Outpatient Prospective Payment Becomes A Reality

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Do you know your APCs? July 1, 2000, is the start date for the Ambulatory Payment Classification (APC) prospective payment system for Medicare reimbursement. CPT coding skills will directly affect revenue as the current Ambulatory Surgery Center (ASC) methodology is abandoned and more hospital outpatient services are included in a predetermined payment system. Provisions for provider-based clinics will be implemented in October 2000. The APC system for non-hospital-based Ambulatory Surgical Centers is not expected to be implemented until 2001.

The final rules and comments were published in the April 7, 2000, *Federal Register*. The number of APCs has increased from the proposed 341 to 451 groups. A full listing of the four-digit APC groups can be found in Addendum A.[1] Additional groups were developed to allow additional payment for specific drugs and new drugs and devices.

Facility-specific Criteria for E/M Code Levels

Coding professionals will not be required to apply evaluation and management (E/M) documentation guidelines to facility services for medical visits, according to the provisions in the final rule. After exploring several methods for determining medical visit APCs, such as a combination of ICD-9-CM and CPT codes, it has been decided that the CPT code will determine the three possible APC groups for clinic visits (APC 600, 601, and 602) and emergency visits (APC 610, 611, and 612). Additional APCs are available for interdisciplinary team conferences (APC 603) involving more than three physicians reported by HCPCS code G0175 and for critical care (APC 620).

The regulations emphasize the importance of hospitals assessing the intensity of clinic and emergency department visits and the associated charges for each level. The Health Care Financing Administration will hold each hospital accountable for following its established system to assign the various levels available in the E/M codes. Hospitals are cautioned against failing to distinguish between low-level and mid- or high-level visits because the payment result is the same in levels 1, 2, 4, and 5. The billing information submitted during the first years of the APC system may guide changes to procedure-relative weights and other adjustments that affect future reimbursement. Each facility must develop its own credible system for mapping the services provided to the correct CPT code. For provider-based clinic services, the difference between a new and established patient is whether the patient has an existing medical record number.

Hospital-based coding professionals who also code professional services for emergency room or hospital-based clinic services should continue to use the existing HCFA/AMA documentation guidelines (1995 or 1997 versions) as the basis for physician reporting code levels.

Coding and Record Processing for APCs

Although the billing functions and claims processing for Medicare beneficiaries will change due to line-item HCPCS coding requirements, coding professionals will continue to assign CPT-4 or HCPCS Level II codes to those services that require an analysis of clinical records for code assignment. Other services are likely to have the required codes furnished by chargemaster systems where the clinical departments determine code choices. Coding professionals may be asked to expand their knowledge of the billing and claims process to facilitate a smooth transition to a system that requires grouping of both coder-assigned and chargemaster-assigned codes to determine payment for outpatient Medicare services. The emergency department (ED) and clinic E/M codes may be chargemaster-assigned, as long as the designation is consistent with facility criteria that determines the level of service and associated charges. It will no longer be possible or desirable to submit one E/M code for all outpatient visits.

APCs Demand Teamwork

Coding for APCs requires teamwork to ensure that all services are captured for the claim and mapped to the correct codes for billing. Taking a simplistic view, hospital outpatient services can be divided into three categories:

- medical visits
- surgical services
- ancillary services

Status indicators available in the *Federal Register* tell us whether the service will be reduced or the entire APC allowance will be paid. New status indicators in the final regulations as well as those mentioned previously are shown below. The status indicators are listed in Addendum F on page 18,787 of the *Federal Register*. A list of the CPT codes with the associated indicators can be found in Addendum B.

status indicators: how various services are treated under outpatient PPS

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not paid under PPS
C	Inpatient Procedures	Admit patient; bill as inpatient
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS fee schedule
E	Non-Covered Items and Services	Non-paid
A	Physical, Occupational and Speech Therapy	Rehabilitation fee schedule
A	Ambulance	Ambulance fee schedule
A	EPO for ESRD Patients	National rate
A	Clinical Diagnostic Laboratory Services	Laboratory fee schedule
A	Physician Services for ESRD Patients	Not paid under PPS
A	Screening Mammography	National rate
N	Incidental Services, packaged into APC Rate	Packaged
P	Partial Hospitalization	Paid per diem APC
S	Significant Procedure, Not Discounted When Multiple	Paid at 100 percent
T	Procedure, Multiple When Discount Applies	Paid at 100 percent, then 50 percent
V	Visit to Clinic or Emergency Department	Paid
X	Ancillary Service	Paid
F	Acquisition of Corneal Tissue	Paid at reasonable cost
G	Current Drug/Biological Pass-Through	Additional payment
H	Device Pass-Through	Additional payment
J	New Drug/Biological Pass-Through	Additional payment

