

Summary of Express Terms

General Summary for 86-8.1 through 86-8.12

The amendments to Part 86 adding sections 86-8.1 through 86-8.12 of Title 10 (Health) NYCCR are required to implement a new payment methodology for certain ambulatory care fee-for-service (FFS) Medicaid services based on Ambulatory Patient Groups (APGs). APGs group together procedures and medical visits that share similar characteristics and resource utilization patterns so as to pay for services based on relative intensity.

86-8.1 – Scope of services and effective dates

The proposed addition of section 86-8.1 of Title 10 (Health) NYCCR defines the categories of facilities subject to APGs and the time frames for implementation.

Outpatient services and ambulatory surgery services provided by general hospitals will be subject to the new payment methodology on and after December 1, 2008. Emergency department services provided by general hospitals will be subject to the new payment methodology on and after January 1, 2009. Ambulatory services provided by diagnostic and treatment centers and free-standing ambulatory surgery center services will be subject to the new payment methodology on and after March 1, 2009. However, this new payment methodology does not apply to: Federally Qualified Health Centers except when they voluntarily agree to participate; services which are not provided pursuant to a facility's licensure under article 28 of the public health law; payments on behalf of Medicaid managed care and family health plus enrollees; and facilities located outside New York State.

86-8.2 – Definitions

The proposed addition of section 86-8.2 of Title 10 (Health) NYCCR provides definitions for the following components of the new reimbursement methodology: Ambulatory Patient Group (APG); Allowed APG weight; APG relative weight; Base rate; Consolidation; Current Procedure Terminology, fourth edition (CPT-4); Discounting; APG software system; Final APG weight; International Classification of Diseases, 9th Revision (ICD-9); Packaging; Downstate region; Upstate region; Significant procedure APG; Medical visit APG; Visit; Peer Group; Ambulatory surgery permissible procedures; Ancillary services, and Case mix index.

86-8.3 Record keeping, reports and audits

The proposed addition of section 86-8.3 of Title 10 (Health) NYCCR requires general hospitals, diagnostic and treatment centers, and free-standing ambulatory surgery centers which are governed by this Subpart will continue to maintain financial and statistical data and records in accordance with regulations as set forth in Subpart 86-1 and 86-4 of this Part, as applicable. Affected providers will continue to submit cost reports, and make records and books available to the Department for audit.

86-8.4 Capital cost reimbursement

The proposed addition of section 86-8.4 of Title 10 (Health) NYCCR requires that a capital cost component be added to Medicaid payments. The computation of the capital cost component of payments for general hospital outpatient and emergency services and diagnostic and treatment center services shall remain subject to otherwise applicable statutory provisions. The computation of the capital cost component of payments for ambulatory surgery services provided by hospital-based and free-standing ambulatory surgery centers shall be the result of dividing the total capital cost reimbursement paid to each such facilities for the 2005 calendar

year (CY) for upstate region and downstate region, respectively, and then dividing each regional amount by the total number of claims paid within each such region for the 2005 CY.

86-8.5 Administrative rate appeals

The proposed addition of section 86-8.5 of Title 10 (Health) NYCCR requires that administrative rate appeals of rates of payment must be submitted to the Department in writing within 120 days of the date such rates are published by the Department to the facility. Each rate appeal submitted to the Department must set forth the basis for the appeal and must be accompanied by relevant documentation. The Department will respond by affirming the original rates, revising the rates or requesting additional information. Failure of a provider to respond to the Department's request for additional information within 30 days will constitute a withdrawal of the appeal unless the Department grants an extension.

The Department's written response to a facility's rate appeal will be considered final unless a written request for further consideration is submitted within 30 days of the ruling, provided, however, that the Department's denial of an appeal on the grounds that it constitutes a challenge to the rate-setting methodology shall be considered final and there shall be no further administrative review available. Otherwise, the Department will respond in writing to the request for further consideration of the appeal and either affirm or revise its original rate appeal determination.

86-8.6 - Rates for new facilities during the transition period

The proposed addition of section 86-8.6 of Title 10 (Health) NYCCR stipulates that 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 section 2807(2) are not available, will 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:

A) for the period December 1, 2008 through December 31, 2009, 75% of such rates will reflect the historical 2007 regional average payment per visit as calculated by the department, and 25% of such rates will reflect APG rates as computed in accordance with this Subpart;

B) 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 computed in accordance with this Subpart;

C) 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 computed in accordance with this Subpart;

D) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

Further, Diagnostic and Treatment Centers which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to public health law section 2807(2) are not available, will have their 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 cost component of their rates computed in accordance with the following:

A) for the period March 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 computed in accordance with this Subpart;

B) 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 computed in accordance with this Subpart;

C) 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 computed in accordance with this Subpart;

D) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

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 section 2807(2) are not available, will have the capital cost component of their rates based computed in accordance with section 86-8.4 of this subpart and the operating cost component of their rates computed in accordance with the following:

A) for the period March 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 shall reflect APG rates as computed in accordance with this Subpart;

B) 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 computed in accordance with this Subpart;

C) 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 computed in accordance with this Subpart;

D) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

86-8.7 APGs and relative weights

The proposed addition of section 86-8.7 of Title 10 (Health) NYCCR provides a listing of APGs utilized in their relative weights.

86-8.8 Base rates

The proposed addition of section 86-8.8 of Title 10 (Health) NYCCR delineates the methodology for establishing APG base rates under the APG system. Separate base rates shall be established for each of the five categories of providers set forth in subdivision (a) of section 86-8.1 of this subpart. Further, separate rates for each of the five categories of providers shall be established based on the location of such providers in the upstate region or the downstate region and shall reflect differing regional cost factors as determined by the Department. Additional

discrete base rates may be developed by the Department for such peer groups as may be established in regulation. Base rates will be established based on estimated historical per visit payment amounts, adjusted to reflect the level of State appropriations made available for such purposes and calculated on a per visit basis utilizing the same historical visit volume. Base rates shall be peer group specific and reflect the estimated case mix index for each peer group and any projected changes in provider coding patterns for each peer group. These base rates may be periodically adjusted to reflect changes in provider coding patterns and case mix.

86-8.9 Diagnostic coding and rate computation

The proposed addition of section 86-8.9 of Title 10 (Health) NYCCR requires that facilities assign and submit ICD-9 diagnostic codes and HCPCS/CPT procedure codes to each claim as appropriate in accordance with written billing and reporting instructions issued by the Department. The Department will use the claim coding information to assign APG(s) for each patient visit identified on the claim, utilizing the APG software system to determine the significant procedure APG or the medical visit APG, the applicable ancillary services APGs and the final APG weight applicable to each such visit. The APG software system will incorporate methodologies for consolidation, packaging and discounting to be reflected in the final APG weight to be assigned to each patient visit on the claim.

The operating component of the payment rate will be computed by multiplying the final APG weight for each visit by the applicable base rate. A capital component will then be added to each such payment.

The Department's written billing and reporting instructions will define ambulatory surgery permissible procedures to which the ambulatory surgery rates apply. No visits may be

billed as ambulatory surgery unless at least one procedure designated as ambulatory surgery permissible appears on the claim for the date of service for the visit.

In cases where the only reimbursable APGs for a visit are one or more ancillary service APGs, there shall be no reimbursement for capital costs included in the payment for that visit.

86-8.10 Exclusions from payment

The proposed addition of section 86-8.10 of Title 10 (Health) NYCCR stipulates which payments are not subject to the APG payment methodology, including:

- A) Drugs and other pharmaceutical products; HIV counseling and testing visits; 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; and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007,
- B) Visits solely for the purpose of receiving ordered ambulatory services.
- C) Visits solely for the purpose of receiving pharmacy services.
- D) 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 section 2807 of the Public Health Law.
- E) 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 subject to reimbursement pursuant to this Subpart.

F) 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 subject to reimbursement pursuant to this Subpart and provided, however, that reimbursement for such group services shall be determined in accordance with paragraph (h) of section 86-4.9 of this Title.

G) 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 and provided, however, that reimbursement for such offsite services shall be determined in accordance with paragraph (i) of section 86-4.9 of this Title.

H) Specific listed APGs not eligible for payment in the initial implementation.

I) Specific listed APGs not eligible for reimbursement when they are presented as the only APG applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in subdivision (h).

86-8.11 System updating and incorporation by reference

The proposed addition of section 86-8.11 of Title 10 (Health) NYCCR stipulates that the following elements of the APG rate-setting system will be updated no less frequently than every three years:

A) The listing of reimbursable APGs and the relative weight assigned to each such APG;

B) base rates;

C) applicable ICD-9 codes utilized in the APG software system;

D) applicable CPT-4/HCPCS codes utilized in the APG software system, and

E) the APG software system

This proposed section also incorporates by reference the ICD-9-CM, HCPCS and CPT-4 code systems utilized in the APG rate-setting system.

86-8.12 Payments for extended hours of operation during the transition period

The proposed addition of section 86-8.12 of Title 10 (Health) NYCCR stipulates that for visits provided on or after January 1, 2009, by hospital outpatient clinics and Diagnostic and Treatment Centers which are scheduled and occur on evenings, weekends and on holidays as specified by the Department, a supplemental APG payment amount shall be added on to the otherwise applicable payment amount for each such visit.

Pursuant to the authority vested in the Commissioner of Health by Section 2807(2-a) of the Public Health Law, Part 86 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new Subpart 86-8, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

SUBPART 86-8

OUTPATIENT SERVICES: AMBULATORY PATIENT GROUP

(Statutory authority: Public Health Law § 2807(2-a)(e))

Sec.

- 86-8.1 Scope
- 86-8.2 Definitions
- 86-8.3 Record keeping, reports and audits
- 86-8.4 Capital reimbursement
- 86-8.5 Administrative rate appeals
- 86-8.6 Rates for new facilities during the transition period
- 86-8.7 APGs and relative weights
- 86-8.8 Base rates
- 86-8.9 Diagnostic coding and rate computation
- 86-8.10 Exclusions from payment
- 86-8.11 System updating
- 86-8.12 Payments for extended hours of operation

§ 86-8.1 Scope

(a) This Subpart shall govern Medicaid rates of payments for ambulatory care services provided in the following categories of facilities for the following periods:

(1) outpatient services provided by general hospitals on and after December 1, 2008;

(2) emergency department services provided by general hospitals on and after January 1, 2009;

(3) ambulatory surgery services provided by general hospitals on and after December 1, 2008;

(4) ambulatory services provided by diagnostic and treatment centers on and after March 1, 2009; and

(5) ambulatory surgery services provided by free-standing ambulatory surgery centers on and after March 1, 2009.

