Coding for APCs: Case Studies

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When APC implementation begins on August 1, HIM professionals can expect increased complexity when coding outpatient encounters. Examining case studies in selected areas subject to APC payment may help coding professionals better understand the APC reporting process. Although coding guidelines will not change for the APC system, reimbursement will depend on the accuracy and completeness of code selection. Hospital coders must also consider the National Correct Coding Initiative (NCCI) Edits, which become part of the Outpatient Code Editor with APC implementation. These edits will be applied to all CPT-reported services. There are 451 APC groups represented by four-digit APC group numbers.

Medical Visits

Emergency room encounters and hospital-based clinic visits both result in medical APC groups when evaluation and management (E&M) codes from CPT are reported.[1] When significant or surgical procedures are performed as part of the treatment, the medical visit may be considered incidental to the surgical service performed. CPT codes from the E&M section will drive reimbursement in medical visit groups. It is possible to receive reimbursement for both a medical and a surgical service APC, but modifier -25 will be required on the E&M code to show that the medical visit services are distinct from the significant procedure and deserve the extra payment. Visit services reported by an E&M code without a modifier may be bundled into any surgical service that occurs at the same time as part of the NCCI edits.

Example: A Medicare patient presents to the emergency room for assessment of injuries from a fall on the steps of her home. She lives alone and cannot get regular physician care because she must rely on a neighbor for transportation. The emergency department physician evaluates the injuries, which include a 2.4 cm skin tear to the right elbow, a swollen left knee, and a significant bump on the forehead. A detailed history is taken and a thorough examination is performed, including a cardiovascular assessment and a detailed orthopedic exam. Knee x-rays are taken and a skull series is performed, even though the patient did not lose consciousness. The patient complains of back pain and dysuria and is found to have elevated blood pressure. A CBC and urinalysis are ordered. The laceration is repaired by the emergency department physician and the patient is placed in an observation bed for four hours before she is discharged to the care of her neighbor. Norvasc was prescribed for the hypertension and Bactrim prescribed for the urinary tract infection. No fractures were found, but neurologic assessment was suspicious for a mild concussion. The CBC revealed a hemoglobin of 11.4. The diagnoses listed by the physician were slight concussion due to fall at home; hypertension; laceration of the elbow, repaired with sutures; contusion and joint effusion of the knee; and urinary tract infection.

Diagnosis codes:	850.0, 881.01, 924.11, 719.06, 599.0, 401.9
Procedure codes:	99284-25, 12001, 70250, 73560, 81001, 85022
APC results:	Medical Visit APC 0612 for 99284 (V) Surgical APC 0024 (T) Ancillary APCs 0260, APC 0260 (X) Laboratory tests paid according to fee schedule (A)

Discussion: The alpha characters listed are the status indicators taken from the APC system and are assigned to each CPT code to guide reimbursement impact. In this case, payment would be provided for the emergency room service separately from the surgical APC, because the E&M services were above and beyond what would have been expended if only the laceration was repaired. In a case where the treatment (laceration repair or fracture care) is the only service performed, only a surgical APC would be reimbursed. The medical service would be considered incidental to the surgical service. Modifier -25 is required to report cases where the two services are distinct. Services with the ancillary (X) or significant procedure (S) status indicator are not reduced, and 100 percent of the APC payment will be approved. Services with the "T" designation are

paid at 100 percent only when they are the only surgical service. When more than one are provided during an episode of care, the subsequent procedures are discounted by 50 percent.

Although diagnosis and CPT code combinations were considered in APC grouping for medical visits, that method was rejected as too complex. Only the CPT code drives the medical visits. Three levels are possible, depending on the intensity of the services provided. Any observation services provided following the emergency room services are included in the codes for the medical visit and will not receive additional payment. However, HCFA still requires the hospital to report the observation services using revenue code 762 and report the observation hours in the units field. No HCPCS codes are required at this time.

