

§1 Section 841.1 (a) is amended to read as follows:

Section 841.1 Background and intent

(a) The purpose of this Part is to establish standards for reimbursement and participation in the Medical Assistance Program, as authorized by title 11 of article 5 of the Social Services Law, for services provided by chemical dependence providers certified or co-certified by the Office of Alcoholism and Substance Abuse Services. This Part does not apply to [facilities certified by the Office of Alcoholism and Substance Abuse Services and licensed pursuant to Article 28 of the Public Health Law] hospital based programs.

§2 A new subdivision (g) is added to Section 841.2 to read as follows:

(g) Pursuant to section 23 of Part C of chapter 58 of the laws of 2009, the Commissioner is authorized, with the approval of the Commissioner of Health and the Director of the Budget, to promulgate regulations pursuant to Article 32 of the Mental Hygiene Law utilizing the Ambulatory Patient Group (APG) methodology described in subdivision (c) of section 841.14 of this Part for the purpose of establishing standards and methods of payments made by government agencies pursuant to title 11 of article 5 of the Social Services Law for chemical dependence outpatient clinic services otherwise subject to the provisions of this Part.

§3 Section 841.4 (b)(3) is amended to read as follows:

(3) a chemical dependence outpatient or opioid treatment program ~~service which is~~ certified under Part 822 of this Title by the Office of Alcoholism and Substance Abuse Services; or

§4 Sections 841.14, 841.15 and 841.16 are renumbered sections 841.15, 841.16 and 841.17 and a new section 841.14 is added to read as follows:

Section 841.14 Medical assistance payments for chemical dependence outpatient and opioid

treatment programs

(a) This section shall be effective on July 1, 2011 and shall govern Medicaid rates of payments for OASAS certified or co-certified ambulatory care services provided in the following categories of facilities:

(1) chemical dependence outpatient clinics certified or co-certified pursuant to Part 822 of this Title;

(2) opioid treatment clinics certified or co-certified pursuant to Part 822 of this Title;

(3) chemical dependence outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title; and

(4) chemical dependence outpatient services for youth certified or co-certified pursuant to Part 823 of this Title.

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

(1) hospital based chemical dependence outpatient clinics;

(2) hospital based opioid treatment providers; and

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

(c) Definitions

As used in this Part, the following definitions apply:

(1) Ambulatory Patient Group (APG) shall mean a defined group of outpatient procedures or services which reflect similar patient characteristics and resource utilization and which incorporate the ICD-9-CM diagnosis codes and CPT and HCPCS procedure codes as defined below.

(2) Ancillary services shall mean those laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment.

(3) APG weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average utilization for all other APG's. Procedure-

based APG weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a specific procedure. A procedure that has been assigned its own weight shall have its payment derived from its procedure-specific weight without regard to the weight of the APG to which the procedure groups.

(4) Base rate shall mean the numeric value that must be multiplied by the APG weight for a given APG to determine the total Medicaid payment for a service.

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

(6) Coding Improvement Factor (CIF) is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. The CIF will be developed to assure that New York State Department of Health is in full compliance with federally approved reimbursement levels.

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

(8) Current Procedural Terminology (CPT) Codes is the systemic listing and coding of procedures and services provided to a patient. It is a subset of the Healthcare Procedure Coding system (HCPCS). The CPT and HCPCS are maintained by the American Medical Association and the Federal Centers for Medicare and Medicaid Services (CMS) and are updated annually.

(9) Discounting shall mean the reduction in APG payment that results when unrelated, additional procedures or ancillary services are performed during a single patient visit.

(10) Episode shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes cannot be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode-based depending on the rate code used to access the APG software logic. References to "visits" in this Part shall be deemed to refer also to "episodes" for billing purposes.

(11) Existing Payment for Blend shall mean the reimbursement rate/fee in effect on June 30, 2011.

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

(13) Healthcare common procedure coding system (HCPCS codes) shall mean a comprehensive, standardized coding and classification system for health services and products.

(14) Hospital based shall mean a program that is operated by and certified as a hospital pursuant to Article 28 of the Public Health Law and identified as such by the Department of Health.

(15) International Classification of Diseases, 9th Revision (ICD-9) is a comprehensive coding system maintained by the Federal Centers for Medicare and Medicaid Services. It is maintained for the purpose of

providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

(16) 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. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software.

(17) 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.

(18) 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.

