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APG Reimbursement Methodology – Freestanding Clinics

For the purposes of sections pertaining to the Ambulatory Patient Group, and excepted as otherwise noted, the term freestanding clinics shall mean freestanding Diagnostic and Treatment Centers (D&TCs) and shall include freestanding ambulatory surgery centers.

For dates of service beginning September 1, 2009 through March 31, [2013] 2014, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates 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 in the APG Rate Computation 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 (3M). 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.

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Upper Payment Limit

The State, in order to comply with the Upper Payment Limit (UPL) regulations at 42 CFR 447.321, will mandate the following for all clinics licensed by the NY State Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse.

- All clinic providers will prepare and file cost reports. The cost reports must be independently audited for cost and visit data;
- The State will issue notices to all clinic providers no later than December 31, 2009, that providers must maintain beneficiary "threshold visit" data for all payers, in a format that will be independently audited and reported on the provider's annual cost report and/or as a supplemental report for all cost reporting periods beginning on or after January 1, 2010;
- All clinic claims will be subjected to appropriate eMedNY payment edits, which will deny a claim for incorrect and/or inaccurate billing and coding information, starting no later than December 31, 2009;
- The aggregate UPL for each category of clinic (private, state owned or operated, non-state government owned or operated) will be calculated using an average cost per visit or such other method that may be authorized by federal statute or regulation;
- All costs must be costs that would be allowable using Medicare cost reporting and allocation principles;
- The State will remove all costs and payments associated with services that do not meet the definition of a clinic as described in 42 CFR 440.90, for example, transportation, in-home services, etc.;
- The State will provide a progress report to Centers for Medicare and Medicaid Services (CMS) by June 30, 2011 on eMedNY editing, claims coding, and the cost reporting process;
- The State will [provide] submit an addendum to the July 12, 2012 progress report by [December 31, 2011] September 30, 2013 to include the status of providers who submitted 2010 and 2011 audited cost reports, and such audited reports will be provided to CMS based on CMS' sample; and
- The State will submit a full UPL using [2010] 2011 cost data by December 31, [2012] 2013.