Making a Proactive Transition to APCs

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by Lyn Willett, RHIT

There's no doubt APCs are going to change the way your facility operates, but do you know how? By taking a look at your existing systems, you'll get a better idea of how to prepare for changes. This article spotlights specific functions to consider and optimize for the new outpatient prospective payment system.

Ambulatory Payment Classifications (APCs) are one of the many forces promising to change the way your HIM department operates in the near future. Although the Health Care Financing Administration (HCFA) did not publish the final regulations for the new outpatient prospective payment system until April 7, 2000, the implementation date will be August 1, 2000. While HCFA's revised implementation schedule allowing a three-year phase-in period may ease some of the operational impact and financial risks of this new payment system, it will do little to minimize the significant operational changes that must occur for many facilities to continue providing a broad range of outpatient services. This means the time to prepare your facility for APCs is now.

By virtue of their complexity, APCs will demand teamwork and partnerships among all departments connected to patient encounters. Facilities will have to develop work flow and data processes that run like well-oiled clocks. Enhanced data capture capabilities will be necessary, and accurate and timely coding of all outpatient encounters will be a necessity. Failure to understand the significance of APCs and their far-reaching operational and financial impact will most certainly translate to lost revenues and even place in question the long-term survival of some facilities.

What Do We Know About APCs?

Drawing from our experiences with inpatient prospective payment, we can quickly recognize the similarities between Diagnosis Related Groups (DRGs) and APCs. Both systems are driven by coded data. Patient encounters are classified using grouping methodologies and payments are weighted in both systems.

The differences, however, are significant. Under DRGs, facilities are reimbursed for each admission. Under APCs, facilities will be reimbursed for each encounter. While ICD-9 codes drive both the DRG assignment and subsequent reimbursement, APCs are determined based on ICD-9 diagnostic codes and CPT/HCPCS coding, which are unfamiliar to many hospital-based coders. A single DRG is reimbursed for each inpatient admission while multiple APCs can be reimbursed for a single patient encounter. The current UB-92 billing document provides adequate data capture and transmission for the billing of inpatient services. In contrast, APCs require that numerous CPT/HCPCS codes and their associated dates of service must be captured and accurately transferred to the billing claim form. Many existing information systems may have to be modified or even replaced to ensure adequate data capture for billing purposes.

Finally, impatient modeling and financial forecasting was relatively easy due to the abundance and quality of inpatient coded data. Conversely, many facilities have minimal outpatient coded data and the data that is available is frequently suspect in terms of integrity. Contributing to the scarcity and questionable integrity of outpatient data is the lack of comprehensive outpatient documentation. This lack of data may make it very difficult for facilities to assess their financial risks under this system and almost impossible for them to ascertain whether or not any services can be discounted.

Which Departments Will Be Affected?

APCs will require teamwork and partnerships between departments. Staff who schedule tests and procedures will need to understand the issues associated with compliance and medical necessity. Registration and admitting personnel must know ICD-9 diagnosis coding. Clinical personnel working at the points of service must appreciate how the charges they enter through the chargemaster become CPT or HCPCS codes that may affect the APC grouping. Coders need to become familiar with the

chargemaster, CPT coding, and E&M coding. Billing personnel must comprehend modifiers and know CPT codes well enough to distinguish billable services from nonbillable services. Information systems personnel will have to understand how data captured at scheduling, admitting, and the point of service must be aggregated and submitted on the billing document.

The first step to understanding the significance of APCs is to follow a patient or series of patients through your outpatient facility. Because many encounters begin when a patient is scheduled, your scheduling personnel must understand their role in outpatient prospective payment and consider the following questions:

- Should the test, procedure, or exam be scheduled as inpatient or outpatient?
- Is the patient having any additional tests or procedures performed elsewhere at the facility on the same day?
- Will the services scheduled be reimbursed by Medicare or should registration personnel be notified of the need to have an advance beneficiary notice (ABN) signed at the time of registration?

The role of registration and admitting personnel will also expand under APCs. To ensure adequate admitting processes, your facility will need to answer the following questions:

- Are registration sites centralized or decentralized?
- Do all registrars require a written physician's order or referral form?
- Is there an efficient mechanism or system in place to determine the correct ICD-9 and CPT codes at the time of registration?
- Have registrars been trained to understand medical necessity as it relates to Medicare patients?
- Do registration personnel understand the need to issue an advance beneficiary notice (ABN) for services not covered by Medicare?
- Do registrars have adequate policies and procedures to guide them when a patient refuses to sign an ABN?