Fracture Care Coding in the ER

Coding professionals must keep in mind that fracture care reporting in the emergency department would result in a significant procedure or a surgical APC. According to CPT guidelines, fracture care codes are reported only when the physician providing provides the entire service, including follow-up visits.[2] When casting or strapping is applied without restorative care, or to afford comfort to the patient while awaiting orthopedic consultation, then the codes from the application of casts and strapping section of CPT are reported rather than a fracture care code. In the APC system, codes 29000 through 29799 in CPT have a status indicator of "S" and generate a separate APC.

Ancillary Service Visits

Medicare patients that are served in the ancillary areas of hospital outpatient departments will be reimbursed according to an ancillary visit group APC assignment. Ancillary services are also paid in combination with medical and surgical services when provided. These CPT codes, usually chargemaster-assigned in hospitals, have a status indicator of "X" and are not subject to either discounting or packaging with other services.

Example: Following complaints of indigestion and abdominal pain, a Medicare beneficiary is referred from a physician's office for x-rays to rule out cholecystitis. The patient presents to the hospital radiology department, where technicians perform an upper GI examination. No gallstones or evidence of cholecystitis are documented by the radiologist, so the diagnosis codes reported are taken from the diagnosis provided by the referring physician. This would be 780.00 and 536.8. If a more definitive diagnosis were available from the radiologist (i.e., cholelithiasis or cholecystitis), it would have been appropriate to report the more definitive codes.

APC results: CPT code 74240 = APC 0276

Discussion: Because no other services are rendered, only the payment for APC 0276 results. In the APC methodology, this service is not considered a "visit." A visit is defined as "direct personal contact between a registered hospital outpatient and a physician (or other person who is authorized by state licensure laws and where applicable hospital staff bylaws to order or provide services for the patient)." Because an x-ray or lab test is performed by technical personnel, no E&M code would be applied to generate a medical APC for this patient type. If this test were provided in conjunction with an emergency room visit, both a medical APC and an ancillary APC would be reimbursed by Medicare.

Example: A patient with squamous cell carcinoma of the posterior pharyngeal wall has metastasis to the cervical lymph nodes. Following consultation with the oncology team, the patient refused surgical intervention and elected to begin radiation therapy daily on a 6 MV linear accelerator. The radiation was delivered by hyperfractionation technique; each field was treated twice each day, through a pair of large opposing lateral head and neck fields covering the primary cancer, the suspected areas of extension and the lymph nodes in the neck. Three separate treatment areas are involved and customized shielding blocks are employed to shield normal tissue and shape the field to follow the anatomic boundaries. Prior to the encounter under consideration, the clinical treatment parameters and dosimetry calculations have been completed and the simulation-aided field settings have been accomplished. Treatment is provided for five dates on this claim.

In the APC system, significant procedures are found outside the surgical section of CPT in the radiology section as this one for reporting radiation therapy.

APC results: Code 77413 is the correct radiation treatment delivery code. Note that the services were provided twice a day. In the case of hyperfractionation, where the patient is treated in the morning and afternoon of the same day, two units of service are charged for each day resulting in 10 assignments of APC 0301. Medicare requires reporting the time of day of each treatment, commonly six hours apart.

Discussion: The units field is very important in the APC payment methodology. Medicare instructions for recording units may be different than other payers. Billing instructions for the units field of the UB-92 for Medicare use are found in section 460 of the Hospital Manual Publication 10.[3]

Other ancillary services, like laboratory services and physical, occupational, and speech therapies are not subject to APC reimbursement at this time and show status indicators of "A." These services are reimbursed by Medicare according to a fee schedule.

Ambulatory Surgery

In the APC method, significant procedures are found within the surgical section of CPT, as well as the radiology and medicine sections. A significant procedure is paid at 100 percent of the allowed amount in a case with more than one procedure performed in a visit. An example is the insertion of an emergency airway reported with code 31500. Other procedures that are performed on an outpatient basis in the emergency department or scheduled in the operating room or endoscopy suites may have a status indicator of "T." These procedures will be reimbursed at 100 percent of the highest-weighted procedure, with all subsequent procedures paid at 50 percent of the allowed amount.

