>	<u>Date of Service</u>
• Header	1543	6/6/2011 to 6/12/2011
• At the line level:	H0020	6/6/2011
• At the line level:	H0002	6/6/2011
• At the line level:	90862	6/6/2011
• At the line level:	G0396	6/8/2011
• At the line level:	H0020	6/8/2011
• At the line level:	H0020	6/10/2011
• At the line level:	M0064	6/10/2011
• At the line level:	H0005	6/10/2011
• At the line level:	H0020	6/11/2011
• At the line level:	H0020	6/12/2011



Methadone Episodic Billing

- Per page 44
<http://www.oasas.state.ny.us/admin/hcf/APG/documents/APGManual-April2011.pdf> :
- **APG Billing for Part 822 Opiate Treatment Programs – Weekly Episode of Care**
- OTP claims will be submitted using a weekly episode of care of care construct. As with the prior weekly threshold claims process, under APGS one weekly episode claim per opiate patient will be submitted. However, under APGS the single episode claim must include the discrete visit dates and the multiple CPT or HCPCS codes to reflect the services that are delivered on the individual days encased within the episode
- As it was pre APGs, the episode will be defined as the from / thru date for the calendar week (Mon – Sun) and the OTP Sunday billing (claim submission) date should reflect the Sunday that closed that weekly episode.



Methadone Episodic Billing

- Example: If the episode dates of service were Monday Jan 3, through Sunday, January 9, the actual billing (claim submission) date would be Sunday, January 9. To receive payment for services delivered within the episode, the program will submit to Medicaid a single episode claim, indicated by the appropriate OASAS APG rate code listed on page 45, 51 and the claim will reflect the CPT or HCPCS code, for each discrete service that is delivered on a specific dates within the weekly billing range. The episode payment will be equal to the sum of the lines, by visit date, that are encompassed within the episode. This calculation will be done by centrally the Medicaid system.
- *As per page 45 of the same manual, Buprenorphone (aka Suboxone) will continue to utilize the weekly rate codes.*