(b) Notwithstanding subdivision (a) of this section, the provisions of this Subpart shall not apply to the following:

(1) facilities whose Medicaid reimbursement is governed by subdivision 8 of section 2807 of the public health law, except when the provisions of this Subpart are made applicable pursuant to paragraph (f) of such subdivision;

(2) payments for services which are not provided pursuant to a facility's licensure under article 28 of the public health law;

(3) payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program; and

(4) payments made to facilities located outside the boundaries of New York State.

§ 86-8.2 Definitions

As used in this Subpart, the following definitions shall apply:

- (a) Ambulatory Patient Group (“APG”) shall mean a defined group of outpatient procedures, encounters or ancillary services, as specifically identified and published by the Department, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis codes and CPT-4 and HCPCS procedure codes, as defined below;
- (b) Allowed APG weight shall mean the relative resource utilization for a given APG after adjusting for consolidation, packaging, and discounting.
- (c) 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.
- (d) Base rates shall mean the numeric value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG relative weight to determine the total allowable Medicaid operating payment for a visit.
- (e) Consolidation, also known as “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.
- (f) 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 and HCPCS are maintained by the American Medical Association and the federal Centers for Medicare and Medicaid Services and are updated annually.
- (g) Discounting shall mean the reduction in APG payment that results when unrelated additional procedures or ancillary services are performed during a single patient visit.

(h) APG Software System shall mean the New York State-specific version of the APG computer software developed and published by Minnesota Mining and Manufacturing Corporation (3M) to process CPT-4 and ICD-9 code information in order to assign patient visits to the appropriate APG category or categories and apply appropriate bundling, packaging and discounting to assign the appropriate final APG weight and associated reimbursement.

(i) Final APG Weight shall mean the allowed APG weight for a given visit as expressed in the applicable APG software, and as adjusted by all applicable consolidation, packaging and discounting and other applicable adjustments.

(j) International Classification of Diseases, 9th Revision (ICD-9) 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 diagnoses, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

(k) 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.

(l) The Downstate Region shall consist of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

(m) The Upstate Region shall consist of all counties in the State other than those counties included in the Downstate Region.

(n) Significant procedure APG shall mean an APG incorporating a medical procedure that constitutes the primary reason for the visit in terms of time and resources expended.

(o) Medical visit APG shall mean an APG representing a visit during which a patient received medical treatment, but did not have a significant procedure performed.

(p) Visit shall mean a unit of service consisting of all the APG services performed for a patient on a single 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.

(q) Peer Group shall mean a group of providers that share a common APG base rate. Peer groups may be established based on geographic region, types of services provided or categories of patients.

(r) Ambulatory surgery permissible procedures shall mean those surgical procedures designated by the Department as reimbursable as ambulatory surgery pursuant to this Subpart.

(s) Ancillary services APGs shall mean those APGs designated by the Department as reflecting those tests and procedures ordered by physicians to assist in patient diagnosis and/or treatment.

(t) Case mix index shall mean the actual or estimated average final APG weight for a defined group of APG visits.

§ 86-8.3 Record keeping, reports and audits

(a) General hospitals whose rates of payments are governed by this Subpart shall:

(1) continue to maintain financial and statistical data and records in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-1 of this Part;

(2) continue to submit to the Department all cost reports and other information in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-1 of this Part;

(3) continue to have all books and records subject to audit in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-1 of this Part.

(b) Diagnostic and treatment centers and free-standing ambulatory surgery centers whose rates of payments are governed by this Subpart shall:

(1) continue to maintain financial and statistical data and records in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-4 of this Part;

(2) continue to submit to the Department all cost reports and other information in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-4 of this Part;

(3) continue to have all books and records subject to audit in accordance with otherwise applicable statutes and regulations, including, but not limited to, regulations as set forth in Subpart 86-4 of this Part.

§ 86-8.4 Capital cost reimbursement

A capital cost component shall be added to Medicaid payments made pursuant to this Subpart and computed in accordance with the following:

(a) The computation of the capital cost component for payments for general hospital outpatient and emergency services shall remain subject to otherwise applicable statutory provisions as set forth in subparagraphs (i) and (ii) of paragraph (g) of subdivision 2 of section 2807 of the public health law.

(b) The computation of the capital cost component for payments for diagnostic and treatment center services shall remain subject to otherwise applicable statutory provisions as set forth in paragraph (b) of subdivision 2 of section 2807 of the public health law.

(c) The computation of the capital cost component for payments for ambulatory surgery services provided by hospital-based and free-standing ambulatory surgery centers shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to Section 86-4.40 of this Title for the 2005 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 pursuant to such Section 86-4.40 within each such region for the 2005 calendar year.

§ 86-8.5 Administrative rate appeals

(a) Administrative rate appeals of rates of payment issued pursuant to this Subpart must be submitted to the Department in writing within 120 days of the date such rates are published by the Department to the facility. Such rate appeals must set forth in detail the basis for such appeal and be accompanied by any relevant documentation. Thereafter the Department shall respond to such rate appeals in writing and shall either affirm the original rates, revise such rates or request additional information. A failure to respond to the Department's request for additional information within 30 days shall be deemed to constitute the withdrawal, with prejudice, of the facility's rate appeal, provided, however, that the Department may extend that time period upon a request by the facility and for good cause shown. Upon its receipt of the requested additional information the Department shall issue a written determination of such rate appeal.

(b) The Department's written determination of a facility's rate appeal shall be deemed final unless the facility submits a written request for further consideration of the rate appeal within 30 days of the date the Department issued such written determination, provided, however, that if

such written determination advises the facility that its rate appeal is being denied on the ground that the appeal constitutes a challenge to the rate-setting methodology set forth in this subpart such denial shall be deemed to be the Department's final administrative determination with regard to such appeal and there shall be no further administrative review available. The Department shall otherwise respond in writing to the facility's request for further consideration and either affirm or revise its original rate appeal determination and this response by the Department shall be deemed its final administrative determination with regard to such rate appeal.

§ 86-8.6 Rates for new facilities during the transition period

(a) 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 section 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:

(1) 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;

(2) 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 computed in accordance with this Subpart;

(3) 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 computed in accordance with this Subpart;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) For the purposes of this subdivision, the historical 2007 regional average payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for general hospital outpatient clinic 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 except those specifically excluded pursuant to section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

(b) Diagnostic and treatment centers which commence operation after December 31, 2007 and prior to January 1, 2012, and for which rates computed pursuant to public health law section 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 cost component of their rates computed in accordance with the following:

(1) for the period March 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 computed in accordance with this Subpart;

(2) 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 computed in accordance with this Subpart;

(3) 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 computed in accordance with this Subpart;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) 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 diagnostic and treatment center claims for each peer group, as defined in section 86-4.13 of this Part, paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology except those specifically excluded pursuant to section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

(c) Free-standing 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 section 2807(2) are not available shall have the capital cost component of their rates computed in accordance with section 86-8.4(c) of this Subpart and shall have the operating cost component of their rates computed in accordance with the following:

(1) for the period March 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 shall reflect APG rates as computed in accordance with this Subpart;

(2) 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 computed in accordance with this Subpart;

(3) 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 computed in accordance with this Subpart;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) For the purposes of this subdivision, the historical 2007 regional average payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for free-standing ambulatory surgery centers 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 except those specifically excluded pursuant to section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

§ 86-8.7 APGs and relative weights

(a) The APGs and each associated relative weight in effect for the period beginning December 1, 2008, are:

<u>APG</u>	<u>APG Description</u>	<u>Weight</u>
<u>1</u>	<u>Photochemotherapy</u>	<u>0.4974</u>
<u>2</u>	<u>Superficial Needle Biopsy And Aspiration</u>	<u>5.7662</u>
<u>3</u>	<u>Level I Skin Incision And Drainage</u>	<u>2.2638</u>
<u>4</u>	<u>Level II Skin Incision And Drainage</u>	<u>6.3519</u>
<u>5</u>	<u>Nail Procedures</u>	<u>0.8389</u>
<u>6</u>	<u>Level I Skin Debridement And Destruction</u>	<u>1.5306</u>
<u>7</u>	<u>Level II Skin Debridement And Destruction</u>	<u>5.6395</u>

<u>8</u>	<u>Level III Skin Debridement And Destruction</u>	<u>6.0904</u>
<u>9</u>	<u>Level I Excision And Biopsy Of Skin And Soft Tissue</u>	<u>4.1402</u>
<u>10</u>	<u>Level II Excision And Biopsy Of Skin And Soft Tissue</u>	<u>7.7910</u>
<u>11</u>	<u>Level III Excision And Biopsy Of Skin And Soft Tissue</u>	<u>13.4426</u>
<u>12</u>	<u>Level I Skin Repair</u>	<u>2.0269</u>
<u>13</u>	<u>Level II Skin Repair</u>	<u>10.5571</u>
<u>14</u>	<u>Level III Skin Repair</u>	<u>10.5571</u>
<u>15</u>	<u>Level IV Skin Repair</u>	<u>10.8329</u>
<u>20</u>	<u>Level I Breast Procedures</u>	<u>9.8221</u>
<u>21</u>	<u>Level II Breast Procedures</u>	<u>12.7319</u>
<u>22</u>	<u>Level III Breast Procedures</u>	<u>18.3671</u>
<u>30</u>	<u>Level I Musculoskeletal Procedures Excluding Hand And Foot</u>	<u>8.3113</u>
<u>31</u>	<u>Level II Musculoskeletal Procedures Excluding Hand And Foot</u>	<u>10.3281</u>
<u>32</u>	<u>Level III Musculoskeletal Procedures Excluding Hand And Foot</u>	<u>13.1830</u>
<u>33</u>	<u>Level I Hand Procedures</u>	<u>7.8928</u>
<u>34</u>	<u>Level II Hand Procedures</u>	<u>10.7450</u>
<u>35</u>	<u>Level I Foot Procedures</u>	<u>10.1117</u>
<u>36</u>	<u>Level II Foot Procedures</u>	<u>10.2147</u>
<u>37</u>	<u>Level I Arthroscopy</u>	<u>11.5379</u>
<u>38</u>	<u>Level II Arthroscopy</u>	<u>17.9246</u>
<u>39</u>	<u>Replacement Of Cast</u>	<u>1.6870</u>
<u>40</u>	<u>Splint, Strapping And Cast Removal</u>	<u>1.6166</u>
<u>41</u>	<u>Closed Treatment Fx & Dislocation Of Finger, Toe & Trunk</u>	<u>3.4623</u>