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

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

(d) System Transition

There will be a transition to APG reimbursement consisting of a blended payment. For chemical dependence outpatient clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 18 NYCRR 505.27 and the APG reimbursement established pursuant to this Part. For opioid treatment clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 10 NYCRR 86-4.39 and the APG reimbursement established pursuant to this Part. The blended payment will be calculated as follows:

(1) The Office shall identify the existing payment for blend payment for each provider based upon the reimbursement rate/fee in effect on June 30, 2011; and

(2) Payments will be made pursuant to the following transition schedule:

(i) Phase 1 shall be the 12 month period beginning on July 1, 2011. Providers shall receive 75% of the existing payment for blend payment and 25% of the calculated value of the APG reimbursement established pursuant to this Part;

(ii) Phase 2 shall be the 12 month period following Phase 1. Providers shall receive 50% of the existing payment for blend payment and 50% of the calculated value of the APG reimbursement established pursuant to this Part;

(iii) Phase 3 shall be the 6 month period following Phase 2. Providers shall receive 25% of the existing payment for blend payment and 75% of the calculated value of the APG reimbursement established pursuant to this Part;

(iv) Phase 4 providers will receive 100% APG reimbursement established pursuant to this Part.

(e) Rates for new providers during the transition period

(1) Newly certified providers commencing outpatient services pursuant to this section will receive the existing payment for blend payment they would have received had they begun providing services prior to commencement of this Part.

(f) APG Categories and associated weights

(1) APG categories shall be subject to periodic revision. The APG categories specific to chemical dependency outpatient and opioid treatment services include the following:

| APG | HCPCS/CPT | APG Description |
|-----|-----------|--|
| 315 | G0396 | Counseling or Individual brief Psychotherapy, alcohol or substance abuse intervention |
| 315 | 90804 | Counseling or Individual brief Psychotherapy, office visit |
| 316 | G0397 | Individual Normative, Comprehensive Psychotherapy, alcohol or substance abuse intervention |
| 316 | 90806 | Individual Normative, Comprehensive Psychotherapy, office |
| 317 | T1006 | Family/Couple Counseling |

| | | |
|-----|-------|--|
| 317 | 90846 | Family Psychotherapy without patient |
| 318 | H0005 | Group Counseling, alcohol and or drug services |
| 318 | 90849 | Group Counseling, multiple family group therapy session for multiple similarly situated families |
| 318 | 90853 | Group Counseling, Group psychotherapy |
| 322 | H0020 | Methadone Administration |
| 322 | H0033 | Oral medication administration, direct observation |
| 323 | H0001 | Metal Hygiene Assessment, alcohol or drug assessment |
| 323 | H0002 | Metal Hygiene Assessment, behavioral health screening for admission eligibility determination |
| 323 | 90801 | Metal Hygiene Assessment, Normative, Psychiatric diagnosis interview |
| 324 | H0049 | Mental Health Screening and Brief Assessment, Alcohol and/or Drug screening |
| 324 | H0050 | Mental Health Screening and Brief Assessment, Alcohol and/or Drug service, brief intervention |
| 324 | T1023 | Mental Health Screening and Brief Assessment, Program intake assessment |
| 327 | S9480 | Intensive Outpatient Program (IOP) |
| 328 | H2001 | Outpatient Rehab 2-4 Hour Duration |
| 329 | H2036 | Outpatient Rehab 4 Hour and Above Duration |
| 426 | H0014 | Routine Medication Management and Monitoring, Alcohol and/or drug services |
| 426 | M0064 | Routine Medication Management and Monitoring, Visit for Drug Monitoring |
| 426 | 90862 | Routine Medication Management and Monitoring, Medication Management |
| 490 | H0038 | Peer Counseling |
| 490 | 90882 | Complex Care Coordination |

(2) The Department of Health, in consultation with the Office shall assign weights associated with all CPT and HCPCS procedure codes which can be used to bill any APG category, including those referenced in this Part. The assigned weights shall be set forth at 10 NYCRR Part 86. The Office shall maintain and update a list of weights associated with APG categories set forth in this Part. Such list may include APG categories not specifically associated with chemical dependency outpatient and opioid treatment services, but which may

appropriately be billed by providers subject to this Part. Such list shall be published in the State Register and posted on the Office's website.

(g) Base Rates

Base rates for chemical dependence outpatient services as set forth in 14 NYCRR 822 and outpatient chemical dependency services for youth as set forth in 14 NYCRR Part 823 shall be developed by the Office, and subject to the approval of the Department of Health, in accordance with the following:

(1) Separate base rates shall be established based on the location of such provider in the Upstate or Downstate region and such base rates shall reflect differing regional cost factors and include capital reimbursement;

(2) Additional discrete base rates may be developed by the Office for such peer groups as may be established by regulation in this Part; and

(3) Base rates may be periodically adjusted to reflect changes in provider case mix, service costs and other factors as determined by the Office.

(h) System Updating

(1) The following elements of the APG rate-setting system shall be reviewed at least annually, with all changes published in the State Register and posted on the Office's website:

(i) The listing of reimbursable APG categories and associated weights assigned to each such APG set forth in this Part;

(ii) The base rates;

(iii) The applicable ICD-9 codes, or subsequent ICD categorization, utilized in the APG software system;

(iv) The Applicable CPT/HCPCS codes utilized in the APG software system; and

(v) The APG software system.