SECTION IV

CLINICAL DOCUMENTATION FOR APGs

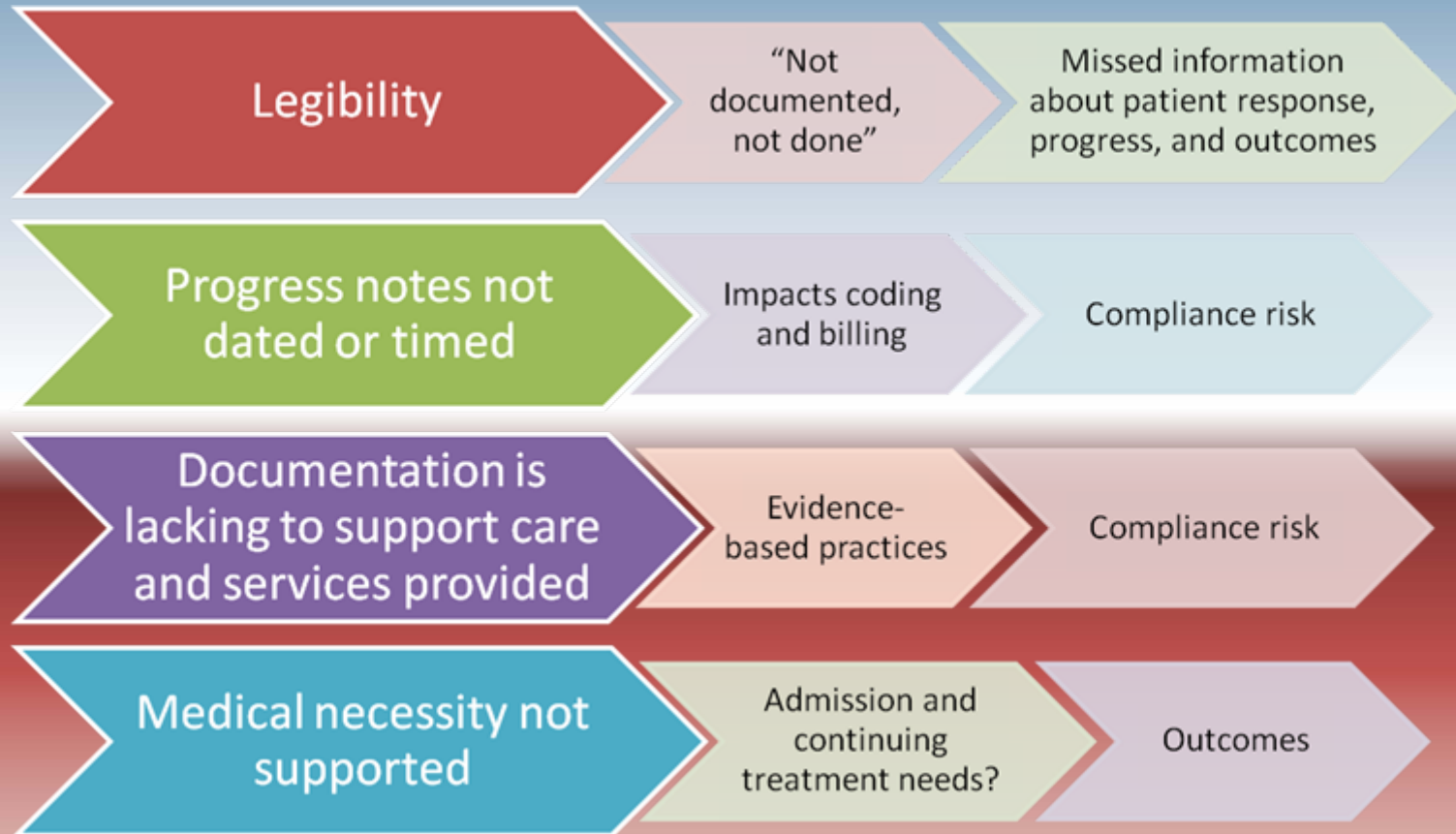


Clinical Documentation





QUALITY ISSUES: Crosswalk to Coding





Coding & Documentation Tool

- Millin has compiled a Tool based upon the information contained within the OASAS APG manual, coupled with recommendations for documentation from sources such as the New York State Clinical Record Initiative (NYSCRI).
- A copy of the tool will be posted to the Millin website with this presentation.
 - *Evaluation & Management coding will be addressed in a future webinar due to the volume of information necessary to cover these services.*

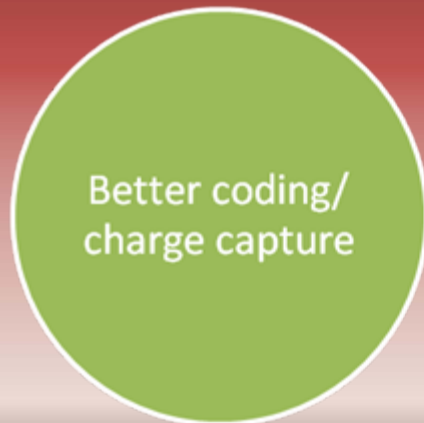


Coding = DATA

- Data analysis is often based on diagnosis and procedure codes, which impacts:
 - **Clinical outcomes & disease research:** NIH, CDC, State DOH
 - **Pay for Performance:** Medicare and Private Payers
 - **Operational Changes:** Service volumes, clinical outcomes
 - **Payment Systems:** OASAS APGs based on level of service
- Selecting a code is like “translating” your work into a numerical “language”
 - If we took a sample patient and laid out all of the codes for services in a 3 month timeframe, what would that look like? *Frequency of group, individual, and medication encounters?*