<u>42</u>	<u>Closed Treatment Fx & Dislocation Exc Finger, Toe & Trunk</u>	<u>2.8556</u>
<u>43</u>	<u>Open Or Percutaneous Treatment Of Fractures</u>	<u>12.3224</u>
<u>44</u>	<u>Bone Or Joint Manipulation Under Anesthesia</u>	<u>6.5896</u>
<u>45</u>	<u>Bunion Procedures</u>	<u>14.8239</u>
<u>46</u>	<u>Level I Arthroplasty</u>	<u>8.1577</u>
<u>47</u>	<u>Level II Arthroplasty</u>	<u>8.1597</u>
<u>48</u>	<u>Hand And Foot Tenotomy</u>	<u>9.4465</u>
<u>49</u>	<u>Arthrocentesis And Ligament Or Tendon Injection</u>	<u>1.6853</u>
<u>60</u>	<u>Pulmonary Tests</u>	<u>1.0413</u>
<u>61</u>	<u>Needle And Catheter Biopsy, Aspiration, Lavage And Intubation</u>	<u>5.8355</u>
<u>62</u>	<u>Level I Endoscopy Of The Upper Airway</u>	<u>2.2767</u>
<u>63</u>	<u>Level II Endoscopy Of The Upper Airway</u>	<u>11.1571</u>
<u>64</u>	<u>Endoscopy Of The Lower Airway</u>	<u>7.8804</u>
<u>65</u>	<u>Respiratory Therapy</u>	<u>0.0000</u>
<u>66</u>	<u>Pulmonary Rehabilitation</u>	<u>0.0000</u>
<u>67</u>	<u>Ventilation Assistance And Management</u>	<u>2.5126</u>
<u>80</u>	<u>Exercise Tolerance Tests</u>	<u>1.1689</u>
<u>81</u>	<u>Echocardiography</u>	<u>2.6278</u>
<u>82</u>	<u>Cardiac Electrophysiologic Tests</u>	<u>11.5958</u>
<u>83</u>	<u>Placement Of Transvenous Catheters</u>	<u>9.5834</u>
<u>84</u>	<u>Diagnostic Cardiac Catheterization</u>	<u>12.6153</u>
<u>85</u>	<u>Angioplasty And Transcatheter Procedures</u>	<u>14.0636</u>
<u>86</u>	<u>Pacemaker Insertion And Replacement</u>	<u>32.3512</u>

<u>87</u>	<u>Removal And Revision Of Pacemaker And Vascular Device</u>	<u>23.0197</u>
<u>88</u>	<u>Level I Cardiothoracic Procedures</u>	<u>10.8885</u>
<u>89</u>	<u>Level II Cardiothoracic Procedures</u>	<u>15.6179</u>
<u>90</u>	<u>Secondary Varicose Veins And Vascular Injection</u>	<u>2.8374</u>
<u>91</u>	<u>Vascular Ligation And Reconstruction</u>	<u>13.4829</u>
<u>92</u>	<u>Resuscitation</u>	<u>2.1938</u>
<u>93</u>	<u>Cardioversion</u>	<u>4.9369</u>
<u>94</u>	<u>Cardiac Rehabilitation</u>	<u>0.0000</u>
<u>95</u>	<u>Thrombolysis</u>	<u>1.6870</u>
<u>96</u>	<u>Atrial And Ventricular Recording And Pacing</u>	<u>7.2120</u>
<u>97</u>	<u>Aicd Implant</u>	<u>39.6069</u>
<u>98</u>	<u>Transcatheter Placement Of Intravenous Shunts</u>	<u>1.0337</u>
<u>110</u>	<u>Pharmacotherapy By Extended Infusion</u>	<u>2.1341</u>
<u>111</u>	<u>Pharmacotherapy Except By Extended Infusion</u>	<u>1.7606</u>
<u>112</u>	<u>Phlebotomy</u>	<u>0.9094</u>
<u>113</u>	<u>Level I Blood And Blood Product Exchange</u>	<u>2.6812</u>
<u>114</u>	<u>Level II Blood And Blood Product Exchange</u>	<u>3.3584</u>
<u>115</u>	<u>Deep Lymph Structure And Thyroid Procedures</u>	<u>10.2770</u>
<u>116</u>	<u>Allergy Tests</u>	<u>1.9176</u>
<u>117</u>	<u>Home Infusion</u>	<u>0.0000</u>
<u>118</u>	<u>Nutrition Therapy</u>	<u>0.0000</u>
<u>130</u>	<u>Alimentary Tests And Simple Tube Placement</u>	<u>2.8788</u>
<u>131</u>	<u>Esophageal Dilation Without Endoscopy</u>	<u>4.3770</u>

<u>132</u>	<u>Anoscopy With Biopsy And Diagnostic Proctosigmoidoscopy</u>	<u>4.8839</u>
<u>133</u>	<u>Proctosigmoidoscopy With Excision Or Biopsy</u>	<u>6.5527</u>
<u>134</u>	<u>Diagnostic Upper Gi Endoscopy Or Intubation</u>	<u>6.5767</u>
<u>135</u>	<u>Therapeutic Upper Gi Endoscopy Or Intubation</u>	<u>6.2914</u>
<u>136</u>	<u>Diagnostic Lower Gastrointestinal Endoscopy</u>	<u>6.5160</u>
<u>137</u>	<u>Therapeutic Colonoscopy</u>	<u>7.1153</u>
<u>138</u>	<u>Ercp And Miscellaneous Gi Endoscopy Procedures</u>	<u>11.5255</u>
<u>139</u>	<u>Level I Hernia Repair</u>	<u>11.6891</u>
<u>140</u>	<u>Level II Hernia Repair</u>	<u>11.7609</u>
<u>141</u>	<u>Level I Anal And Rectal Procedures</u>	<u>6.3398</u>
<u>142</u>	<u>Level II Anal And Rectal Procedures</u>	<u>10.0036</u>
<u>143</u>	<u>Level I Gastrointestinal Procedures</u>	<u>5.7638</u>
<u>144</u>	<u>Level II Gastrointestinal Procedures</u>	<u>12.9141</u>
<u>145</u>	<u>Level I Laparoscopy</u>	<u>9.9064</u>
<u>146</u>	<u>Level II Laparoscopy</u>	<u>11.3295</u>
<u>147</u>	<u>Level III Laparoscopy</u>	<u>14.1128</u>
<u>148</u>	<u>Level IV Laparoscopy</u>	<u>14.1128</u>
<u>160</u>	<u>Extracorporeal Shock Wave Lithotripsy</u>	<u>21.4139</u>
<u>161</u>	<u>Urinary Studies And Procedures</u>	<u>2.5668</u>
<u>162</u>	<u>Urinary Catheterization And Dilatation</u>	<u>2.2016</u>
<u>163</u>	<u>Level I Bladder And Kidney Procedures</u>	<u>7.3162</u>
<u>164</u>	<u>Level II Bladder And Kidney Procedures</u>	<u>11.1336</u>
<u>165</u>	<u>Level III Bladder And Kidney Procedures</u>	<u>17.1732</u>

<u>166</u>	<u>Level I Urethra And Prostate Procedures</u>	<u>4.2392</u>
<u>167</u>	<u>Level II Urethra And Prostate Procedures</u>	<u>12.7219</u>
<u>168</u>	<u>Hemodialysis</u>	<u>1.0803</u>
<u>169</u>	<u>Peritoneal Dialysis</u>	<u>0.4644</u>
<u>180</u>	<u>Testicular And Epididymal Procedures</u>	<u>9.0792</u>
<u>181</u>	<u>Circumcision</u>	<u>6.6820</u>
<u>182</u>	<u>Insertion Of Penile Prosthesis</u>	<u>20.4846</u>
<u>183</u>	<u>Level I Penile And Prostate Procedures</u>	<u>6.0136</u>
<u>184</u>	<u>Level II Penile And Prostate Procedures</u>	<u>9.5554</u>
<u>185</u>	<u>Prostate Needle And Punch Biopsy</u>	<u>6.9950</u>
<u>190</u>	<u>Artificial Fertilization</u>	<u>0.0000</u>
<u>191</u>	<u>Level I Fetal Procedures</u>	<u>1.4708</u>
<u>192</u>	<u>Level II Fetal Procedures</u>	<u>1.4708</u>
<u>193</u>	<u>Treatment Of Incomplete Abortion</u>	<u>8.9442</u>
<u>194</u>	<u>Therapeutic Abortion</u>	<u>6.4533</u>
<u>195</u>	<u>Vaginal Delivery</u>	<u>5.2543</u>
<u>196</u>	<u>Level I Female Reproductive Procedures</u>	<u>4.8933</u>
<u>197</u>	<u>Level II Female Reproductive Procedures</u>	<u>10.7605</u>
<u>198</u>	<u>Level III Female Reproductive Procedures</u>	<u>11.6407</u>
<u>199</u>	<u>Dilation And Curettage</u>	<u>7.5730</u>
<u>200</u>	<u>Hysteroscopy</u>	<u>9.5395</u>
<u>201</u>	<u>Colposcopy</u>	<u>2.1330</u>
<u>210</u>	<u>Extended Eeg Studies</u>	<u>3.9568</u>

