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APG Reimbursement Methodology

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology:

3M Contact Information; effective 12/1/2008:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/contacts.pdf

3M APG Crosswalk, version 3.1, effective 7/1/09:

(prior versions available upon request to the Department of Health)

<https://dashboard.emedny.org/CrossWalk/html/cwAgreement.html>

APG Consolidation/Bundling; effective 12/1/08 and last updated 7/1/09:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/#apg_cons

APG Definitions Manual Versions; effective 12/1/08 and last updated 7/1/09:

[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/versions with effective dates.xls](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/versions_with_effective_dates.xls)

APG Weights; effective 12/1/08:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_payment_components.xls

Associated Ancillaries; effective 7/9/09:

[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proc subject to ancillary policy.xls](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proc_subject_to_ancillary_policy.xls)

Base Rates, Freestanding Clinics, effective 9/1/09:

http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/dtc_apg_base_rates.pdf

Base Rates, Hospital Outpatient Clinics, effective 7/1/09:

http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/hosp_base_rates.pdf

Coding Improvement Factors; effective 12/1/08 and last updated 7/1/09:

[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_cifs by rate period.xls](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_cifs_by_rate_period.xls)

Uniform Packaging Ancillaries; effective 12/1/08:

[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/uniform packaging apgs.xls](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/uniform_packaging_apgs.xls)

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Hospital-Based APG Base Rate Table

| <u>Peer Group</u> | <u>Region</u> | <u>Rate Start Date</u> | <u>Base Rate Effective 9/1/2009*</u> |
|------------------------------|------------------|------------------------|--------------------------------------|
| <u>Ambulatory Surgery</u> | <u>Downstate</u> | <u>12/01/08</u> | <u>\$156.91</u> |
| <u>Ambulatory Surgery</u> | <u>Upstate</u> | <u>12/01/08</u> | <u>\$122.55</u> |
| <u>Emergency Department</u> | <u>Downstate</u> | <u>01/01/09</u> | <u>\$175.11</u> |
| <u>Emergency Department</u> | <u>Upstate</u> | <u>01/01/09</u> | <u>\$135.27</u> |
| <u>Outpatient Department</u> | <u>Downstate</u> | <u>12/01/08</u> | <u>\$258.90</u> |
| <u>Outpatient Department</u> | <u>Upstate</u> | <u>12/01/08</u> | <u>\$199.00</u> |

*These rates became effective on 7/1/2009, but are still in effect as of 9/1/2009.

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Freestanding Diagnostic and Treatment Center APG Base Rate Table

| <u>Peer Group</u> | <u>Region</u> | <u>Rate Start Date</u> | <u>Base Rate Effective 09/1/2009</u> |
|---------------------------------|------------------|------------------------|--------------------------------------|
| <u>General Clinic</u> | <u>Downstate</u> | <u>09/01/09</u> | <u>\$212.07</u> |
| <u>General Clinic</u> | <u>Upstate</u> | <u>09/01/09</u> | <u>\$174.74</u> |
| <u>General Clinic MR/DD/TBI</u> | <u>Downstate</u> | <u>09/01/09</u> | <u>\$254.48</u> |
| <u>General Clinic MR/DD/TBI</u> | <u>Upstate</u> | <u>09/01/09</u> | <u>\$209.69</u> |
| <u>Dental School</u> | <u>Downstate</u> | <u>09/01/09</u> | <u>\$268.35</u> |
| <u>Dental School</u> | <u>Upstate</u> | <u>09/01/09</u> | <u>\$223.22</u> |
| <u>Renal</u> | <u>Downstate</u> | <u>09/01/09</u> | <u>\$235.70</u> |
| <u>Renal</u> | <u>Upstate</u> | <u>09/01/09</u> | <u>\$196.06</u> |
| <u>Ambulatory Surgery</u> | <u>Downstate</u> | <u>09/01/09</u> | <u>\$ 88.69</u> |
| <u>Ambulatory Surgery</u> | <u>Upstate</u> | <u>09/01/09</u> | <u>\$ 86.39</u> |

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Ambulatory Patient Group System

For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through March 31, 2010, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described on Page 1(k) of this section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems. When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system. Links to detailed APG Reimbursement Methodology lists are located in the APG Reimbursement Methodology section.

