DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

June 10, 2010

Donna Frescatore
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Frescatore:

This is to notify you that New York State Plan Amendment (SPA) #09-01 has been approved for adoption into the State Medicaid Plan with an effective date of September 1, 2009. The SPA would establish a new reimbursement methodology, known as Ambulatory Patient Group (APG), for freestanding diagnostic and treatment center (clinic) and ambulatory surgery center services. Reimbursement under APG will be phased in over a four-year period for all clinic services effective September 1, 2009.

This SPA approval consists of 14 Pages. We are approving the following Pages which was submitted with the State's May 28, 2010 electronic submission to the CMS SPA Mailbox: Attachment 4.19-B-Pages 2(h), 2(i), 2(j), 2(k), 2(l), 2(m) 2(n), 2(o), 2(p), 2(q), 2(r), 2(s), 2(t), and 2(u). At that time, New York requested that these 14 Pages replace the Pages which were provided with its SPA submission of September 19, 2008 (originally, only Attachment 4.19-B-Page 2(h), 2(i), 2(j), 2(k), 2(l), 2(m), 2(n), 2(o) and 2(p), a total of 9 Pages, were submitted). These are 14 new Pages; they do not replace any existing State Plan Pages. In addition, in that electronic transmission, New York requested that the originally requested effective date of March 1, 2009 be changed to September 1, 2009. This approval reflects the change in the effective date for 09-01 to September 1, 2009, and the approval is for the 14 newly provided Pages.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of the SPA #09-01 and the HCFA-179, as approved.

If you have any questions or wish to discuss this SPA further, please contact Michael Melendez or Shing Jew of this office. Mr. Melendez may be reached at (212) 616-2430, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

/s/

Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: SPA #09-01
HCFA-179 Form

CC: JUlberg
PMossman
SIrwin
SGaskins
LTavener
GCritelli
PMarra
MSamuel
SJew

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-01**

2. STATE: **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(30) of the Social Security Act, and 42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY **9/1/09-9/30/09 $1,190,000**
b. FFY **10/01/09-9/30/10 $11,000,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 2(h), 2(i), 2(j), 2(k), 2(l), 2(m), 2(n), 2(o), 2(p), 2(q), 2(r), 2(s), 2(t), 2(u)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
APGs (Diagnostic & Treatment Centers) **** SEE REMARKS**

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Donna Frescatore**

14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**

15. DATE SUBMITTED: **May 28, 2010**
(originally submitted September 19, 2008)

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **JUN 10 2010**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **SEP 01 2009**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Sue Kelly**

22. TITLE: **Associate Regional Administrator Division of Medicaid and State Operations**

23. REMARKS:

The following pages were submitted via State's May 28, 2010 electronic submission:

Attachment 4.19-B-Pages 2(h), 2(i), 20), 2(k), 2(1), 2(m) 2(n), 2(o), 2(p), 2(q), 2(r), 2(s), 2(t), and 2(u).
At that time, New York requested that these 14 Pages replace the Pages which were provided with its SPA submission of September 19, 2008 (originally, only Attachment 4.19-B-Page 2(h), 2(i), 2(j), 2(k), 2(1), 2(m), 2(n), 2(o) and 2(p), a total of 9 Pages, were submitted).
These are 14 new Pages; they do not replace any existing State Plan Pages.
In addition, in that electronic transmission, New York requested that the originally requested effective date of March 1, 2009 be changed to September 1, 2009.
This approval reflects the change in the effective date for 09-01 to September 1, 2009, and the approval is for the 14 newly provided Pages.

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New York
2(h)

Attachment 4.19-B
(1/09)

Ambulatory Patient Group System

For dates of service beginning September 1, 2009 through June 30, 2012, 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 on Page 2(m) 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 (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.

The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.

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. APG are defined under 3M's grouping logic outlined in the APG Definitions Manual 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.

TN #09-01 **Approval Date** JUN 10 2010

Supersedes TN New **Effective Date** SEP 01 2009

Ancillary Services shall mean laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment. A list of ancillary services is available on the NYSDOH website at: http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm.

APG Software shall mean the New York State-specific version of the APG computer software developed and published by 3M Health Information Systems (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 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 website. The appropriate link can also be found on the NYSDOH website.

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 coding improvement factors are 10.20 for freestanding clinics, 3.59 for ambulatory surgery centers, 2.14 for renal centers, and 4.57 for dental schools.

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.

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.

"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 U.S. 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.

"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. There are ten DTC peer groups for initial APG implementation: General Clinic upstate; General Clinic downstate; Academic Dental upstate; Academic Dental downstate; Ambulatory Surgery upstate; Ambulatory Surgery downstate; Renal upstate; Renal downstate; Mental Retardation, Developmental Disability, Traumatic Brain Injured upstate; and Mental Retardation, Developmental Disability, Traumatic Brain Injured 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.