<u>211</u>	<u>Electroencephalogram</u>	<u>1.5873</u>
<u>212</u>	<u>Electroconvulsive Therapy</u>	<u>1.6691</u>
<u>213</u>	<u>Nerve And Muscle Tests</u>	<u>0.2671</u>
<u>214</u>	<u>Nervous System Injections, Stimulations Or Cranial Tap</u>	<u>4.4348</u>
<u>215</u>	<u>Level I Revision Or Removal Of Neurological Device</u>	<u>15.6821</u>
<u>216</u>	<u>Level II Revision Or Removal Of Neurological Device</u>	<u>22.3865</u>
<u>217</u>	<u>Level I Nerve Procedures</u>	<u>6.8137</u>
<u>218</u>	<u>Level II Nerve Procedures</u>	<u>33.9919</u>
<u>219</u>	<u>Spinal Tap</u>	<u>5.7197</u>
<u>220</u>	<u>Injection Of Anesthetic And Neurolytic Agents</u>	<u>4.5493</u>
<u>221</u>	<u>Laminotomy And Laminectomy</u>	<u>21.2239</u>
<u>222</u>	<u>Sleep Studies</u>	<u>3.3322</u>
<u>230</u>	<u>Minor Ophthalmological Tests And Procedures</u>	<u>0.8903</u>
<u>231</u>	<u>Fitting Of Contact Lenses</u>	<u>0.6789</u>
<u>232</u>	<u>Laser Eye Procedures</u>	<u>2.5744</u>
<u>233</u>	<u>Cataract Procedures</u>	<u>11.3881</u>
<u>234</u>	<u>Level I Anterior Segment Eye Procedures</u>	<u>8.9944</u>
<u>235</u>	<u>Level II Anterior Segment Eye Procedures</u>	<u>11.4464</u>
<u>236</u>	<u>Level III Anterior Segment Eye Procedures</u>	<u>11.6685</u>
<u>237</u>	<u>Level I Posterior Segment Eye Procedures</u>	<u>5.9604</u>
<u>238</u>	<u>Level II Posterior Segment Eye Procedures</u>	<u>13.4878</u>
<u>239</u>	<u>Strabismus And Muscle Eye Procedures</u>	<u>9.2203</u>
<u>240</u>	<u>Level I Repair And Plastic Procedures Of Eye</u>	<u>3.8145</u>

<u>241</u>	<u>Level II Repair And Plastic Procedures Of Eye</u>	<u>11.2306</u>
<u>242</u>	<u>Vitrectomy</u>	<u>7.8193</u>
<u>250</u>	<u>Cochlear Device Implantation</u>	<u>95.0639</u>
<u>251</u>	<u>Otorhinolaryngologic Function Tests</u>	<u>0.8766</u>
<u>252</u>	<u>Level I Facial And Ent Procedures</u>	<u>5.7932</u>
<u>253</u>	<u>Level II Facial And Ent Procedures</u>	<u>7.3266</u>
<u>254</u>	<u>Level III Facial And Ent Procedures</u>	<u>11.3140</u>
<u>255</u>	<u>Level IV Facial And Ent Procedures</u>	<u>14.4004</u>
<u>256</u>	<u>Tonsil And Adenoid Procedures</u>	<u>7.3579</u>
<u>257</u>	<u>Audiometry</u>	<u>0.5955</u>
<u>270</u>	<u>Occupational Therapy</u>	<u>0.6220</u>
<u>271</u>	<u>Physical Therapy</u>	<u>0.3497</u>
<u>272</u>	<u>Speech Therapy And Evaluation</u>	<u>0.3699</u>
<u>273</u>	<u>Manipulation Therapy</u>	<u>0.3987</u>
<u>280</u>	<u>Vascular Radiology Except Venography Of Extremity</u>	<u>10.7456</u>
<u>281</u>	<u>Magnetic Resonance Angiography - Head And/Or Neck</u>	<u>1.9022</u>
<u>282</u>	<u>Magnetic Resonance Angiography - Chest</u>	<u>2.5831</u>
<u>283</u>	<u>Magnetic Resonance Angiography - Other Sites</u>	<u>2.3248</u>
<u>284</u>	<u>Myelography</u>	<u>7.9443</u>
<u>285</u>	<u>Miscellaneous Radiological Procedures With Contrast</u>	<u>1.7444</u>
<u>286</u>	<u>Mammography</u>	<u>1.0933</u>
<u>287</u>	<u>Digestive Radiology</u>	<u>1.6779</u>
<u>288</u>	<u>Diagnostic Ultrasound Except Obstetrical And Vascular Of Lower</u>	<u>1.7234</u>

Extremities

<u>289</u>	<u>Vascular Diagnostic Ultrasound Of Lower Extremities</u>	<u>10.7832</u>
<u>290</u>	<u>Pet Scans</u>	<u>6.6637</u>
<u>291</u>	<u>Bone Densitometry</u>	<u>0.2435</u>
<u>292</u>	<u>Mri- Abdomen</u>	<u>2.2816</u>
<u>293</u>	<u>Mri- Joints</u>	<u>2.1786</u>
<u>294</u>	<u>Mri- Back</u>	<u>2.2816</u>
<u>295</u>	<u>Mri- Chest</u>	<u>2.2349</u>
<u>296</u>	<u>Mri- Other</u>	<u>2.1853</u>
<u>297</u>	<u>Mri- Brain</u>	<u>2.2816</u>
<u>298</u>	<u>Cat Scan Back</u>	<u>1.3814</u>
<u>299</u>	<u>Cat Scan - Brain</u>	<u>1.3814</u>
<u>300</u>	<u>Cat Scan - Abdomen</u>	<u>1.3814</u>
<u>301</u>	<u>Cat Scan - Other</u>	<u>1.2983</u>
<u>302</u>	<u>Angiography, Other</u>	<u>1.6509</u>
<u>303</u>	<u>Angiography, Cerebral</u>	<u>1.6509</u>
<u>310</u>	<u>Neuropsychological Testing</u>	<u>0.8706</u>
<u>311</u>	<u>Full Day Partial Hospitalization For Substance Abuse</u>	<u>0.0000</u>
<u>312</u>	<u>Full Day Partial Hospitalization For Mental Illness</u>	<u>0.0000</u>
<u>313</u>	<u>Half Day Partial Hospitalization For Substance Abuse</u>	<u>0.0000</u>
<u>314</u>	<u>Half Day Partial Hospitalization For Mental Illness</u>	<u>0.0000</u>
<u>315</u>	<u>Counselling Or Individual Brief Psychotherapy</u>	<u>0.3521</u>
<u>316</u>	<u>Individual Comprehensive Psychotherapy</u>	<u>0.7905</u>

<u>317</u>	<u>Family Psychotherapy</u>	<u>0.4979</u>
<u>318</u>	<u>Group Psychotherapy</u>	<u>0.2828</u>
<u>319</u>	<u>Activity Therapy</u>	<u>0.0000</u>
<u>320</u>	<u>Case Management - Mental Health Or Substance Abuse</u>	<u>0.0000</u>
<u>330</u>	<u>Level I Diagnostic Nuclear Medicine</u>	<u>2.0592</u>
<u>331</u>	<u>Level Ii Diagnostic Nuclear Medicine</u>	<u>2.8311</u>
<u>332</u>	<u>Level Iii Diagnostic Nuclear Medicine</u>	<u>5.2893</u>
<u>340</u>	<u>Therapeutic Nuclear Medicine</u>	<u>1.4501</u>
<u>341</u>	<u>Radiation Therapy And Hyperthermia</u>	<u>13.8980</u>
<u>342</u>	<u>Afterloading Brachytherapy</u>	<u>9.1805</u>
<u>343</u>	<u>Radiation Treatment Delivery</u>	<u>2.1725</u>
<u>344</u>	<u>Instillation Of Radioelement Solutions</u>	<u>5.2725</u>
<u>345</u>	<u>Hyperthermic Therapies</u>	<u>1.2275</u>
<u>346</u>	<u>Radiosurgery</u>	<u>60.9920</u>
<u>347</u>	<u>High Energy Neutron Radiation Treatment Delivery</u>	<u>1.0337</u>
<u>348</u>	<u>Proton Treatment Delivery</u>	<u>5.9633</u>
<u>350</u>	<u>Level I Adjunctive General Dental Services</u>	<u>0.3754</u>
<u>351</u>	<u>Level II Adjunctive General Dental Services</u>	<u>0.5753</u>
<u>352</u>	<u>Periodontics</u>	<u>0.4817</u>
<u>353</u>	<u>Level I Prosthodontics, Fixed</u>	<u>0.3097</u>
<u>354</u>	<u>Level II Prosthodontics, Fixed</u>	<u>1.5945</u>
<u>355</u>	<u>Level III Prosthodontics, Fixed</u>	<u>1.8493</u>
<u>356</u>	<u>Level I Prosthodontics, Removable</u>	<u>0.4194</u>

<u>357</u>	<u>Level II Prosthodontics, Removable</u>	<u>1.4189</u>
<u>358</u>	<u>Level III Prosthodontics, Removable</u>	<u>1.8009</u>
<u>359</u>	<u>Level I Maxillofacial Prosthetics</u>	<u>0.3188</u>
<u>360</u>	<u>Level II Maxillofacial Prosthetics</u>	<u>0.3623</u>
<u>361</u>	<u>Level I Dental Restorations</u>	<u>0.3385</u>
<u>362</u>	<u>Level II Dental Restorations</u>	<u>0.4993</u>
<u>363</u>	<u>Level III Dental Restoration</u>	<u>1.6216</u>
<u>364</u>	<u>Level I Endodontics</u>	<u>0.4874</u>
<u>365</u>	<u>LEVEL II Endodontics</u>	<u>0.9627</u>
<u>366</u>	<u>Level III Endodontics</u>	<u>1.2303</u>
<u>367</u>	<u>Level I Oral and Maxillofacial Surgery</u>	<u>0.7622</u>
<u>368</u>	<u>Level II Oral and Maxillofacial Surgery</u>	<u>3.0174</u>
<u>369</u>	<u>Level III Oral and Maxillofacial Surgery</u>	<u>3.0174</u>
<u>370</u>	<u>Level IV Oral and Maxillofacial Surgery</u>	<u>3.0174</u>
<u>371</u>	<u>Orthodontics</u>	<u>0.0000</u>
<u>372</u>	<u>Sealant</u>	<u>0.3287</u>
<u>373</u>	<u>Level I Dental Film</u>	<u>0.2624</u>
<u>374</u>	<u>Level II Dental Film</u>	<u>0.3182</u>
<u>375</u>	<u>Dental Anesthesia</u>	<u>1.2646</u>
<u>376</u>	<u>Diagnostic Dental Procedures</u>	<u>0.2334</u>
<u>377</u>	<u>Preventive Dental Procedures</u>	<u>0.2009</u>
<u>380</u>	<u>Anesthesia</u>	<u>0.4324</u>
<u>390</u>	<u>Level I Pathology</u>	<u>0.3762</u>

