APC Checklist (2010 update)

Save to myBoK

This practice brief has been retired. It is made available for historical purposes only.

Editor's note: This update replaces the September 2000 practice brief "An APC Checklist."

Ambulatory Payment Classifications (APCs) were implemented August 1, 2000, for hospital outpatient services provided to Medicare beneficiaries. When the Centers for Medicare and Medicaid Services (CMS) implemented APCs, it fundamentally changed the way hospitals are reimbursed for outpatient services.

Before 2000, since the beginning of the Medicare program in the 1960s, hospital outpatient services were almost entirely based on cost. Now services provided under the hospital outpatient prospective payment system (OPPS) are classified into APCs.

APCs are made up of CPT and HCPCS level II codes that are divided into approximately 900 categories. Each APC is assigned a national payment rate that is based on the median cost for all services within the APC. Organizations can receive payment on one or more APC per hospital encounter; however, if no payable HCPCS code is assigned to the claim, no payment is received.

Since 2000, there have been a number of significant updates to the APC system. These updates are the result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and the Deficit Reduction Act of 2005. Organizations can stay abreast of annual changes to the APC system via the annual updates to the OPPS that go into effect each January.

The OPPS annual updates include almost all services provided in an outpatient setting (e.g., ancillary departments, hospital-based clinics, emergency departments, and outpatient/same-day surgeries). In addition, OPPS updates can include certain inpatient Part B-only services.

Services and organizations excluded from OPPS updates include:

- Any service paid on a prospective basis
- Critical access hospitals
- Diagnostic treatment centers
- Skilled nursing facilities
- Nursing homes

This practice brief provides guidance on how organizations can use HIM processes to optimize success with OPPS. The following list, although not exhaustive, outlines four critical areas of organizational system involvement for APC success. These areas include:

- Development of the APC coordinator or team charged with managing the APC revenue cycle
- Examination of the revenue cycle and documentation processes for APC outcomes
- Validation of code selection and reimbursement data that affect APC groups
- Identification and implementation of information systems and technological changes to meet APC requirements and use the system for organizational advantage

APC Management Points to Consider

In general, APC management requires consideration of the following points:

- Training information and APC processing information have been provided by CMS via the Internet and by educational programs conducted by CMS contractors. To stay informed about APC details and updates, visit the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp.
- Chapter 4 of the Medicare Claims Processing Manual (Publication 100-04) provides information on OPPS claims processing and can be accessed at www.cms.hhs.gov/manuals/downloads/clm104c04.pdf.
- Hospital OPPS –regulations and notices are available on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.
- Outpatient Code Editor (OCE) specifications can be accessed at www.cms.hhs.gov/OutpatientCodeEdit/01_Overview.asp.

APC Coordinator: Leading the Process

Critical to the success of APC processing is the appointment of the appropriate individual to coordinate and lead the APC revenue cycle process. Key factors to consider include:

- The nature of the system requires knowledge and expertise of outpatient information management that goes beyond the HIM department. Like HIM processes, OPPS regulations affect the billing systems and clinical departments, so it is important to select someone with knowledge of how HIM and other hospital departments interact, collaborate, and complement each other.
- The coordinator's skill set must include a working knowledge of the information systems used throughout the facility. Furthermore, the coordinator must ensure that the systems provide accurate billing and associated reimbursement regardless of the patient's insurance plan.
- The coordinator may be dedicated to APC work or, in smaller facilities, have responsibilities in addition to APC coordination. It is important to outline what and where the additional job tasks and functions would be.

The APC coordinator must possess skills that support the following functions:

- Management of the processes surrounding APC grouping structure and payment systems
- Analysis of information flows for the billing process and cycle and clinical documentation in the organization that provides support to the billing process
- Education and training initiation, delivery, and follow-up for hospital staff and physicians about APCs
- Coordination of outpatient reimbursement monitoring by providing feedback and facilitating corrective action as needed to keep APC processes on track
- Collaboration with all departments that select or assign ICD-9-CM and HCPCS or CPT codes. This may occur directly by chargemaster, be specified by encounter form or order entry at the point of service, or be assigned by coding professionals after analysis of completed records in the HIM department.

Team Approach: Ensuring Compliance

No individual is capable of ensuring APC success without top-level organizational buy-in and support. A team or committee should be developed for problem solving and oversight of the APC revenue cycle process because so many departments and functions are involved. There should be representation from the following departments:

- HIM
- Information technology
- Diagnostic services
- Nursing staff from ambulatory surgery and ancillary areas
- Case management or utilization review staff
- Corporate compliance representation
- Patient finance
- Business office or patient accounts
- Registration services
- Administration

A medical staff liaison should be an ad hoc member to consult when issues arise that require physician insight or action. The APC coordinator and team must first secure support from the executive administration of the organization so that resources are appropriated and continue for APC optimization.