Coding = DATA





Improving Clinical Documentation

- Use terminology to enhance the documentation
- “Patient is improving”
 - *Is improvement ...*
 - Significant (advancement in behavior ... examples)
 - Mild/minimal (changes as compared to prior ... timeframe)
 - Moderate (improvement in behavior ... examples)
 - Severe (relapse/regression ... examples)
- Positive/Negative response to intervention



Improving Clinical Documentation

- Key descriptive words to enhance documentation:
 - “as evidenced by”
 - “as seen through”
 - “as noted by”
 - The patient is making progress, as evidenced by improvement in ... This is a ...*significant, modest, etc...* improvement since ... *the last session on DATE or over the past (timeframe).*”



Improving Clinical Documentation

- Key descriptive words to enhance documentation:
 - Consistent, inconsistent (with reference to participation or clinical observations)
 - Greater than/Less than
 - “less frustration with family members than in prior months as client implements breathing techniques to reduce stress”
 - Unusual (with reference to patterns or observations of patient progress) versus normal demonstration during encounters
 - “Passive”, “active”, “unresponsive”, “actively” all describe the patient’s involvement



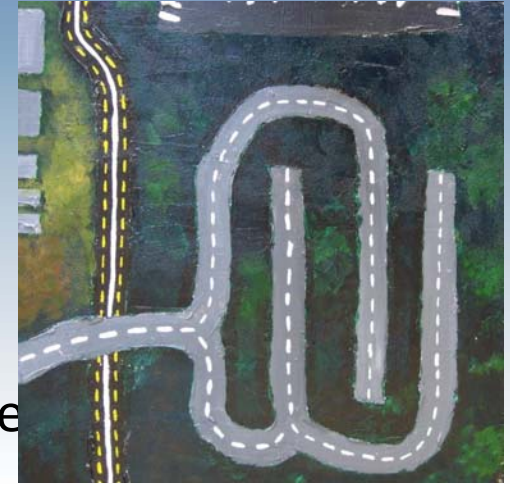
Improving Clinical Documentation

- **Subjective:**
 - Patient/family information
 - Patient’s own response to treatment; patient’s own description of progress
 - Patient lifestyle or compliance difficulties
- **Objective:**
 - Therapy measurements and achievement of activities
 - “Client provided a list of 3 triggers for anger ...” (as requested in prior session or as part of activities for specific goals)
 - Detailed descriptions of interventions provided
 - Observations for improvement of outcomes



Treatment Plan

- The Plan of Care/ Treatment Plan provides a “roadmap” for the patient:
 - Anticipated goals and expected outcomes of all proposed interventions
 - Proposed interventions must take into consideration the active participation of the patient
 - Frequency and duration of all proposed interventions to achieve the goals and outcomes as appropriate from evidence-based clinical practices
 - Progress notes should reflect a **RELATIONSHIP** to the Treatment Plan CURRENTLY IN EFFECT for that Date of Service (DOS)





Documentation Example

- Client has not relapsed, U/A is negative. Client is attending all medical visits. Client completed application for internship as directed by Vocational Counselor. Client has not attended groups in two weeks. Client will be encouraged to attend groups and follow up with Vocational Counselor on internship opportunity.
 - *Could the writer have obtained this information from other sources? Where is the Patient's own participation in setting and achieving goals demonstrated?*
 - *Patient's progress? Response to treatment? Evidence-based interventions noted?*



Documentation Example

- Client has not relapsed, U/A is negative. **Patient expressed it is still a struggle to stay sober and is proud of his ability to maintain sobriety given the barriers he faces with other life issues (housing, family, work).** Client is attending all medical visits and indicated he is sleeping better and feeling less tired during the day as a direct result of the medication changes. Client completed application for internship as directed by Vocational Counselor. **He is excited to start working on the computer repair program as he states this will help him focus on activities other than using.** Client has not attended groups in two weeks. **He stated he is bored with one particular group.** Client ~~will be~~ was encouraged to attend **a group for advanced relapse prevention** groups and follow up with Vocational Counselor on internship opportunity.