<u>391</u>	<u>Level II Pathology</u>	<u>0.6149</u>
<u>392</u>	<u>Pap Smears</u>	<u>0.1464</u>
<u>393</u>	<u>Blood And Tissue Typing</u>	<u>0.1548</u>
<u>394</u>	<u>Level I Immunology Tests</u>	<u>0.1688</u>
<u>395</u>	<u>Level II Immunology Tests</u>	<u>0.3007</u>
<u>396</u>	<u>Level I Microbiology Tests</u>	<u>0.1687</u>
<u>397</u>	<u>Level II Microbiology Tests</u>	<u>0.2270</u>
<u>398</u>	<u>Level I Endocrinology Tests</u>	<u>0.1787</u>
<u>399</u>	<u>Level II Endocrinology Tests</u>	<u>0.2470</u>
<u>400</u>	<u>Level I Chemistry Tests</u>	<u>0.1102</u>
<u>401</u>	<u>Level II Chemistry Tests</u>	<u>0.2411</u>
<u>402</u>	<u>Basic Chemistry Tests</u>	<u>0.0838</u>
<u>403</u>	<u>Organ Or Disease Oriented Panels</u>	<u>0.3618</u>
<u>404</u>	<u>Toxicology Tests</u>	<u>0.3917</u>
<u>405</u>	<u>Therapeutic Drug Monitoring</u>	<u>0.2152</u>
<u>406</u>	<u>Level I Clotting Tests</u>	<u>0.0895</u>
<u>407</u>	<u>Level II Clotting Tests</u>	<u>0.1904</u>
<u>408</u>	<u>Level I Hematology Tests</u>	<u>0.0857</u>
<u>409</u>	<u>Level II Hematology Tests</u>	<u>0.2557</u>
<u>410</u>	<u>Urinalysis</u>	<u>0.1139</u>
<u>411</u>	<u>Blood And Urine Dipstick Tests</u>	<u>0.1899</u>
<u>412</u>	<u>Simple Pulmonary Function Tests</u>	<u>0.2771</u>
<u>413</u>	<u>Cardiogram</u>	<u>0.1870</u>

<u>414</u>	<u>Level I Immunization And Allergy Immunotherapy</u>	<u>0.1155</u>
<u>415</u>	<u>Level II Immunization</u>	<u>0.2358</u>
<u>416</u>	<u>Level III Immunization</u>	<u>0.4323</u>
<u>417</u>	<u>Minor Reproductive Procedures</u>	<u>1.3550</u>
<u>418</u>	<u>Minor Cardiac And Vascular Tests</u>	<u>1.5511</u>
<u>419</u>	<u>Minor Ophthalmological Injection, Scraping And Tests</u>	<u>0.6102</u>
<u>420</u>	<u>Pacemaker And Other Electronic Analysis</u>	<u>0.6782</u>
<u>421</u>	<u>Tube Change</u>	<u>3.5313</u>
<u>422</u>	<u>Provision Of Vision Aids</u>	<u>0.4068</u>
<u>423</u>	<u>Introduction Of Needle And Catheter</u>	<u>0.9391</u>
<u>424</u>	<u>Dressings And Other Minor Procedures</u>	<u>1.2969</u>
<u>425</u>	<u>Other Miscellaneous Ancillary Procedures</u>	<u>1.0663</u>
<u>426</u>	<u>Psychotropic Medication Management</u>	<u>0.3535</u>
<u>427</u>	<u>Biofeedback And Other Training</u>	<u>0.0000</u>
<u>428</u>	<u>Patient Education, Individual</u>	<u>0.1202</u>
<u>429</u>	<u>Patient Education, Group</u>	<u>0.0668</u>
<u>430</u>	<u>Class I Chemotherapy Drugs</u>	<u>0.0000</u>
<u>431</u>	<u>Class II Chemotherapy Drugs</u>	<u>0.0000</u>
<u>432</u>	<u>Class III Chemotherapy Drugs</u>	<u>0.0000</u>
<u>433</u>	<u>Class IV Chemotherapy Drugs</u>	<u>0.0000</u>
<u>434</u>	<u>Class V Chemotherapy Drugs</u>	<u>0.0000</u>
<u>435</u>	<u>Class I Pharmacotherapy</u>	<u>0.1068</u>
<u>436</u>	<u>Class II Pharmacotherapy</u>	<u>0.9989</u>

<u>437</u>	<u>Class III Pharmacotherapy</u>	<u>2.1521</u>
<u>438</u>	<u>Class IV Pharmacotherapy</u>	<u>6.3796</u>
<u>439</u>	<u>Class V Pharmacotherapy</u>	<u>13.6454</u>
<u>448</u>	<u>Expanded Hours Access</u>	<u>0.0356</u>
<u>449</u>	<u>Additional Undifferentiated Medical Visit/Services</u>	<u>0.0000</u>
<u>450</u>	<u>Observation</u>	<u>0.0000</u>
<u>451</u>	<u>Smoking Cessation Treatment</u>	<u>0.1090</u>
<u>452</u>	<u>Diabetes Supplies</u>	<u>0.0000</u>
<u>453</u>	<u>Motorized Wheelchair</u>	<u>0.0000</u>
<u>454</u>	<u>Tpn Formulae</u>	<u>0.0000</u>
<u>455</u>	<u>Implanted Tissue Of Any Type</u>	<u>4.8634</u>
<u>456</u>	<u>Motorized Wheelchair Accessories</u>	<u>0.0000</u>
<u>457</u>	<u>Venipuncture</u>	<u>0.0675</u>
<u>470</u>	<u>Obstetrical Ultrasound</u>	<u>0.9504</u>
<u>471</u>	<u>Plain Film</u>	<u>0.6885</u>
<u>472</u>	<u>Ultrasound Guidance</u>	<u>1.3612</u>
<u>473</u>	<u>Ct Guidance</u>	<u>0.8405</u>
<u>474</u>	<u>Radiological Guidance For Therapeutic Or Diagnostic Procedures</u>	<u>2.9696</u>
<u>475</u>	<u>Mri Guidance</u>	<u>1.5646</u>
<u>476</u>	<u>Level I Therapeutic Radiation Treatment Preparation</u>	<u>1.0796</u>
<u>477</u>	<u>Level II Therapeutic Radiation Treatment Preparation</u>	<u>1.8461</u>
<u>478</u>	<u>Medical Radiation Physics</u>	<u>1.5197</u>
<u>479</u>	<u>Treatment Device Design And Construction</u>	<u>4.4205</u>

<u>480</u>	<u>Teletherapy/Brachytherapy Calculation</u>	<u>2.4697</u>
<u>481</u>	<u>Therapeutic Radiology Simulation Field Setting</u>	<u>6.0354</u>
<u>482</u>	<u>Radioelement Application</u>	<u>1.8353</u>
<u>483</u>	<u>Radiation Therapy Management</u>	<u>2.4471</u>
<u>484</u>	<u>Therapeutic Radiology Treatment Planning</u>	<u>2.9833</u>
<u>490</u>	<u>Incidental To Medical, Significant Procedure Or Therapy Visit</u>	<u>0.0000</u>
<u>491</u>	<u>Medical Visit Indicator</u>	<u>1.1276</u>
<u>492</u>	<u>Direct Admission For Observation Indicator</u>	<u>0.0000</u>
<u>500</u>	<u>Direct Admission For Observation - Obstetrical</u>	<u>0.0000</u>
<u>501</u>	<u>Direct Admission For Observation - Other Diagnoses</u>	<u>0.0000</u>
<u>510</u>	<u>Major Signs, Symptoms And Findings</u>	<u>0.9701</u>
<u>520</u>	<u>Spinal Disorders & Injuries</u>	<u>0.6416</u>
<u>521</u>	<u>Nervous System Malignancy</u>	<u>1.4170</u>
<u>522</u>	<u>Degenerative Nervous System Disorders Exc Mult Sclerosis</u>	<u>0.6992</u>
<u>523</u>	<u>Multiple Sclerosis & Other Demyelinating Diseases</u>	<u>0.6393</u>
<u>524</u>	<u>Level I Cns Disorders</u>	<u>0.6783</u>
<u>525</u>	<u>Level II Cns Disorders</u>	<u>0.8319</u>
<u>526</u>	<u>Transient Ischemia</u>	<u>1.4601</u>
<u>527</u>	<u>Peripheral Nerve Disorders</u>	<u>0.7120</u>
<u>528</u>	<u>Nontraumatic Stupor & Coma</u>	<u>1.0393</u>
<u>529</u>	<u>Seizure</u>	<u>0.9756</u>
<u>530</u>	<u>Headaches Other Than Migraine</u>	<u>0.9609</u>
<u>531</u>	<u>Migraine</u>	<u>0.8847</u>