Examination of the Revenue Cycle and Documentation Processes

Organizations should follow these steps to assess their processes:

- Examine the revenue cycle to enhance all outpatient service processing
- Map the information flow through the organization's automated information systems to ensure completeness and accuracy of information transfer
- Chart the physical process and software that supports high-level overview of the systems and the detailed, lower-level information flows
- Use tools that support process mapping, data-flow diagrams, schematic overviews, and data definitions
  Identify redundancies and gaps within and between the information systems and standardize data definitions
- Define the relationship between systems
- Identify potential errors that occur from rekeying coded data and mapping or crosswalking data between systems
- Review the information systems that generate supporting documentation for charges included on the CMS-1450 (UB-04)
- Determine the adequacy, types of access, and efficiency of documentation
- Include the transcription system, document repository, and results reporting in the information systems review
- Review all services eligible for reimbursement

Validation of Code Selection and Reimbursement Data

Organizations should follow these steps to validate code selection and reimbursement data:

- Perform an in-depth review of the chargemaster detail because the majority of charges associated with services paid under OPPS are generated through the chargemaster
- Review claims data periodically against source documents to ensure correct information transfer through the organization's system and adequate documentation to support billing
- Include a review of compliance to coding guidelines, interpretation of documentation, and the quality of the documentation available for code selection
- Designate clearly who is responsible for the code used on the claim and what the consequences might be if more than one department submits codes for the same service
- Determine whether a comprehensive review might be accomplished with the assistance of outside consultants
- Ensure that this review includes the accuracy of codes in the chargemaster and the possibility that modifiers may be required for some chargemaster-assigned codes for services
- Develop a system in which the HCPCS codes must be matched to the appropriate revenue codes because revenue codes drive the packaging in the APC system
- Make sure that the revenue codes are specific to the right level and that the integrity of information from chargemaster to claim form is infallible
- Review all denied claims, claims marked "return to provider," and all rejected line items to scrutinize the processes that should be improved to minimize these occurrences

Using IT to Meet APC Requirements

Organizations should embrace and expand their information technology to assist in decision making and analysis of outpatient services' profit and loss. Although the APC system objective is to control costs for Medicare beneficiaries, it is possible that successful APC management will indicate areas in which quality services may be provided with reasonable return. Follow these steps:

- Group outpatient services by APC to provide a tool for reviewing revenue, cost, use of services, and identification of areas where efficiency or improvement is needed. It may be used for all patients regardless of payer type for operational assessment and review.

- Integrate or interface two groupers. Medical record information abstracting and reporting systems must be able to support a minimum of two groupers (APC and DRG) so that both inpatient and outpatient services can be processed. Some systems can support only one grouper in real time, so it is necessary to perform additional processes, such as severity grouping of patient information by batch processing on a stand-alone system.
- Explore and develop the optimal placement of the APC grouper. Unlike the DRG system, the APC system has the additional challenge of using both chargemaster-assigned and coder-assigned procedures in the final grouping process. This creates a question about the optimal placement of the APC grouper and the point of APC group assignment for data collection and reporting purposes. As with DRGs, the fiscal intermediary or Medicare Administrative Contractor will perform the actual grouping on the basis of the codes submitted. However, for monitoring and evaluation purposes, facilities should consider the APC case's effect before a claim is submitted. This allows any clarification or adjustments to be made or additional services to be added to a claim that were inadvertently missed.

The APC system can be used for organizational advantage if all areas collaborate to find APC solutions and work together to improve data quality and consistency for outpatient service reporting.

Resources

AHIMA OPPS Community of Practice. Available online at http://cop.ahima.org. https://cop.ahima.org/COP.

AHIMA. "Medicare Reimbursement Highlights." Available online at www.ahima.org/reimbursement.

Baril, Arlene F. "Charge Description Master: Understanding Its Role in OPPS." 2007 AHIMA Convention Proceedings, October 2007. Available online in the AHIMA Body of Knowledge at www.ahima.org.

Centers for Medicare and Medicaid Services (CMS). "Hospital Outpatient Prospective Payment System Overview." Available online at www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp.

CMS. "Hospital Outpatient Prospective Payment System Regulations and Notices." Available online at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.

CMS. "Outpatient Code Editor (OCE) specifications."Available online at www.cms.hhs.gov/OutpatientCodeEdit/01_Overview.asp.

Kuehn, Lynn. "Hunting for Hidden Treasure in Your Coded Data." 2008 AHIMA Convention Proceedings, October 2008. Available online in the AHIMA Body of Knowledge at www.ahima.org.

Lenahan, Monica. "Coding Cardiovascular Catheterization: Accuracy Requires a Multidisciplinary Effort." *Journal of AHIMA* 80, no. 1 (Jan. 2009): 68–70.

CMS. Medicare Claims Processing Manual (Publication 100-04). Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)." Available online at www.cms.hhs.gov/manuals/downloads/clm104c04.pdf.

Russell, Jean C. "Medicare APCs 2007: Where We Are Seven Years Later." AHIMA's 79th National Convention and Exhibit Proceedings, October 2007. Available online in the AHIMA Body of Knowledge at www.ahima.org.

Walk, Gerri. "Coding Radiology Services." *Journal of AHIMA* 80, no. 1 (Jan. 2009): 72–74.

Youmans, Karen, and Staci Smith, Staci. "Revenue Cycle Management-Key Indicators and Reports that You Need to Know." 2008 AHIMA Convention Proceedings, October 2008. Available online in the AHIMA Body of Knowledge at www.ahima.org.

Prepared by

Judy A. Bielby, MBA, RHIA, CPHQ, CCS

Prepared by (original)

Rita Scichilone, MHSA, RHIA, CCS, CCS-P and Karen Youmans, MPA, RHIA, CCS, practice managers, coding products and services, AHIMA

Acknowledgments (original)

Sandra Fuller, MA, RHIA
Mary Uppena, RHIA, CPHQ
Ann Zeisset, RHIT, CCS, CCS-P

Article citation:
AHIMA. "APC Checklist (2010 update)." *Journal of AHIMA* (Updated March 2010).