If a hospital wants to take advantage of the data analysis by APC, an APC grouper will be required. Because APCs result from both coder-assigned and chargemaster-assigned services, placement of this grouper will need to be addressed. Facilities choosing not to purchase a grouper will be at a disadvantage because there will be no way of knowing the reimbursement amount when the claim is generated.

Many of the 107,082 NCCI edits used by Medicare carriers on physician claims will be incorporated into the outpatient code editor (OCE) for hospital APC implementation. Claims may be rejected, denied, suspended, or returned if specific edits occur. Line-item rejection and denials are also possible with this version of the OCE. Hospital-approved modifiers should be appended to CPT codes when they apply. Edits began on April 1, 2000, for use of modifiers.[2,3,4]

Medical Visits

Emergency room encounters and hospital-based clinic visits result in medical APC groups unless significant procedures are performed as part of the treatment. CPT codes from the E/M and Medical sections will drive the reimbursement in these groups. It is possible to receive reimbursement for both a medical and a surgical service APC, but modifier -25 may 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.

Aside from the six medical visit APC groups for low-, mid-, and high-level services in the ER or hospital-based clinics, there is a separate APC for an interdisciplinary team conference and one for critical care. The critical care APC is designated as an "S" or "significant procedure" APC, so it would be paid separately, even if a surgical procedure is also performed at the same encounter or some other service is rendered. ER services and the critical care designation are mutually exclusive.

Ancillary Service Visits

Medicare patients that are served in the ancillary areas of hospital outpatient departments may result in an ancillary visit group APC assignment. Ancillary services are also paid in combination with medical and surgical services. These CPT codes, often chargemaster-assigned, will have a status indictor of "X" and are not subject to discounting.

In the final rule, chemotherapy drugs, blood products, and other high-cost services are assigned to specific APC groups for additional payment. These services are delineated by HCPCS Level II (national) codes.

The units field is very important in the APC payment methodology. Medicare instructions for recording units may be different than those of other payers, including those states in which APGs are used. Billing instructions for the units field of the UB-92 for Medicare use are found in section 460 of the Hospital Manual Publication 10.5 Laboratory services and physical, occupational, and speech therapies are not subject to APC reimbursement at this time, but instead are reimbursed according to a fee schedule.

Ambulatory Surgery

For APCs, 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 ED or scheduled in the OR 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.

Most of the normal services associated with an operating room procedure are "packaged" in the APC system. This includes routine medical and surgical supplies and pharmaceuticals, some implanted devices, and anesthesia and recovery services. The proposed rules packaged blood products as well, but that was rescinded in the final regulations.

Coding for Observation Services in the APC System

Observation services following any procedure are included in the code for the surgery and do not result in an additional APC. This is also true of observation following emergency care. The final rules state that hospitals should continue to bill for observation using revenue center 762 and showing the hours in the units field. No HCPCS code is required for facilities. Observation must represent some level of active monitoring by medical personnel and not used as a method of capturing room and board for outpatients, according to HCFA. If a patient requires critical care, an inpatient admission would be expected and a DRG payment would result rather than an APC payment. The data will be examined to determine if observations services should be separately recognized for payment in the future. Careful attention to diagnosis coding to reflect the reason for observation services will be important in this process.

Notes

1. *Federal Register* 65, no. 68, April 7, 2000; pp. 18434-18820. available at www.access.gpo.gov/su_docs/ fedreg/a000407c.html.
2. HCFA Transmittal A-00-07. Available at www.hcfa.gov/ pubforms/transmit/memos/comm_date_dsc.htm.
3. HCFA Transmittal A-99-60. Available at www.hcfa. gov/pubforms/transmit/a996060.htm.
4. Hospital Manual Publication 10, section 442.9, available at www.hcfa.gov/pubforms/10%5Fhospital/ho400.htm.
5. Hospital Manual Publication 10, section 460, available at www.hcfa.gov/pubforms/10%5Fhospital/ho400.htm.

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