<u>532</u>	<u>Head Trauma</u>	<u>1.7436</u>
<u>533</u>	<u>Aftereffects Of Cerebrovascular Accident</u>	<u>0.7435</u>
<u>534</u>	<u>Nonspecific Cva & Precerebral Occlusion W/O Infarc</u>	<u>0.9273</u>
<u>535</u>	<u>Cva & Precerebral Occlusion W Infarct</u>	<u>0.7053</u>
<u>550</u>	<u>Acute Major Eye Infections</u>	<u>0.6763</u>
<u>551</u>	<u>Cataracts</u>	<u>0.6273</u>
<u>552</u>	<u>Glaucoma</u>	<u>0.6453</u>
<u>553</u>	<u>Level I Ophthalmic Diagnoses</u>	<u>0.6725</u>
<u>554</u>	<u>Level II Ophthalmic Diagnoses</u>	<u>0.8497</u>
<u>555</u>	<u>Conjunctivitis</u>	<u>0.7007</u>
<u>560</u>	<u>Ear, Nose, Mouth, Throat, Cranial/Facial Malignancies</u>	<u>1.7033</u>
<u>561</u>	<u>Vertiginous Disorders Except For Benign Vertigo</u>	<u>1.1915</u>
<u>562</u>	<u>Infections Of Upper Respiratory Tract</u>	<u>0.6893</u>
<u>563</u>	<u>Dental & Oral Diseases & Injuries</u>	<u>0.4805</u>
	<u>Level I Other Ear, Nose, Mouth,Throat & Cranial/Facial</u>	
<u>564</u>	<u>Diagnoses</u>	<u>0.7397</u>
	<u>Level II Other Ear, Nose, Mouth,Throat & Cranial/Facial</u>	
<u>565</u>	<u>Diagnoses</u>	<u>1.4495</u>
<u>570</u>	<u>Cystic Fibrosis - Pulmonary Disease</u>	<u>0.9766</u>
<u>571</u>	<u>Respiratory Malignancy</u>	<u>1.8361</u>
<u>572</u>	<u>Bronchiolitis & Rsv Pneumonia</u>	<u>0.8498</u>
<u>573</u>	<u>Community Acquired Pnuemonia</u>	<u>1.3077</u>
<u>574</u>	<u>Chronic Obstructive Pulmonary Disease</u>	<u>0.6739</u>

<u>575</u>	<u>Asthma</u>	<u>0.9150</u>
<u>576</u>	<u>Level I Other Respiratory Diagnoses</u>	<u>1.0672</u>
<u>577</u>	<u>Level II Other Respiratory Diagnoses</u>	<u>0.7956</u>
<u>578</u>	<u>Pneumonia Except For Community Acquired Pneumonia</u>	<u>0.8720</u>
<u>579</u>	<u>Status Asthmaticus</u>	<u>0.5124</u>
<u>591</u>	<u>Acute Myocardial Infarction</u>	<u>5.7122</u>
<u>592</u>	<u>Level I Cardiovascular Diagnoses</u>	<u>0.8157</u>
<u>593</u>	<u>Level II Cardiovascular Diagnoses</u>	<u>0.8157</u>
<u>594</u>	<u>Heart Failure</u>	<u>0.7967</u>
<u>595</u>	<u>Cardiac Arrest</u>	<u>3.6827</u>
<u>596</u>	<u>Peripheral & Other Vascular Disorders</u>	<u>0.7664</u>
<u>597</u>	<u>Phlebitis</u>	<u>0.7434</u>
<u>598</u>	<u>Angina Pectoris & Coronary Atherosclerosis</u>	<u>0.8736</u>
<u>599</u>	<u>Hypertension</u>	<u>0.6952</u>
<u>600</u>	<u>Cardiac Structural & Valvular Disorders</u>	<u>1.0466</u>
<u>601</u>	<u>Level I Cardiac Arrhythmia & Conduction Disorders</u>	<u>1.1985</u>
<u>602</u>	<u>Atrial Fibrillation</u>	<u>0.9954</u>
<u>603</u>	<u>Level II Cardiac Arrhythmia & Conduction Disorders</u>	<u>0.9165</u>
<u>604</u>	<u>Chest Pain</u>	<u>2.0030</u>
<u>605</u>	<u>Syncope & Collapse</u>	<u>1.8564</u>
<u>620</u>	<u>Digestive Malignancy</u>	<u>2.1345</u>
<u>621</u>	<u>Peptic Ulcer & Gastritis</u>	<u>1.2964</u>
<u>623</u>	<u>Esophagitis</u>	<u>0.6373</u>

<u>624</u>	<u>Level I Gastrointestinal Diagnoses</u>	<u>0.8882</u>
<u>625</u>	<u>Level II Gastrointestinal Diagnoses</u>	<u>0.8004</u>
<u>626</u>	<u>Inflammatory Bowel Disease</u>	<u>0.6867</u>
<u>627</u>	<u>Non-Bacterial Gastroenteritis, Nausea & Vomiting</u>	<u>1.0670</u>
<u>628</u>	<u>Abdominal Pain</u>	<u>1.4513</u>
<u>629</u>	<u>Malfunction, Reaction & Complication Of Gi Device Or Procedure</u>	<u>1.4552</u>
<u>630</u>	<u>Constipation</u>	<u>0.9378</u>
<u>631</u>	<u>Hernia</u>	<u>0.7912</u>
<u>632</u>	<u>Irritable Bowel Syndrome</u>	<u>0.6018</u>
<u>633</u>	<u>Alcoholic Liver Disease</u>	<u>0.7923</u>
<u>634</u>	<u>Malignancy Of Hepatobiliary System & Pancreas</u>	<u>1.4269</u>
<u>635</u>	<u>Disorders Of Pancreas Except Malignancy</u>	<u>1.5278</u>
<u>636</u>	<u>Hepatitis Without Coma</u>	<u>0.7291</u>
<u>637</u>	<u>Disorders Of Gallbladder & Biliary Tract</u>	<u>0.8423</u>
<u>638</u>	<u>Cholecystitis</u>	<u>1.1519</u>
<u>639</u>	<u>Level I Hepatobiliary Diagnoses</u>	<u>0.9891</u>
<u>640</u>	<u>Level II Hepatobiliary Diagnoses</u>	<u>0.6674</u>
<u>650</u>	<u>Fracture Of Femur</u>	<u>0.9813</u>
<u>651</u>	<u>Fracture Of Pelvis Or Dislocation Of Hip</u>	<u>0.9780</u>
<u>652</u>	<u>Fractures & Dislocations Except Femur, Pelvis & Back</u>	<u>1.1211</u>
	<u>Musculoskeletal Malignancy & Pathol Fracture D/T Muscskel</u>	
<u>653</u>	<u>Malig</u>	<u>1.4795</u>
<u>654</u>	<u>Osteomyelitis, Septic Arthritis & Other Musculoskeletal Infections</u>	<u>0.6728</u>

<u>655</u>	<u>Connective Tissue Disorders</u>	<u>0.6743</u>
<u>656</u>	<u>Back & Neck Disorders Except Lumbar Disc Disease</u>	<u>0.9519</u>
<u>657</u>	<u>Lumbar Disc Disease</u>	<u>0.8104</u>
<u>658</u>	<u>Lumbar Disc Disease With Sciatica</u>	<u>1.0996</u>
	<u>Malfunction, Reaction, Complic Of Orthopedic Device Or</u>	
<u>659</u>	<u>Procedure</u>	<u>1.5171</u>
	<u>Level I Other Musculoskeletal System & Connective Tissue</u>	
<u>660</u>	<u>Diagnoses</u>	<u>0.8196</u>
	<u>Level II Other Musculoskeletal System & Connective Tissue</u>	
<u>661</u>	<u>Diagnoses</u>	<u>0.9314</u>
<u>662</u>	<u>Osteoporosis</u>	<u>0.4961</u>
<u>663</u>	<u>Pain</u>	<u>0.8372</u>
<u>670</u>	<u>Skin Ulcers</u>	<u>0.7420</u>
<u>671</u>	<u>Major Skin Disorders</u>	<u>0.6644</u>
<u>672</u>	<u>Malignant Breast Disorders</u>	<u>1.7630</u>
<u>673</u>	<u>Cellulitis & Other Bacterial Skin Infections</u>	<u>0.9183</u>
	<u>Contusion, Open Wound & Other Trauma To Skin &</u>	
<u>674</u>	<u>Subcutaneous Tissue</u>	<u>1.3805</u>
<u>675</u>	<u>Other Skin, Subcutaneous Tissue & Breast Disorders</u>	<u>0.6997</u>
<u>676</u>	<u>Decubitus Ulcer</u>	<u>0.7085</u>
<u>690</u>	<u>Malnutrition, Failure To Thrive & Other Nutritional Disorders</u>	<u>0.6268</u>
<u>691</u>	<u>Inborn Errors Of Metabolism</u>	<u>0.5511</u>
<u>692</u>	<u>Level I Endocrine Disorders</u>	<u>0.6921</u>

<u>693</u>	<u>Level II Endocrine Disorders</u>	<u>0.6921</u>
<u>694</u>	<u>Electrolyte Disorders</u>	<u>1.6055</u>
<u>695</u>	<u>Obesity</u>	<u>0.4691</u>
<u>710</u>	<u>Diabetes With Ophthalmic Manifestations</u>	<u>0.7201</u>
<u>711</u>	<u>Diabetes With Circulatory Diagnoses</u>	<u>0.8197</u>
<u>712</u>	<u>Diabetes With Neurologic Manifestations</u>	<u>0.6362</u>
<u>713</u>	<u>Diabetes Without Complications</u>	<u>0.6435</u>
<u>714</u>	<u>Diabetes With Renal Manifestations</u>	<u>0.7749</u>
<u>720</u>	<u>Renal Failure</u>	<u>0.8922</u>
<u>721</u>	<u>Kidney & Urinary Tract Malignancy</u>	<u>1.4204</u>
<u>722</u>	<u>Nephritis & Nephrosis</u>	<u>0.6984</u>
<u>723</u>	<u>Kidney And Chronic Urinary Tract Infections</u>	<u>1.4546</u>
<u>724</u>	<u>Urinary Stones & Acquired Upper Urinary Tract Obstruction</u>	<u>1.8679</u>
<u>725</u>	<u>Malfunction, Reaction, Complic Of Genitourinary Device Or Proc</u>	<u>1.7307</u>
<u>726</u>	<u>Other Kidney & Urinary Tract Diagnoses, Signs & Symptoms</u>	<u>0.7469</u>
<u>727</u>	<u>Acute Lower Urinary Tract Infections</u>	<u>1.0652</u>
<u>740</u>	<u>Malignancy, Male Reproductive System</u>	<u>0.8480</u>
<u>741</u>	<u>Male Reproductive System Diagnoses Except Malignancy</u>	<u>0.8631</u>
<u>742</u>	<u>Neoplasms Of The Male Reproductive System</u>	<u>0.5886</u>
<u>743</u>	<u>Prostatitis</u>	<u>0.7853</u>
<u>744</u>	<u>Male Reproductive Infections</u>	<u>0.9622</u>
<u>750</u>	<u>Female Reproductive System Malignancy</u>	<u>1.9785</u>
<u>751</u>	<u>Female Reproductive System Infections</u>	<u>0.8237</u>