Allowed APG Weight shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting.

Ambulatory Patient Group (APG) shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M Health Information Systems' grouping logic outlined in the APG Definitions Manual. A link to the APG Definitions Manuals versions and effective dates is available in the APG Reimbursement Methodology section. [version 3.1 dated March 6, 2008 and as subsequently amended by 3M]

APG Relative Weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs. A link to the APG relative weights for all periods is available in the APG Reimbursement Methodology section.

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Associated Ancillaries shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology section.

APG Software shall mean the New York State-specific version of the APG computer software developed and published by (3M) Health Information Systems, Inc. (3M) to process HCPCS/CPT-4 and ICD-9-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M HIS will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software, can perform the computations by accessing the APG definitions manual, which is available on the 3M web site.

Base Rate shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

Case Mix Index is the actual or estimated average final APG weight for a defined group of APG visits.

Coding Improvement Factor is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. [The current] A link to the coding improvement factors [are 1.05 for emergency department, 1.085 for outpatient hospital, and 1.01 for ambulatory surgery] for all periods is available in the APG Reimbursement Methodology section.

Consolidation/Bundling shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual, [version 3.1 dated March 6, 2008 and as subsequently amended by 3M;] a link to which is provided in the APG Reimbursement Methodology section.

Current Procedural Terminology-fourth edition (CPT-4) is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and HCPCS are maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

Discounting shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting is always at the rate of 50%.

Final APG Weight shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable bundling, packaging, and discounting.

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"HCPCS Codes" are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

Packaging shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. There is no packaging logic that resides outside the software. A link to a list of the uniform packaging APGs for all periods is available in the APG Reimbursement Methodology section.

"Peer Group" shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. The six hospital peer groups are outpatient department - upstate, outpatient department - downstate, ambulatory surgery - upstate, ambulatory surgery - downstate, emergency department - upstate, and emergency department - downstate.

"Region" shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

"APG Visit" shall mean a unit of service consisting of all the APG services performed for a patient [on a single] that are coded on the same claim and share a common date of service, provided, however, that services provided in an emergency department which extend into a second calendar date may be treated as one visit for reimbursement purposes].

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- III. The APG base rates shall be updated at least annually. The initial update will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent updates will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.
- a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. APG payments shall also reflect an investment of \$178 million on an annualized basis. The case mix index shall be calculated using 2005 claims data.
- IV. For the period December 1, 2008 to December 31, 2009, the APG base rates shall be calculated using the total operating reimbursement for services and associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of \$178 million on an annualized basis. The case mix index shall be calculated using 2005 claims data.
- a. For all rate periods subsequent to December 31, 2009, estimated total operating reimbursement and the estimated number of visits shall be calculated based on historical claims data. The initial reestimation will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent reestimations will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate data.
- b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. The initial reestimation will be based on claims data from the December 1, 2008 through April 30, 2009 period, and subsequent reestimations will be based on Medicaid claims data from the most recent twelve month period, and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.
- V. Rates for new facilities during the transition period
- (1) General hospital outpatient clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:
- (2) For the period December 1, 2008 through December 31, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as computed in accordance with this [Subpart] Attachment;

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Effective September 1, 2009, immunization services provided in a general hospital outpatient department, when no other medical services are provided during that patient visit, shall be reimbursed entirely on the APG methodology.

Effective for dates of service on and after September 1, 2009, payments to general hospital outpatient departments for the following services shall be based on fees or rates established by the Department of Health: (1) wheelchair evaluations, (2) eyeglass dispensing, and (3) individual psychotherapy services provided by licensed social workers to persons under the age of 21, and to persons requiring such services as a result of or related to pregnancy or giving birth. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates for the services listed in this paragraph were set September 1, 2009 and are effective for services provided on or after that date. The rates are published on the Department of Health web-site at the following link:

www.health.ny.gov/health_care/medicaid/rates/apg/docs/apg_alternative_payment_fee_schedule.pdf

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