"Visit" shall mean a unit of service consisting of all the APG services performed for a patient on a single date of service and related ancillary services.

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Reimbursement Methodology

I. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights shall be updated at least annually based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. The APG's and their relative weights are published on the NYS Department of Health website at: http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proposed_regulations.pdf.

b. The APG relative weights shall be re-weighted prospectively. The initial re-weighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re-weightings will be based on Medicaid hospital 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.

c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

II. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. The initial recalculation of case mix indices will be based on freestanding D&TC and ambulatory surgery center Medicaid data from the January 1, 2009 through November 30, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve month period.

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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 September 1, 2009 through November 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 $13.54 million for dates of service from September 1, 2009 through March 31, 2010, and $12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.

IV. For the period September 1, 2009 to November 30, 2009, the APG base rates shall be calculated using the total operating reimbursement for services and related 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 $13.54 million for dates of service from September 1, 2009 through March 31, 2010, and $12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.

a. For all rate periods subsequent to November 30, 2009, estimated total operating reimbursement for services and related ancillaries 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 September 1, 2009 through November 30, 2009, and subsequent modifications 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. This initial estimate will be adjusted based on Medicaid freestanding D&TC and ambulatory surgery center claims data from the September 1, 2009 through November 30, 2009 period, and subsequent modifications will be based on Medicaid freestanding D&TC and ambulatory surgery center 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.

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V. Rates for new D&TC clinics during the transition period

a. D&TC clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to the Public Health Law 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:

b. For the period September 1, 2009 through December 31, 2009, 75% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;

c. For the period January 1, 2010 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;

d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;

e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;

f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for D&TC clinic claims for each peer group, as defined on Page 2(j) of this plan amendment paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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VI. Rates for new freestanding ambulatory surgery centers during the transition period

a. Freestanding ambulatory surgery centers 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 computed in accordance with the methodology described in item IV on page 2(o) of this plan amendment and shall have the operating cost component of their rates computed in accordance with the following:

b. For the period September 1 2009 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 as described beginning on Page 2(k) of this plan amendment;

c. For the period January 1, 2010 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described beginning on Page 2(k) of this plan amendment;

d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment;

e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described on Page 2(k) of this plan amendment; and

f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for freestanding ambulatory surgery centers services claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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APG Rate Computation

The following is a description of the methodology to be utilized in calculating rates of payment under the Ambulatory Patient Group classification and reimbursement system.

I. Claims containing ICD-9 diagnostic and CPT-4 procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.

II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.

III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.

IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For freestanding clinic services, capital will continue to be paid as an add-on using the existing, previously approved methodology. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2007 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2007 calendar year.

V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., freestanding clinic and ambulatory surgery center services); during the 2007 calendar year and associated ancillary payments will be added to an investment of $13.54 million for dates of service from September 1, 2009 through March 31, 2010, and $12.5 million for each annual period thereafter to form the numerator. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

The following is an example of a sample APG base rate calculation:

a.	2007 Peer Group Reimbursement	$51,000,000
b.	Additional Investment	$25,000,000
c.	Case Mix Index	8.1610
d.	Coding Improvement Factor	1.05
e.	2007 Base Year Visits	50,000

($51,000,000 + $25,000,000) / (8.1610 x 1.05 x 50,000) = $177.38 (Base Rate)

VI. During the transition period, reimbursement for freestanding clinic and ambulatory surgery center services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending December 31, 2009), 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. During 2010, the blend will be 50/50. During 2011, the blend will be 75/25. Payments will be based upon 100% of the APG operating component beginning on January 1, 2012. Per the enabling statute, as new services the Education APGs and the Extended Hours APGs are not subject to the blend requirement.

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New York
2(q)

Attachment 4.19-B
(1/09)

The following shall be excluded from the APG reimbursement system:

- Drugs and other pharmaceutical products and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007, and as set forth by the Department in written billing instructions issued to providers.
- HIV counseling and testing visits, HIV counseling (no testing), post-test HIV counseling visits (positive results), day health care service (HIV).
- TB/directly observed therapy - downstate levels 1 and 2, TB/directly observed therapy.
- Upstate levels 1 and 2, AIDS clinic therapeutic visits in general hospital outpatient clinics.
- Child rehabilitation services provided under rate code 2887 in general hospital outpatient clinics.
- Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.
- Visits solely for the purpose of receiving ordered ambulatory services.
- Visits solely for the purpose of receiving pharmacy services.
- Visits solely for the purpose of receiving education or training services, except with regard to services authorized pursuant to clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving services from licensed social workers, except with regard to psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving group services, except with regard to clinical group psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system and provided, however, that reimbursement for such group services shall be determined in accordance with state regulation.
- Offsite services, defined as medical services provided by a facility's outpatient staff at locations other than those operated by and under the facility's licensure under Article 28 of the Public Health Law, or visits related to the provision of such offsite services, except with regard to offsite services provided by Federally Qualified Health Centers or Rural Health Centers.