Example: A 66-year-old patient with thyroid ophthalmopathy hyperplasia requires a correction of an eyelid retraction on the left side. The blepharoplasty is performed using a graft from the buccal area as a spacer.

Diagnosis codes:	242.00
Procedure codes:	67911, 20926
APC results:	APC 0240 results from code 67911, with APC 0026 added for code 20926

Discussion: Both procedures have a "T" indicator status, which means 100 percent of the higher-weighted procedure is paid, while the lesser procedures are discounted by 50 percent. ASC reimbursement for this case would have grouped to ASC group 3 for the lid retraction repair and ASC group 4 for the tissue graft. ASC methods would allow 100 percent of the highest group (4) and 50 percent of the lower group (3) blended with cost amounts to calculate payment for hospital outpatient services. It is clear how reimbursement could be affected by incomplete coding. If the tissue graft code was not reported, $293.59 (or 50 percent of $587.18, unadjusted payment) would be lost. When multiple procedures are reported, the APC pricer program selects the one with the highest weight for 100 percent reimbursement and applies the 50 percent discount to all other procedures. Because the code 67911 has a higher relative value, it is the procedure that is paid in full. The tissue graft code is discounted by half. If there were any additional procedure in the same session, they would also be discounted by 50 percent unless they were designated as an "S" as a significant procedure. These procedures are not subject to APC discounting.

Example: A patient had thermal balloon ablation of the endometrium, also called UBT (uterine balloon therapy). A mild sedative is administered to relieve the patient's anxiety. A ThermaChoice Uterine Balloon Therapy System device is inserted through the vagina into the uterus. Once in place, the balloon is inflated with 5 percent water/Dextrose solution to a pressure of 160-180mm Hg. The solution is heated to 87 degrees Centigrade. The balloon was left in place for seven minutes to coagulate the endometrium. The patient is then transferred to the outpatient recovery area for observation to assure no complications and then released to the group home where she lives.

APC results:	APC 0190 results from assignment of code 58563

Discussion: There is only one code that describes endometrial ablation in CPT. Because the procedure was reduced (no hysteroscopy involved), the service could be reported with modifier -52 for reduced services. It is not clear what reimbursement impact reporting modifier -52 for surgical services may have. For radiology procedures, no reduction in the payment amount occurs.[4] The Federal Register discusses modifier -52 for discontinued procedures that do not require

anesthesia and states that a 50 percent reduction in reimbursement will be applied.5 Alternatively, the unlisted code 58579 could be reported, which results in the same APC group (0190).

As the APC system unfolds, there will certainly be more questions about modifier application and reporting of code combinations that will affect Medicare APC payments. Watch the HCFA and AHIMA Web sites for updates, and pay attention to Medicare Bulletins from your fiscal intermediary. Attend any intermediary-sponsored training sessions in your area for additional clarification and code reporting instructions. Future "Coding Notes" columns will cover any special coding requirements for APCs as they develop.

Notes

1. *Federal Register* 65, no. 68 (April 7, 2000): 18434-18820. Available at www.access.gpo.gov/su_docs/fedreg/a000407c.html.

2. American Medical Association. *CPT 2000* Professional Edition. Chicago, IL: American Medical Association (1999): 130-131.

3. Medicaid and Medicare 1999 Hospital Manual, Publication 10, page 460. Available at www.hcfa.gov/pubforms/progman.htm.

4. Medicaid and Medicare 1999 Program Memos, Transmittal No. A-99-41, *Clarification of Modifier Usage in Reporting Outpatient Hospital Services,* September 1999. Available at www.hcfa.gov/pubforms/transmit/A994160.htm.

5. *Federal Register* 65, no. 68 (April 7, 2000): 18475. Available at www.access.gpo.gov/su_docs/fedreg/a000407c.html.

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