Working Smarter with APCs

by Deborah J. Thoman, MA, RHIA

Are HIM professionals ready to make the most of APCs? This article suggests some strategies to improve the way we work with APCs, focus on complete and accurate coding, and improve our expertise.

Are HIM professionals ready for the next step in APCs? Are we ready to use APC data to examine the type and range of services provided? Are we ready to feed information back to providers on their patterns of care? At this early stage, my guess is the answer is a resounding "no."

In fact, hospitals are still struggling just to get claims out the door. We are only just beginning to understand the impact of the "Outpatient Code Editor with Ambulatory Payment Classification (OCE/APC) for Medicare Billing" edits on claims. And we have hundreds of questions on when and how to use modifiers.

Many of us remember the struggle to understand DRGs and their intricacies. Now we regularly use the DRG system to assist in managing length of stay, analyzing and improving the care we provide, assisting in planning for a new unit, reconfiguring our inpatient beds, conducting research, and in many other avenues to impact patient care and improve our services.

Will we be prepared to do the same with APCs? I think the answer is yes, but not quite yet. This article attempts to provide some practical suggestions on how to get us there. As with DRGs, however, the focus needs to be on quality and complete and accurate coding as the conduit to reach this next step.

It's All in the Details

So how do we get to the next step? That answer lies in the details. And it is in attending to the details where we have the hope of improving the quality and thoroughness of coding to maximize reimbursement and completely capture the provision of services. Only through attention to quality can we proceed to that next step of using APC data for improving patient care, identifying opportunities for increased efficiencies, planning for services, and research.

HIM professionals' role is to bring to the table everyone involved in the process of generating a claim to focus on quality. It is this collaboration and collective pursuit of understanding that will prepare us to use data and information from the APC process for that next step. Here are some practical recommendations for improving the quality of an APC program and steps to engage others.

Purchase an APC Grouper

A critical first step in creating a quality APC program is to purchase a grouper. Relying on feedback from your fiscal intermediary (FI) for APC information is not an effective way to manage claims or move to the next level in analysis. The grouper provides the key to correcting errors and identifying problems proactively.

To move to that next step and use APC data internally, develop a thorough and complete understanding of how services are grouped and reimbursed. The grouper allows you to test scenarios and validate assumptions on the proper way to code and to test the impact of changes to the chargemaster and claims processing.

Involve other departments in the use of the grouper. It is extremely helpful for the financial management department to be an active participant in understanding how weights and payments are calculated. Understanding this calculation can be very helpful in making sure your pricing is appropriate.

You may find some unusual and unanticipated groupings that affect how you price services. Take a look at the patients' copayment in relation to the charge. There may be instances where the copayment under APCs is more than you have historically charged for a service. Financial management will need to take a look at these and make adjustments as appropriate. Without a grouper installed and operating, it's difficult to locate and resolve scenarios like these.

Be aware that there are quarterly updates to the grouper. Ensure that the documentation that accompanies each quarterly grouper install is routed to your attention. Often this information gets routed only to the programmer updating the grouper, but the detail of the quarterly grouper changes is of major importance for the HIM department.

Work Closely with Business Office Staff

Working hand in hand with your business office staff in the daily processing of claims is critical. These staff members need to notify you of any errors kicking out of the claims editor that require HIM review and expertise. Review these with a focus on finding patterns of coding that are in error or causing problems.

For instance, is the urology clinic routinely charging for a urinary catheterization with a more complex urinary procedure, and is this hitting an unbundling edit? Detection of these kinds of scenarios can focus your education efforts in a constructive manner.

The business office staff will want to account for all the dollars and claims that are being held up for APC errors. Acknowledging that HIM has an important role and responsibility in resolving many of the errors and that you are willing to partner with the business office to account for the claims and dollars "in process" is an important step. Creating a detailed "work list" for HIM will ensure that you can celebrate your successful partnership as the dollars begin to go down through your education and correct coding efforts.