TN # 09-01 **Approval Date** JUN 10 2010

SEP 01 2009

Supersedes TN New New **Effective Date**

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The following APGs shall not be eligible for reimbursement through the APG system:

065	RESPIRATORY THERAPY
066	PULMONARY REHABILITATION
094	CARDIAC REHABILITATION
117	HOME INFUSION
118	NUTRITION THERAPY
190	ARTIFICIAL FERTILIZATION
311	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
312	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
313	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
314	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
319	ACTIVITY THERAPY
320	CASE MANAGEMENT - MENTAL HEALTH OR SUBSTANCE ABUSE
371	ORTHODONTICS
427	BIOFEEDBACK AND OTHER TRAINING
430	CLASS I CHEMOTHERAPY DRUGS
431	CLASS II CHEMOTHERAPY DRUGS
432	CLASS III CHEMOTHERAPY DRUGS
433	CLASS IV CHEMOTHERAPY DRUGS
434	CLASS V CHEMOTHERAPY DRUGS
450	OBSERVATION
452	DIABETES SUPPLIES
453	MOTORIZED WHEELCHAIR
454	TPN FORMULAE
456	MOTORIZED WHEELCHAIR ACCESSORIES
492	DIRECT ADMISSION FOR OBSERVATION INDICATOR
500	DIRECT ADMISSION FOR OBSERVATION - OBSTETRICAL
501	DIRECT ADMISSION FOR OBSERVATION - OTHER DIAGNOSES
999	UNASSIGNED

The following APGs shall not be eligible for reimbursement when they are presented as the only APG or APGs applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in the list of APGs not eligible for reimbursement:

280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY
284	MYELOGRAPHY
285	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
286	MAMMOGRAPHY
287	DIGESTIVE RADIOLOGY
288	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES
289	VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES
290	PET SCANS
291	BONE DENSITOMETRY
298	CAT SCAN - BACK
299	CAT SCAN - BRAIN
300	CAT SCAN - ABDOMEN
301	CAT SCAN - OTHER
302	ANGIOGRAPHY, OTHER
303	ANGIOGRAPHY, CEREBRAL
330	LEVEL I DIAGNOSTIC NUCLEAR MEDICINE
331	LEVEL II DIAGNOSTIC NUCLEAR MEDICINE
332	LEVEL III DIAGNOSTIC NUCLEAR MEDICINE
380	ANESTHESIA
390	LEVEL I PATHOLOGY
391	LEVEL II PATHOLOGY
392	PAP SMEARS
393	BLOOD AND TISSUE TYPING
394	LEVEL I IMMUNOLOGY TESTS
395	LEVEL II IMMUNOLOGY TESTS
396	LEVEL I MICROBIOLOGY TESTS
397	LEVEL II MICROBIOLOGY TESTS
398	LEVEL I ENDOCRINOLOGY TESTS
399	LEVEL II ENDOCRINOLOGY TESTS
400	LEVEL I CHEMISTRY TESTS
401	LEVEL II CHEMISTRY TESTS
402	BASIC CHEMISTRY TESTS
403	ORGAN OR DISEASE ORIENTED PANELS
404	TOXICOLOGY TESTS
405	THERAPEUTIC DRUG MONITORING

406 LEVEL I CLOTTING TESTS
407 LEVEL II CLOTTING TESTS
408 LEVEL I HEMATOLOGY TESTS
409 LEVEL II HEMATOLOGY TESTS
410 URINALYSIS
411 BLOOD AND URINE DIPSTICK TESTS
413 CARDIOGRAM
414 LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY
415 LEVEL II IMMUNIZATION
416 LEVEL III IMMUNIZATION
435 CLASS I PHARMACOTHERAPY
436 CLASS II PHARMACOTHERAPY
437 CLASS III PHARMACOTHERAPY
438 CLASS IV PHARMACOTHERAPY
439 CLASS V PHARMACOTHERAPY
451 SMOKING CESSATION TREATMENT
455 IMPLANTED TISSUE OF ANY TYPE
457 VENIPUNCTURE
470 OBSTETRICAL
471 PLAIN FILM
472 ULTRASOUND GUIDANCE
473 CT GUIDANCE

System updating

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable ICD-9-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.

OFFICIAL

New York
2(u)

Attachment 4.19-B
(01/09)

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 Services.

- 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 CMS;
- 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 an interim UPL based on 2009 data to CMS by January 1, 2012; and
- The State will submit a full UPL using 2010 cost data by June 30, 2012.

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