Hospital APG Base Rates

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Service Type	**Region**	**Phase 1 July 2009**	**Phase 2 Dec 2009**	**Phase 2 Jan 2010**	**Phase 2 July 2010**
OPD/SBHC	Downstate	$258.90	$199.18	$206.48	$204.33
OPD/SBHC	Upstate	$199.00	$153.11	$158.71	$157.07
Amb Surg	Downstate	$156.91	$156.91	$228.00	$215.50
Amb Surg	Upstate	$122.55	$122.55	$176.13	$166.47
ED	Downstate	$175.11	$175.11	$196.94	$184.98
ED	Upstate	$135.27	$135.27	$153.81	$144.47
Note: Once CMS approves the additional investments that have been requested, the base rates from Dec 2009 and forward will be revised to reflect the increased investment levels.					

Free-standing DTCs

- APG episode rate codes will be loaded to provider rate files with an effective date of April 1, 2011.
- Claims with more than 44 lines could not be reprocessed under the APG rate code in the automatic claim reprocessing of subsumed rate codes. If providers identify claims which were not reprocessed under the APG rate codes, they will need to resubmit the claims under the APG rate code in order for them to process correctly.
- The zeroing out of subsumed rate codes is delayed until April 1, 2011. In April, the rates for subsumed rate codes will be zeroed out with an effective date of September 1, 2009.

APG Changes in 2011

<u>APG Implementation Dates</u>

- Hospital-based mental hygiene services (except MMTP and OASAS Outpatient Rehab services) move to APGs on October 1, 2010 – retroactively upon CMS approval.
- Hospital OASAS Outpatient Rehab services moved to APGs on Jan 1, 2011.
- Hospital MMTP services moved to APGs on Jan 3, 2011.
- The APG start dates for free-standing mental hygiene services are as follows:
    - OMH – October 1, 2010

- OASAS and OPWDD – July 1, 2011
- MMTP – July 4, 2011

Hospital OPD MR/DD/TBI rate codes

- The OPD MR/DD/TBI rate codes (1489 (episode) and 1501(visit)) were loaded to the APG Grouper-Pricer on December 9, 2010 and are effective July 1, 2010.
- The rates in the system for rate codes 1489 and 1501 are the same as the existing OPD base rates.
- Providers should begin to use the OPD MR/DD/TBI rate codes for RE code 95 or 81 persons and may adjust their claims retroactively to this rate code as appropriate.
- Once DOH receives CMS approval for the proposed enhanced rates (20% higher than the current rates), the rate amounts assigned to rate codes 1489 and 1501 will be adjusted to the enhanced rates.

New APG Drug Levels

- Pharmacotherapy classifications will expand from 7 to 13 levels.
- The expanded APG levels will enable further refinement of payment to better reflect actual cost and promote better access to physician administered drugs.
- Level 13 drugs are carved out of APGs.
- Cancer drugs will continue to be carved out of APGs.
- Class 1 pharmacotherapy drugs will continue to package and their payment/cost will be reflected in the weight of the APGs paid for the visit.

New APG Statewide Base Rate

- APGs will have a new statewide base rate feature to reimburse providers for certain APGs (Drugs, Radiology, Lab, Devices) comprised of procedures that have minimal regional cost variation.
- This new feature will enable the APG grouper-pricer to reimburse providers a fixed amount across all regions of the state and all provider types.

- The statewide base rate for 2011 is $165.00.
- A list of the statewide base rate APGs is available at this link: http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/statewide_base_rate.pdf

New Fee Schedule Capability

- A new fee schedule feature will be built into the APG grouper-pricer which allows reimbursement of a fixed amount irrespective of setting or region of the state on a procedure specific basis. This can include units based reimbursement
- Procedures that pay based on a fee schedule will not be eligible for a blended payment or a capital add-on.
- Providers will code charges on all lines for fee schedule procedures and will be paid the lower of the fee schedule or charge amount.
- Beginning January 1, 2011 the following procedures will utilize the new fee schedule feature:

HCPCS Code	HCPCS Code Description	Jan 2011 Fee Schedule Amount	Units Limit
V2600	Hand held low vision aids	$ 150.00	1
V2610	Single lens spectacle mount	$ 545.00	1
V2615	Telescop/other compound lens	$ 835.00	1
J0475	Baclofen 10 MG injection	$ 176.50	8

System Issues

- The January 2011 grouper-pricer will include corrections to APG weight problems for the following APGs:

APG	APG Description	Retroactive Effective Period
250	Cochlear Implant	10/1/2010 to 12/31/2010
377	Preventive Dental Procedures	4/1/2009 to 12/31/2009
671	Major Skin Disorders	10/1/2010 to present
672	Malignant Breast Disorders	10/1/2010 to present

The NYS DOH will request a special input to reprocess the claims with APGs 250 and 377. Since claims with APGs 671 and 672 and dates of service after October 1, 2010 are denied, providers will need to resubmit the claims after the January 2011 grouper-pricer is released.

Packaging/Payment Changes in January 2011

- APG 404 Toxicology and APG 457 Venipuncture will be added to the "Uniform Packaging Ancillary" list so that neither will pay on a line basis but the payment/cost will be reflected in the APGs paid for the visit.
- Essure - HCPCS code A4264 "Permanent implantable contraceptive intratubal occlusion device and delivery system" and the associated implantation code (58565) will be carved out of APGs and paid off the Ordered Ambulatory Fee Schedule.
- CPT 96040 Genetic counseling, 30 min. will pay based on a procedure-based weight and will pay up to a maximum of 4 units. No capital or blend payment will be made for this procedure.
- CPT 97542 Wheelchair Management Training, 15 min. will have its maximum units increased to 8.

Dental Surgery

- For Jan 2011, the weight for APG 375 Dental Anesthesia will be adjusted so that it pays approximately $545 (statewide average).
- In order to be reimbursed for dental anesthesia, hospitals or free-standing ambulatory surgery centers must code one of the four D codes grouping to APG 375 on their dental surgery claim.
- In April 1, 2011 the weight for APG 375 will be further increased so that it pays approximately $908 (statewide average) to address the higher costs of treating individuals with developmental disabilities for dental surgery.
- The payment for APG 375 is just for anesthesia. Additional codes on the APG claim will provide the hospital or free-standing ambulatory surgery center with additional reimbursement.

HIV/AIDS rate codes into APGs delayed until April 1, 2011

- The rate codes for HIV/AIDS counseling and testing services in hospital outpatient departments (2983, 3111 and 3109) and diagnostic and treatment centers (1695, 1802, and 3109) will be subsumed into the APG payment system effective April 1, 2011.

Implementation of the Federal National Correct Coding Initiative (NCCI) edits

- The edits will be implemented on a “pay and report” basis on Jan 1, 2011 and after. The edits will be set to deny on or before April 1, 2011.