As you follow the patient through your facility, here are a few more questions to consider: **do clinical personnel understand that many of the charges they enter through the chargemaster are actually CPT/HCPCS codes that affect APC assignment?** Have clinical personnel been trained to select the correct account number for each patient visit? Are they aware of the need to enter charges in a timely manner because there is no clear provision for supplemental billing under APCs?

Once all the tests or procedures have been completed, the patient will most likely leave your facility. Within hours or sometimes days, this patient encounter will be coded and billed. To ensure the accuracy of all coding, **are all outpatient records coded by HIM professionals? Is documentation sufficient to support the codes are assigned?** Are inadequately documented records withheld from billing until documentation has been completed?

In those circumstances when an outpatient is admitted to your facility due to complications or symptoms such as nausea or vomiting, **does your facility have adequate policies and procedures to ensure all charges are entered correctly?** Do your coders know how to select the principal diagnosis? Do your billing personnel know whether this should be one or two accounts?

Maintaining Coding and Billing Integrity

Typically, patient records are analyzed for documentation deficiencies and coded and abstracted within a few days of patient discharge. However, sometimes hospital-based clinics and outpatient departments process and code their own discharged patient records. Coding these records may present a problem under outpatient prospective payment.

Accurately coding and billing all services provided is essential to appropriate payment under APCs because they are calculated based on CPT/HCPCS codes, revenue codes, and for visits, a combination of the CPT/HCPCS codes and the ICD-9 principal

diagnosis code. Any coding other than that assigned through the chargemaster should be done by skilled and credentialed medical records personnel.

It is also important to understand what information and documentation HIM personnel use to assign codes. Following are a few questions to consider:

- Is the reason for the visit appropriately documented?
- Does the patient record contain the original physician's order or referral form?
- Are the services provided adequately documented?
- Are coding guidelines being followed?
- How are documentation concerns resolved?
- Is documentation completed in a timely manner?
- How is the medical staff given education and feedback about vague or nonspecific diagnoses?
- Is the medical record documentation sufficiently legible to withstand the scrutiny of peer review organizations or the Office of the Inspector General?

Understanding the flow of your coded data will be of utmost importance as all chargemaster-assigned and HIM professional-assigned codes will play a role in the APC grouper logic. When reviewing your flow of internal data, determine the circumstances in which codes assigned by HIM personnel override those assigned through the chargemaster. Further, when two similar CPT/HCPCS codes are assigned by the chargemaster and the coders, facilities will need to be aware of the circumstances that determine whether both codes can appear on the billing claim form.

All patient encounters should generate a billing claim form. However, not all patient encounters are accounted for; therefore, not all are coded or billed. This is lost revenue. Systems must be in place to account for all patient encounters.

Overseeing billing operations is a critical component when operating under outpatient prospective payment. Efforts to reduce days in accounts receivable may have to be reevaluated. Billing personnel must understand the critical nature of ICD-9 and CPT/HCPCS code assignments and that codes can not be changed or resequenced because official coding guidelines dictate the sequence. They must also be aware of compliance issues like the 72-hour rule, bundling and unbundling, series patient billing, and the significance of submitting a duplicate claim to HCFA. Prudent billing departments will implement processes to ensure that an ABN has been signed prior to billing Medicare patients for noncovered services.

Building a Team

Successful facilities under APCs will be those that foster team building. Billing, clinical areas, and HIM personnel will need to cooperate to ensure that all services billed are appropriately documented in the medical record. HIM, billing, and finance will have to collaborate to ensure that all services rendered are appropriately billed. Registration, HIM, billing, and finance will have to form a close partnership to ensure all patient encounters are accounted for and properly documented, coded, and billed.

Similarly, administration will have to work closely with the medical staff to ensure physicians understand what will be expected of them in terms of physician orders, referral forms, and documentation of medical necessity. The information systems department will have to connect with all outpatient service areas and charge-generating departments to ensure appropriate data capture and reporting capabilities. In short, hospital departments will have to communicate more effectively and operate as a single team that is focused on the same goals rather than several individual departments working independently. The departments and teams that work well together to analyze problem areas and take corrective action quickly will have the greatest success under outpatient prospective payment.