<u>752</u>	<u>Level I Menstrual And Other Female Diagnoses</u>	<u>0.7687</u>
<u>753</u>	<u>Level II Menstrual And Other Female Diagnoses</u>	<u>1.0479</u>
<u>760</u>	<u>Vaginal Delivery</u>	<u>0.6670</u>
<u>761</u>	<u>Postpartum & Post Abortion Diagnoses W/O Procedure</u>	<u>0.8171</u>
<u>762</u>	<u>Threatened Abortion</u>	<u>2.4096</u>
<u>763</u>	<u>Abortion W/O D&C, Aspiration Curettage Or Hysterotomy</u>	<u>1.6166</u>
<u>764</u>	<u>False Labor</u>	<u>1.8375</u>
<u>765</u>	<u>Other Antepartum Diagnoses</u>	<u>1.0761</u>
<u>766</u>	<u>Routine Prenatal Care</u>	<u>0.7566</u>
<u>770</u>	<u>Normal Neonate</u>	<u>0.4284</u>
<u>771</u>	<u>Level I Neonatal Diagnoses</u>	<u>1.0195</u>
<u>772</u>	<u>Level II Neonatal Diagnoses</u>	<u>0.6602</u>
<u>780</u>	<u>Other Hematological Disorders</u>	<u>0.6816</u>
<u>781</u>	<u>Coagulation & Platelet Disorders</u>	<u>0.6657</u>
<u>782</u>	<u>Congenital Factor Deficiencies</u>	<u>0.7194</u>
<u>783</u>	<u>Sickle Cell Anemia Crisis</u>	<u>1.7354</u>
<u>784</u>	<u>Sickle Cell Anemia</u>	<u>0.6323</u>
	<u>Anemia Except For Iron Deficiency Anemia And Sickle Cell</u>	
<u>785</u>	<u>Anemia</u>	<u>0.7141</u>
<u>786</u>	<u>Iron Deficiency Anemia</u>	<u>0.6396</u>
<u>800</u>	<u>Acute Leukemia</u>	<u>1.7166</u>
<u>801</u>	<u>Lymphoma, Myeloma & Non-Acute Leukemia</u>	<u>2.0890</u>
<u>802</u>	<u>Radiotherapy</u>	<u>0.7403</u>

<u>803</u>	<u>Chemotherapy</u>	<u>0.7997</u>
	<u>Lymphatic & Other Malignancies & Neoplasms Of Uncertain</u>	
<u>804</u>	<u>Behavior</u>	<u>0.9222</u>
<u>805</u>	<u>Septicemia & Disseminated Infections</u>	<u>1.0837</u>
<u>806</u>	<u>Post-Operative, Post-Traumatic, Other Device Infections</u>	<u>1.0900</u>
<u>807</u>	<u>Fever</u>	<u>1.3409</u>
<u>808</u>	<u>Viral Illness</u>	<u>0.9073</u>
<u>809</u>	<u>Other Infectious & Parasitic Diseases</u>	<u>0.7158</u>
<u>810</u>	<u>H. Pylori Infection</u>	<u>0.6080</u>
<u>820</u>	<u>Schizophrenia</u>	<u>1.2655</u>
<u>821</u>	<u>Major Depressive Disorders & Other/Unspecified Psychoses</u>	<u>1.0514</u>
<u>822</u>	<u>Disorders Of Personality & Impulse Control</u>	<u>0.9219</u>
<u>823</u>	<u>Bipolar Disorders</u>	<u>1.0948</u>
<u>824</u>	<u>Depression Except Major Depressive Disorder</u>	<u>0.7663</u>
<u>825</u>	<u>Adjustment Disorders & Neuroses Except Depressive Diagnoses</u>	<u>1.0154</u>
<u>826</u>	<u>Acute Anxiety & Delirium States</u>	<u>0.9012</u>
<u>827</u>	<u>Organic Mental Health Disturbances</u>	<u>0.7644</u>
<u>828</u>	<u>Mental Retardation</u>	<u>0.5493</u>
<u>829</u>	<u>Childhood Behavioral Disorders</u>	<u>0.5568</u>
<u>830</u>	<u>Eating Disorders</u>	<u>0.4825</u>
<u>831</u>	<u>Other Mental Health Disorders</u>	<u>0.6736</u>
<u>840</u>	<u>Opioid Abuse & Dependence</u>	<u>1.3467</u>
<u>841</u>	<u>Cocaine Abuse & Dependence</u>	<u>1.7477</u>

<u>842</u>	<u>Alcohol Abuse & Dependence</u>	<u>2.0693</u>
<u>843</u>	<u>Other Drug Abuse & Dependence</u>	<u>1.7857</u>
<u>850</u>	<u>Allergic Reactions</u>	<u>0.9385</u>
<u>851</u>	<u>Poisoning Of Medicinal Agents</u>	<u>1.9830</u>
<u>852</u>	<u>Other Complications Of Treatment</u>	<u>1.2746</u>
<u>853</u>	<u>Other Injury, Poisoning & Toxic Effect Diagnoses</u>	<u>1.3262</u>
<u>854</u>	<u>Toxic Effects Of Non-Medicinal Substances</u>	<u>1.1333</u>
<u>860</u>	<u>Extensive 3Rd Degree Or Full Thickness Burns W/O Skin Graft</u>	<u>0.7269</u>
<u>861</u>	<u>Partial Thickness Burns W Or W/O Skin Graft</u>	<u>0.8125</u>
<u>870</u>	<u>Rehabilitation</u>	<u>0.4118</u>
<u>871</u>	<u>Signs, Symptoms & Other Factors Influencing Health Status</u>	<u>0.6547</u>
<u>872</u>	<u>Other Aftercare & Convalescence</u>	<u>0.8845</u>
<u>873</u>	<u>Neonatal Aftercare</u>	<u>0.9984</u>
<u>874</u>	<u>Joint Replacement</u>	<u>0.5778</u>
<u>880</u>	<u>Hiv Infection</u>	<u>0.9364</u>
<u>881</u>	<u>Aids</u>	<u>0.9932</u>
<u>999</u>	<u>Unassigned</u>	<u>0.0000</u>

§ 86-8.8 Base rates

Base rates shall be developed by the Department for each of the five categories of providers set forth in subdivision (a) of section 86-8.1 of this Subpart, in accordance with the following:

- (a) Separate base rates for each of the five categories for such providers shall be established based on the location of such providers in the Upstate Region or the Downstate Region and such base rates shall reflect differing regional cost factors as determined by the Department.
- (b) Additional discrete base rates may be developed by the Department for such peer groups as may be established by regulation in this Subpart.
- (c) Such base rates shall be established based on estimated historical per visit payment amounts, as adjusted to reflect the level of State appropriations made available for such purposes. Such adjustments shall be calculated on a per visit basis, utilizing the same historical visit volume used to calculate the estimated per visit payment amounts.
- (d) Such base rates shall be peer group specific and shall reflect the estimated case mix index for each peer group and any projected changes in provider coding patterns for each peer group.
- (e) Such base rates may be periodically adjusted to reflect changes in provider coding patterns and case mix.

§ 86-8.9 Diagnostic coding and rate computation

- (a) Facilities shall assign ICD-9 diagnostic codes and HCPCS/CPT procedure codes to each claim as appropriate and shall submit such information to the Department or the Department's designee in accordance with written billing and reporting instructions issued by the Department. The Department shall utilize such claim coding information to assign each the applicable APG or APGs for each patient visit identified on the claim, utilizing the APG software system to determine the significant procedure APG or the medical visit APG, the applicable ancillary services APGs and the final APG weight applicable to each such visit. The APG software system shall incorporate methodologies for consolidation, packaging and discounting to be reflected in the final APG weight to be assigned to each visit on the claim.

(b) The operating component of the payment rate for each patient shall be computed by multiplying the final APG weight for each visit, as computed in accordance with subdivision (a) of this section, by the applicable base rate, as determined in accordance with section 86-8.7 of this Subpart. A capital component shall then been added to each such payment rate in accordance with the provisions of section 86-8.4 of this Subpart.

(c) The Department's written billing and reporting instructions shall set forth a complete listing of all ambulatory surgery permissible procedures which are reimbursable pursuant to this Subpart. No visits may be billed as ambulatory surgery unless at least one procedure designated as ambulatory surgery permissible appears on the claim for the date of service for the visit.

(d) In cases where the only reimbursable APGs for a visit are one or more ancillary service APGs, there shall be no reimbursement for capital costs included in the payment for that visit.

§ 86-8.10 Exclusions from payment

Payments for the following shall be excluded from rates set pursuant to this Subpart:

(a) 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 subject to this Subpart, and as may be subsequently modified by the Department, HIV counseling and testing visits, 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, and Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.

(b) Visits solely for the purpose of receiving ordered ambulatory services.

(c) Visits solely for the purpose of receiving pharmacy services.

(d) 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 section 2807 of the Public Health Law.

(e) 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 subject to reimbursement pursuant to this Subpart, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the Public Health Law.

(f) 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 subject to reimbursement pursuant to this Subpart and provided, however, that reimbursement for such group services shall be determined in accordance with paragraph (h) of section 86-4.9 of this Title.

(g) 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 and provided, however, that reimbursement for such offsite services shall be determined in accordance with paragraph (i) of section 86-4.9 of this Title.

(h) The following APGs shall not be eligible for reimbursement pursuant to this Subpart:

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 LEVEL I ORTHODONTICS

372 LEVEL II 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

(i) The following APGs shall not be eligible for reimbursement pursuant to this Subpart when they are presented as the only APGs applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in subdivision (h) of this section:

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 ULTRASOUND

471 PLAIN FILM

472 ULTRASOUND GUIDANCE

473 CT GUIDANCE

§ 86-8.11 System updating and incorporation by reference

(a) The following elements of the APG rate-setting system shall be updated no less frequently than annually:

(1) the listing of reimbursable APGs subject to this Subpart and the relative weight assigned to each such APG;

(2) the base rates;

(3) the applicable ICD-9 codes utilized in the APG software system;

(4) the applicable CPT-4/HCPCS codes utilized in the APG software system;

(5) the APG software system

(b) The Current Procedure Code, fourth edition (CPT-4) and the Healthcare Common Procedure Coding System (HCPCS), published by the American Medical Association, and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), published by the United States Department of Health and Human Services, as described in this Subpart, are hereby incorporated by reference, with the same force and effect as if fully set forth herein. Copies of these documents are available for public inspection and copying at the Office of Regulatory Reform, New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237. Copies of the CPT-4 and HCPCS are also available from the American Medical Association, Order Department, P.O. Box 930876, Atlanta, Georgia 31193-0876. Copies of the ICD-9-CM are also available from the United States Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954.