Know Who's Responsible for Errors

Errors from the APC grouper are each assigned a number and descriptor. Create a grid or table that assigns accountability for error resolution. Include the edit type and claim disposition. Understand and become knowledgeable of the disposition of each edit (claim rejection, claims denial, claim returned to provider, claims suspension, line-item rejection, and line-item denial).

Perhaps some errors that result in line-item rejections will be overridden as you let them pass to the intermediary. But detailing responsibility for error resolution is necessary to get a handle on types and frequency of errors.

It's also important to understand that any given claim may have several types of errors and that joint resolution will be required to free up a claim—complicating this process. "The Buck Stops Here: Sample Error Grid," left, is a sample of how this grid might be constructed.

Involve your operating room nursing staff in identifying the inpatient-only procedures. Make sure they are provided with an updated list of the procedures, and institute a mechanism for them to notify clinicians when an inpatient-only procedure is scheduled to be performed as an outpatient procedure.

Create a Hospital Modifier Edit Table

A hospital modifier edit table will establish the criteria for which modifiers are acceptable or not acceptable for a given range of CPT codes. For example, this table will catch such things as:

- use of a non-valid modifier
- use of a -50 modifier outside of the surgery and radiology range
- use of an anatomic site-specific modifier for a noncompatible site
- redundant use of a modifier

"Know Your Edits: Sample Edit Tables," page 34-35, is a sample of how this edit table might be constructed. This table is most useful when implemented as a component of your hospital information system processing, either at the charge entry or prior to

claim processing. Editing for these items can prevent obvious errors and allow you to pass cleaner data on to the grouper.

Pay Careful Attention to the Pass-through List

Keeping abreast of the quarterly changes to the pass-through list is almost a full-time task itself. Therefore, developing a three-way partnership with the clinical staff, financial management, and HIM is essential. The first step is to create clinical liaisons with operating room, nuclear medicine, radiology, cardiology (both adult and pediatrics), and pharmacy staff.

The clinical staff are often the first-line contact with vendors for many of the higher-cost devices such as stents and catheters. They need to be educated on all the items in the pass-through list and push their vendors to do the research on whether or not their products are on the pass-through list if it is appropriate.

Financial management staff involvement will be critical from a chargemaster maintenance standpoint. It is a considerable task to identify which products are eligible for pass-through and an even more daunting task maintaining them in the chargemaster. If you haven't already created a chargemaster task force, consider doing so.

Ensuring that your chargemaster is up to date and accurate is a vital step to the assignment of an accurate APC. The chargemaster drives the majority of what ends up on the claim. Make sure that pharmacy codes are accurate, only billable supplies are on the chargemaster, and your revenue codes are correct. This in itself is a major task, and the HIM contribution is essential to correct coding.

The pass-through process is expected to be simplified, by first grouping the services into categories, then ultimately including them with the associated services. Keeping everyone abreast of the changes and the appropriate nuances in code usage is a challenge. Creating a structure that keeps everyone on top of the changes, ensuring quality, and receiving payment for services rendered is critical to the process.

Document Decisions and Logic

Documenting decisions for automating the application of modifiers or the mapping of evaluation and management (E/M) codes is another important activity.

HCFA has stated that it realizes the physician E/M codes that group to the six medical visit APCs do not adequately describe nonphysician resources. Accordingly, it has gone on record as advising hospitals to develop their own system for mapping the services provided to the different codes (available at www.access.gpo.gov/su_docs/fedreg/ a000407c.html). Therefore, it is important to document your logic. Make sure staff are adequately trained and knowledgeable of this logic and audit a random sample of your records against your documented criteria.

You may also have automated the application of certain modifiers. Make sure that you have documented the logic for applying these modifiers via the chargemaster and that you perform periodic audits of medical record documentation to ensure it supports the continued and correct application of those modifiers.