Considering the Financial Impact

A study in August 1999 found that 95 percent of hospitals did not understand APCs and did not know how to prepare for them. Sixty-two percent believed they did not have adequate outpatient coding staff in place to tackle APCs, while 60 percent had not reviewed outpatient flow to find areas for coding improvement. Finally, 60 percent of participants said their hospital CFO had no idea of the financial impact APCs could have on their bottom line.

A survey of medical records directors conducted by Medical Records Briefing approximately six months later found that 54 percent of facilities had not yet begun preparations for the arrival of outpatient prospective payment. Based on these results, it is not surprising that most CFOs are concerned that APCs will financially harm their organization. At a minimum, CFOs are concerned about the labor and time that will be necessary to redesign the delivery of outpatient services and the needs and costs associated with expanding their credentialed coding personnel and undertaking a comprehensive review and update of the facility chargemaster. In addition, many CFOs have stated that their facilities' information systems may have to be upgraded or even entirely replaced.

Given these factors and the amount of work to be done in a very short time, it will be extremely difficult for hospitals to know if they can take advantage of the opportunity to reduce or waive co-payments. Further, hospitals may be unable to immediately identify profitable and unprofitable services. A comprehensive review and update of the chargemaster will take time, as will educating hospital staff and physicians about outpatient prospective payment. Further, revamping internal processes and building mutual trust and a team attitude between departments and professionals who have historically worked independently will be a work in progress.

Certainly, there are challenges ahead of us with outpatient prospective payment. As professionals we will have to be open to probing questions about our processes and procedures. We will have to challenge ourselves to learn more about revenue codes, the chargemaster, CPT coding, and modifiers. Finally, we will have to listen attentively as issues are identified and stretch our minds to help remove obstacles and improve processes wherever possible.

Getting Started With APCs

getting started with APCs As with many new projects, the most difficult part of preparing your facility for outpatient prospective payment is getting started. Here's a manageable approach for implementing APCs:

Create a multidisciplinary APC implementation team that looks at all the implications of outpatient prospective payment. The team should:

- assess data capture requirements
- review manual and automated processes and systems to identify limitations and opportunities for error
- assess outpatient coding accuracy, including the quality and completeness of physician documentation
- assess your ability to capture both direct and indirect costs for services
- begin developing a comprehensive APC database
- initiate financial impact analysis
- identify profitable and non-profitable services
- explore alternative care settings
- establish accountability at the department level for cost and quality data

Review, update, and *maintain* the chargemaster.

- assess and audit the accuracy of charges: are the patient, date of service, and charge correct?
- audit the chargemaster: review CPT/HCPCS codes for additions, deletions, and changes and verify code assignments to ensure compliance with all applicable regulations
- clarify responsibilities for maintaining the chargemaster: will coding updates be handled at a department level or on a more global basis? How will coding changes and billing requirements be conveyed to the information systems department? And who will review data transfer processes to ensure data integrity?

Review outpatient data flow. Determine if:

- registration data is accurate and complete
- insurance data has been verified and captured correctly
- all chargemaster and coder-assigned codes are included on the claim form
- the sources of all data elements on bills are known
- remittance advices match expected reimbursement

Educate staff and physicians.

- identify and communicate the medical record documentation that will be necessary to schedule cases, register patients, and support coding
- understand and communicate the way services are bundled and discounted
- begin dialogues with physicians and hospital personnel to help them understand terms like "encounter" and "service window"
- identify and communicate exempt services
- assign APCs to historical claims and use this data to understand data quality
- quantify your services under APCs and project financial and product line impacts
- understand and communicate how outpatient prospective payment will affect skilled nursing facilities and home care agencies that use your services
- evaluate programs such as preventive screening and determine how or if these services should be offered
- evaluate the flow of documents and information such as memorandums from your fiscal intermediary. Are all such documents easily accessible to those who have a need to know the information?

Test and *re-test* all processes and applications. Make sure:

- all departments understand the entire process and the significance of their portion of the process
- all communication and data transfer loops are closed
- the appropriate people are notified when process changes are made

This is a very interesting and exciting time for HIM professionals. We have a unique mix of skills — skills that provide an opportunity for us to play a key role in implementing outpatient prospective payment in our respective organizations. Let's not

let this opportunity pass us by.

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Article citation:
Willett, Lyn. "Making a Proactive Transition to APCs." *Journal of AHIMA* 71, no.7 (2000): 44-48.