§ 86-8.12 Payments for extended hours of operation

For visits occurring on and after January 1, 2009, by hospital outpatient clinics and diagnostic and treatment centers otherwise subject to this Subpart, which are scheduled and occur on evenings, weekends and holidays as defined by the Department, a supplemental APG payment amount, as determined in accordance with section 86-8.7 of this Subpart, shall be added on to the otherwise applicable payment amount for each such visit.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The requirement to implement a revised Medicaid ambulatory care reimbursement system based on APGs is established in Section 18 of Part C of Chapter 58 of the Laws of 2008, as amended by Section 19 of Part OO of Chapter 53 of the Laws of 2008. As part of this statute, Section 2807(2-a)(e) of the Public Health Law was created, which authorizes the Department of Health to adopt and amend rules and regulations, subject to the approval of the State Director of the Budget, establishing an Ambulatory Patient Group (APG) methodology for determining Medicaid rates of payment for diagnostic and treatment center services, free-standing ambulatory surgery services and general hospital outpatient clinics, emergency departments and ambulatory surgery services.

Legislative Objective:

After months of discussion between the Executive, Legislature, hospital associations and numerous other stakeholders, the Legislature chose to create a new, uniform reimbursement methodology for all ambulatory care services provided by hospital outpatient departments (including emergency and ambulatory surgery departments) and diagnostic and treatments centers (DTCs), also known as free-standing clinics, as well as freestanding ambulatory surgery centers. Pursuant to statute, the APG methodology was chosen as the new reimbursement system for these services. APGs pay differential amounts for ambulatory care services based on the resources required for each patient visit. Additionally, the Legislature's other objective was to increase Medicaid payments for ambulatory care services, funded with State and Federal monies.

Needs and Benefits:

The proposed regulations implement the provisions of Public Health Law section 2807(2-a), which requires a new ambulatory care reimbursement methodology based on APGs. This reimbursement methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services. This new payment methodology also allows for greater payment homogeneity for comparable services across all ambulatory care settings (i.e., Outpatient Department, Ambulatory Surgery, Emergency Department, and Diagnostic and Treatment Centers). By linking payments to the specific array of services rendered, APGs will make Medicaid reimbursement more transparent. These regulatory amendments, combined with new funding appropriated for APG reimbursed services, will provide strong fiscal incentives for health care providers to improve the quality of, and access to, preventive and primary care services.

The current reimbursement system for ambulatory care services is a mix of out-of-date methodologies that have been, over the years, so frozen and capped as to no longer realistically reflect the cost of providing such care. These methodologies are often based on fixed dollar payments that do not vary by severity of illness. While more and more medicine takes place in outpatient settings, these antiquated reimbursement methodologies thwart the future migration of services from costly acute care settings to less-costly primary and preventive care. Examples of current ambulatory care payment methodologies are as follows:

- Hospital outpatient rates, established under Public Health Law (PHL) § 2807(2)(g)(i) are cost based rates, but the operating cost component has been capped at \$67.50 per-visit since 1991, which is well under costs.

- Hospital emergency department rates, established under PHL § 2807(2)(g)(ii), are cost based rates, but the operating cost component of the rates are capped at \$150 per-visit, which is well under costs.
- DTC rates, established under PHL § 2807(2)(b), are cost based rates, but statutorily frozen since 1995.
- Alternative rates under the Products of Ambulatory Care (PACs) pricing system, available to certain DTCs and hospital outpatient clinics, authorized under PHL § 2807(2)(h), have been frozen since 1995.
- Products of Ambulatory Surgery (PAS) rates for hospitals and DTCs, established under PHL § 2807(2)(e), have been frozen since March of 2003.

Note: The DTC, PACs and PAS rates referenced above are frozen pursuant to an unconsolidated law: § 4 of chapter 81 of the laws of 1995, as most recently amended by § 76 of part C of chapter 58 of the laws of 2007.

The APG methodology addresses the inadequacies of the current system by paying varying amounts per-visit, based on service intensity APGs are a patient classification system designed to explain the amount and type of resources used in various ambulatory visits. Patients in each APG have similar resource use and cost. Consequently, the APG payment for services provided to a person treated in an emergency room for a significant trauma will be relatively more than what would be paid for a patient that receives a minor procedure.

COSTS:

Costs for the Implementation of, and Continuing Compliance with this Regulation to the Regulated Entity:

In aggregate, health care providers subject to this regulation will see an increase in average per-visit Medicaid funding that will more than offset any miscellaneous costs they may incur associated with implementing the APG methodology. However, it is not anticipated that this will be the case for every affected provider. See “*Costs to State Governments*” below, which provides detail regarding the funding increase to health care providers that are subject to the proposed regulatory provisions.

Costs to Local Governments:

There will be no additional cost to local governments as a result of these amendments because local districts’ share of Medicaid costs is statutorily capped.

Costs to State Governments:

Section 19 of Part OO of Chapter 53 of the Laws of 2008 requires a \$56 million aggregate increase in rates of payment for services of general hospital outpatient departments, emergency departments and ambulatory surgical departments for the period December 1, 2008, through March 31, 2009, and \$178 million for periods after April 1, 2009. This new investment of resources is aimed at further incentivizing ambulatory care services. Further, an additional \$1 million was appropriated to enhance APG reimbursement of freestanding clinic services in March 2008, the first month APGs become effective for these providers. These resources, in combination with other appropriated ambulatory care enhanced funding, result in total additional Medicaid reimbursement of \$64.6 million in SFY 08/09 for services that are the subject of this regulation. This investment is funded with \$ \$32.3 million of State funds and \$32.3 million of federal funds.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

This regulation does not duplicate other State or federal regulations.

Alternatives:

These regulations are required by the provisions of Public Health Law section 2807(2-a). During development of the SFY 08/09 Executive Budget, the Department considered various alternatives for creating a new ambulatory care reimbursement methodology. The two major options for a new system were the Ambulatory Patient Group (APG) methodology and the Ambulatory Patient Classification (APC) methodology. The Executive Budget ultimately advanced a proposal to implement the APG methodology because it is comprehensive, covers all medical outpatient services, reimburses based on patients' conditions and severity, and bundles the cost of ancillary services (e.g.: laboratory testing) and procedures into the overall payment. The APC methodology lacks many of these attributes and is more akin with a fee-schedule.

There was much debate during the legislative process regarding the relative merits of enacting APGs or APCs. Associations representing hospitals, clinics, ambulatory surgery centers and other stakeholders made their views known to the Executive and legislature. The ultimate result was enactment into law of the APG reimbursement methodology, because of the strengths of the system described above.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon publication of a Notice of Adoption in the New York State Register.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect on Small Business and Local Governments:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals, diagnostic and treatment centers, and free-standing ambulatory surgery centers. Based on recent data extracted from providers' submitted cost reports, seven hospitals and 245 DTCs were identified as employing fewer than 100 employees.

In aggregate, health care providers subject to this regulation will see an increase in average per-visit Medicaid funding that will more than offset any miscellaneous costs they may incur associated with implementing the APG methodology. However, it is not anticipated that this will be the case for all affected providers.

The APG methodology addresses the inadequacies of the current system by paying varying amounts per-visit, based on service intensity. APGs are a patient classification system designed to explain the amount and type of resources used in various ambulatory visits. Consequently, the new system will be more rational and transparent for health care providers.

The rule will have no direct effect on Local Governments.

Compliance Requirements:

No new reporting, record keeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association (AMA), as is currently required. Some billing rate codes will change, but this will have a minimal impact on providers.

The rule should have no direct effect on Local Governments.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Economic and Technical Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are intended to reform the outpatient/ambulatory care fee-for-service Medicaid payment system and direct new funding to health care providers.

The rule should have no direct effect on Local Governments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent. The Legislature considered various alternatives for creating a new ambulatory care reimbursement methodology. The two major options for a new system were the Ambulatory Patient Group (APG) methodology and the Ambulatory Patient Classification (APC) methodology. The enacted budget adopted the APG methodology, which, unlike APCs, is comprehensive, covers all medical outpatient services, reimburses providers based on patients' conditions and severity, and bundles the cost of procedures and ancillary services (e.g. laboratory tests) into the overall payment.

Small Business and Local Government Participation:

Local governments and small businesses were given notice of these proposals by their inclusion in the SFY 2008-09 enacted budget and the Department's issuance in the State Register

of federal public notices on March 26, 2008, and June 25, 2008. Further, relevant information is published on the Department's website.

Further, the Department has been actively discussing APG implementation issues with providers since the SFY 08/09 budget was enacted, including providing numerous APG training sessions. The Department took into consideration and responded to providers' comments and questions during training sessions and through its APG website.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 44 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene	Saratoga	

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, record keeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes

and ICD-9 codes approved by the American Medical Association (AMA), as is currently required. Some billing rate codes will change, but this will have a minimal impact on providers.

The rule should have no direct effect on Local Governments.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent. The Legislature considered various alternatives for creating a new ambulatory care reimbursement methodology. The two major options for a new system were the Ambulatory Patient Group (APG) methodology and the Ambulatory Patient Classification (APC) methodology. The enacted budget adopted the APG methodology, which, unlike APCs, is comprehensive, covers all medical outpatient services, reimburses providers based on patients' conditions and severity, and bundles the cost of procedures and ancillary services (e.g. laboratory tests) into the overall payment.

Opportunity for Rural Area Participation:

Rural areas and were given notice of these proposals by their inclusion in the SFY 2008-09 enacted budget and the Department's issuance in the State Register of federal public notices on March 26, 2008 and June, 25, 2008. Further, relevant information is published on the Department's website.

JOB IMPACT STATEMENT

Nature of Impact:

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the state Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed regulations, that they will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulations actually result in a greater State investment of Medicaid reimbursement of ambulatory care services.