Documentation Example

- What was different about the second example?
 - Patient participation in encounter documented
 - Patient's perception of progress toward goals documented
 - Patient actively engaged in achieving own treatment goals
 - *If he didn't demonstrate participation and engagement, what would you have documented to show his lack of progress and options to alter treatment to improve outcomes?*



Clinical Documentation

- *Small changes to current documentation practices can make a huge difference*
- Better documentation helps both the organization **AND** the patient
- Communication with your billing staff is important
- Excellent resource for templates and documentation information:
 - **NEW YORK STATE CLINICAL RECORD INITIATIVE (NYSCRI)**
 - Provides standardized templates and guidance for best practices in documentation
 - *Development committees included OMH and OASAS*



Documentation Templates

Individual's Report of Progress Towards Goals/Objectives Since Last Session: John states " I have been anxious this past week . " " I want to be able to work and I need somewhere to live because I haven't been able to pay my rent" " I haven't really been doing much of anything except worrying"

Intervention(s) / Method(s) Provided: This writer and John worked on identifying triggers for his anxiety. John acknowledged that when his new friend rejected his visit it increased his anxiety about being alone. John and counselor worked on breathing techniques to assist John in decreasing his anxiety. John discussed ways to prevent this situation in the future. John knew that if his friend stated she did not want a visit that he should not have gone and that it would have been better to make plans for a different day. John worked on being able to identify ways to think through his thoughts before acting such as calling ahead before going, writing down other choices of things to do instead of acting on his impulses.



Clinical Documentation

- Communication from the provider is important – what tools or systems would assist you to provide better documentation?

“Paint a picture with words”





SECTION V

ACTION PLAN AND RESOURCES



Action Plan

- Update Charge Capture mechanisms
 - Review your encounter form regularly
 - Work with clinical staff to determine if all of the services available for charge capture are on your encounter form or software system
 - Update software systems to capture these items correctly on your claims
- Update references for documentation & coding
 - Capture all elements to meet coding criteria
 - Review OASAS and OMIG report findings to look for potential deficiencies
 - Review NYSCRI recommendations for templates and documentation capture



Action Plan

- Data analysis
 - Look at where you were and where you are today?
 - Identify trends that impact \$ and compliance
 - Determine if re-education is necessary for documentation (clinical staff) and/or claim submission (billing staff)
- Auditing and Monitoring
 - Complete a chart-to-bill audit within 30 days of the APG implementation to determine if your staff (from clinician to biller) is capturing the correct codes for the services rendered.
 - Check the OASAS and OMIG websites for tools to incorporate into your monitoring activities



Resources

- OASAS APG Website:
 - <http://www.oasas.state.ny.us/admin/hcf/APG/Index.cfm>
- Encounter Form
 - *A copy of an encounter form, based on the OASAS model, and modified by Millin will be posted on the Millin website with this presentation and other resource materials.*
- Coding Tool
 - *A copy of the coding and documentation tool, based on the OASAS APG manual April 2011, will be posted on the Millin website with this presentation and other resource materials.*
- Documentation Templates – NYSCRI
 - http://www.mtmservices.org/NYSCRI_2010F/2010-Forms.html



Millin Software Options

- **MillinPro**

- MillinPro is a web-based application
- Internet Access is required for all users to access the system
- No server is required by your organization as the software resides on Millin's servers
- Training is provided in an onsite classroom environment with a software manual provided in both paper and electronic formats
- Customer service directly from the Millin IT and Client Services teams – via email and by phone
- Our data migration begins with a full export of requested data elements from your organization's IT
- MillinPro clients have full access to accounts and reports, including the capability to do ad hoc reports based upon the current database.
- Millin has its own claim processor attached to EMDEON
- Millin uses the 3M grouper as applicable for specific programs
- The software is on track for 5010 implementation



Contact Information

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