Monitor Important Web Sites

It is essential to keep abreast of all the changes and updates from HCFA and your intermediary and to foster and develop close contacts with experts and colleagues. The easiest way to do this is via the Internet. Look into one of the several free software programs that can monitor Web sites of interest and automatically notify you of any changes or updates. This eliminates the need to continually check the sites.

It is also helpful to connect with your AHIMA colleagues on a continual basis. AHIMA's Web site is a great source of information. Checking into the forum section often to view member questions is particularly helpful. Even just "lurking" without participating can provide you with answers and suggestions for such things as what code to use for a particular procedure or how to apply a modifier. Furthermore, AHIMA's upcoming Communities of Practice, which are scheduled to be available this fall, hold great promise for HIM professionals in improving our understanding and expanding our collective consciousness on practice issues.

It's also very helpful to monitor HCFA Web sites. Of particular help is the frequently asked questions (FAQ) section of the Outpatient Prospective Payment System, the Medicare Learning Network Web site (www.hcfa.gov/ medlearn/refguide.htm). HCFA does a reasonably good job of selecting questions that are of broad interest and providing helpful answers. This site is updated often, and you may wish to have it automatically monitored.

Beef Up Your Library

This is not the time to scrimp on your reference books budget. Having ready access to CPT, HCPCS, ICD-9-CM, and UB-92 manuals and other regulatory references is a practical concern. Become well versed in making your way around a UB-92, know what condition codes are, beef up your knowledge of revenue codes, and become an expert at HCPCS and CPT coding. This is your opportunity to shine relative to areas of HIM expertise.

If the next step is to interpret the data, then just as with DRGs, you will have to know what you're doing—or, at the very least, where to find the answer. You need to intimately understand what goes into a given APC or a given grouper error and know your way around the OCE/APC edits and how to research them. You must feel absolutely confident in recommending a given response to a problem.

Keep the Dialogue Going

In collaboration with your business office, create an ongoing dialogue with your FI and, when appropriate, include your hospital association in this dialogue.

Create a process by which you can both formally and informally address issues of concern with your FI. This process ensures that intermediaries are interpreting HCFA directives and guidelines in the same manner as you are and allows the intermediary an opportunity to improve their feedback loop to HCFA when further clarification is necessary.

Don't be afraid to challenge your FI when you feel they are interpreting an issue incorrectly, but do so in a respectful manner and with the support of your hospital association. Including your hospital association on even minor issues can be of great benefit. The association can bring a collective voice to the dialogue and it can communicate that an issue is not unique to your institution and is, in fact, a concern to many of its members.

These suggestions offer active steps you can take to move HIM professionals forward in the mastery of the APC system. Everyone is anxious to move past this learning curve and get to the next level. The most important step in getting there, however, is the sharing of information, frustrations, ideas, and solutions. Once we feel confident that we have a good grasp of the process and that the data is solid in quality, accuracy, and completeness and our claims are flowing out the door, then we can take the next step in using APCs to better understand the way we provide healthcare.

The Buck Stops Here: Sample Error Grid

APC Error Report Distribution (1/01/01 Update)

Edit	Edit Type	Disposition	Responsible Party
1. Invalid diagnosis	Diagnosis edit	Claim returned to provider	HIM
2. Diagnosis and age conflict	Diagnosis edit	Claim returned to provider	HIM

3. Diagnosis and sex conflict	Diagnosis edit	Claim returned to provider	HIM
4. Medicare secondary payer alert	Diagnosis edit	Claim suspension	Business office (inactive 1/01/01)
5. E-code as reason for visit	Diagnosis edit	Claim returned to provider	HIM
6. Invalid procedure code	Procedure edit	Claim returned to provider	HIM
7. Procedure and age conflicta	Procedure edit	Claim returned to provider	HIM
8. Procedure and sex conflict	Procedure edit	Claim returned to provider	HIM
9. Non-covered service	Procedure edit	Line-item denial	Edit overridden
10. Service submitted for verification of denial (condition code 21)	Procedure edit	Claim denial	Business office
11. Service submitted for review (condition code 20)	Procedure edit	Claim suspension	Business office
12. Questionable covered service	Procedure edit	Claim suspension	Edit overridden, corrected post-grouper processing

13. Separate payment for services not provided by Medicare	Procedure edit	Line-item rejection	Edit overridden, corrected post-grouper processing
14. Code indicates a site of service not included in OPPS	Procedure edit	Claim returned to provider	Business office
15. Service unit out of range for procedureb	Unit edit	Claim returned to provider	HIM

[a] Currently not used.

[b] Units for all line items with the same HCPCS code are added together when applying this edit.

Know Your Edits: Sample Edit Tables

Hospital Outpatient Modifiers

Modifier and Definition	Compatible CPT Codes	Coding Guidelines	Issues/ Programming	Modifier valid for physician billing also

25 Significant, separately identifiable evaluation and management service on the same day of the procedure or other service.	Evaluation and Management codes 99201-99215 99281-99285 99291 99241-99245 92002-92004 92012-92014 99271-99275	• The E/M service must go above and beyond the normal pre- and post-op services to indicate that the medical portion of the service is distinct from the diagnostic medical/ surgical and/or therapeutic medical/ surgical procedures. • Hospital does not require same physician to perform E/M and procedure.	• Modifier may be automatically attached per documented APC logic on file in HIM.	• Yes
73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Surgical procedure codes and other diagnostic procedure codes 10040 - 69999 and 90281 - 99199	• Coded to show that due to extenuating circumstances or those that threaten the well-being of the patient, the physician cancels the procedure subsequent to the patient's surgical preparation but prior to the administration of anesthesia. • Code number for the planned procedure would be assigned with the -73 modifier to indicate it was discontinued. • The elective cancellation of a service prior to the anesthesia should not be reported on the hospital side. • Discontinued procedures using	• Code number for the planned procedure would be assigned with the -73 modifier to indicate it was discontinued. • Require V64* ICD-9-CM secondary diagnosis to indicate the procedure was not carried out.	• Yes

		conscious sedation should be reported with the -52 modifier.		

Know Your Edits: Sample Edit Tables *(cont.)*

Level II HCPCS Modifiers—valid for hospital-side reporting only

Modifier and Definition	Compatible CPT Codes	Coding Guidelines	Issues/Programming
LT - Left Side RT - Right Side	Apply to codes which identify procedures that can be performed on paired organs. All surgery, radiology, and other diagnostic procedure CPT codes 10040-69990, 70010-79999, 90281-99199	• RT and LT are not to be used for bilateral service reporting. • RT or LT should be used when a procedure is performed on only one side.	• Do not assign with other Level II HCPCS modifiers that include left or right in the modifier descriptor (E1 - E4, FA, F1 - F9, LC, LD, RC, TA, T1-T9)
E1 - Upper left, eyelid E2 - Lower left, eyelid E3 - Upper right, eyelid E4 - Lower right, eyelid	67700, 67710, 67715 67800, 67801, 67805, 67808, 67810, 67820, 67825, 67830, 67835, 67840, 67850 67875, 67880, 67882 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924 67930, 67935, 67938, 67950, 67961, 67966, 67971, 67973, 67974, 67975 67999	• Should be used when a procedure is performed on the eyelid to designate right vs. left and upper vs. lower eyelid.	• Do not assign RT or LT, left and right is already included in the modifier description.

***Deborah J. Thoman**, MA, RHIA, is the director of health information management and associate director of clinical outcomes and resource management at the University of Iowa Hospitals and Clinics. Thoman has more than 20 years experience in the HIM field. She is a past president of the Iowa Health Information Management Association and is a past chair of the AHIMA Legislative Committee. She frequently consults and lectures on HIM-related topics. She can be reached at ThomanD@uihc.uiowa.edu.*

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