APCs - Another Year Older
Are you Deeper in Debt?

Dr. James Georgoulakis
Deborah Sheets, RN
Objectives

- To dispel APC Myths
- To Share Successful APC Practices
- To Utilize APC Analysis to Improve APC Compliance and Revenues
- To demonstrate how hospital processes effect correct billing and reimbursement
- To provide information on CMS and OIG target APCs
APC Myths

- The APCs are being phased out
- The APCs are a coding problem
- A hospital cannot be profitable under the APC System
**APC Myths**

- The APCs are being phased out
  - APCs are being expanded to include more outpatient services
  - APCs will be expanded to hospitals with less than 100 beds
  - State Medicaid programs are moving to the APCs system
  - Private payors are utilizing APC concepts
The APCs Are A Coding Problem

- The APCs affect the entire hospital both operationally and strategically.
- The APCs represent the single best vehicle to monitor the hospital compliance program.
- A greater increase in revenues can be brought about by operational changes than by “purely” coding.
A Hospital Cannot Be Profitable Under the APC System

- Hospitals have been identified as increasing their APC revenues and Concurrently Improving Compliance Adherence
- Profitable hospitals under the APCs have been identified and share common practices
- All hospitals can improve APC revenues
Successful APC Practices

- Successful Hospital APC Practices
- APC Research
- CMS Information
- OIG Studies and Findings
Successful Hospital APC Practices

- Monitoring APCs on a quarterly basis
- Know APC Winners and Losers
- Know the value of average weighted APC visit
- Know the number of APCs per visit by APC
Successful Hospital APC Practices

- Know the Hospital APC Index
- Know the Hospital Case Mix Index
- Know the Relationship Between the APC Index and the Case Mix Index
- Know the Hospital Procedure Index
- Know the Relationship Between the Procedure Index and the APC Index
Successful Hospital APC Practices

- Conduct Reviews of Identified Charts
- Reconcile projected APC payment with received APC payment
- Maintain an up to date CDM
- Remain current of CMS policies
- Implement OIG recommendations
Successful Hospital APC Practices

● APC Research
  – High and Low Profit Hospitals
    ● Hospitals must have more than 1 million dollars in revenues
    ● Not divided into teaching and non-teaching hospitals because payment differentials not related to teaching status
    ● Do not differ with respect to size
  – So what is the difference?
Successful Hospital APC Practices

- APC Research
  - High Profit APC hospitals
    - Higher relative APC weight per visit
      - May be accounting for more APC procedures per visit
      - Superior Charge Capture Processes
      - Current CDM
      - Knowledgeable of Current CMS practices
Successful APC Practices

- CMS Information
  - Identification of Codes
  - Changes in payment policy
  - Changes in codes for claims submission
Successful Hospital APC Practices

- Implementation of OIG Recommendations
  - Drugs
    - Types of Drugs
    - Codes for the drugs
    - Quantity of Drugs
Processes are Key

- Correct CDM and billing do not ensure proper reimbursement
- Unlike pre-APC billing, processes significantly impact billing
- Inadequate processes result in major loss of reimbursement
Process Issues Can Drive Errors

- The CDM can be set up correctly and billing errors can still occur in some areas such as pharmacy
- Staff can input correct information on the nursing unit and charges can still be incorrect
- Links between the pharmacy system and the charge entry system are often to blame
IV and Injection Billing Errors

- An area where we continue to find a significant number of errors are billing for intravenous push medications (IVP), intravenous infusions (IV’s) and intramuscular and subcutaneous injections (IM and sq)
- An average of $75 per claim is missed in the ER for level 4 and 5 visits
- An average of $125 per claim is missed in observation
Workflow Analysis Infusion and Injection Billing Issue

Physician orders IVP x 3 and IV at 100cc/hr in observation or ER

Nurse administers medication and IV infuses for 10 hours

Nurse does not enter charges for IVP or IV infusion

Facility does not receive reimbursement for these services

Billing error origination point
Infusions and Injections Cont.

- Performing a review from order to payment, identifies these missed charges
- In most facilities nursing is given the task to input these charges
- There are no edits in the system to flag these missed charges and they would be difficult to build
Infusions and Injections Cont.

- Giving nursing this task does not work well for the following reasons:
  1. Low priority versus nursing care and other charting in the ER
  2. Nursing not aware the patient is in observation when placed on an inpatient floor
  3. Nursing turnover
  4. Agency/pool nurses
  5. Lack of understanding of IV infusion requirements
Infusions and Injections Cont.

1. Low priority versus nursing care and other charting in the ER
   - Nursing will always provide emergency care and perform required charting before entry of charges
   - It is very difficult to change this behavior
     - Attitude it is not their job
     - Lack of understanding of effect on hospital reimbursement
     - All patients on inpatient unit viewed as inpatients
Several hospitals have tried to keep this function with the nursing staff
- Education on how to and when to bill for injections and infusion is provided
- Initial response improves charge capture
- Quick return to old behavior
- Confusion over when to input charges for observation patients
  - For all patients vs Medicare only patients
Infusions and Injections Cont.

- Gather all owners and potential owners of the process and think “outside the box”
- High compliance with charge capture for these services had been obtained when one of the two following methods has been used
  1. HIM identifies charges
  2. Designated staff identifies charges
1. HIM identifies charges
   - Already reviewing the record to perform ICD – 9 diagnosis coding and code for procedures
   - Additional review of MAR and order sheet takes a few minutes per chart
   - Reduces duplicate chart review by other staff to identify these charges
   - Understand coding rules and requirements
   - Limited number of staff to educate and monitor
Issues to consider when using this option

- HIM staff usually does not have easy, or any, access to enter charges
- Identified charges will need to be entered by other designated staff
Infusions and Injections Cont.

2. Designated staff identifies charges
   - One person performing this function limits educational requirements
   - Top priority for designated staff
   - Staff can enter charges
   - Additional captured charges in one month or less can pay the salary for this additional staff
Issues to consider when using this option

- Coverage when designated staff is on vacation or sick
- Ensure there is enough work for full time staff or make position part time or identify other tasks staff can perform
- Ensure HIPAA requirements are met when increasing the number of staff reviewing the medical record
Infusions and Injections Cont.

- Pitfalls to watch out for:
  1. IV infusion rate – Must be greater than keep vein open (KVO) to bill
     - The infusion must be for therapeutic or for diagnostic purposes
  2. IVP medications that cannot be mixed and are given in separate syringes must be documented at different times in order to bill for two injections.
     - If both are documented as given at the same time is is difficult to justify two charges
Infusions Into the Future

- IV infusion codes Q0081, Q0083, and Q0084 were no longer valid codes as of January 1, 2005.
- You should have removed all edits from the billing and other systems that has been taking the hourly infusion information entered by your staff and changing it into “Q” codes for Medicare.
Infusions Into the Future Cont.

- This year CMS released 18 new “G” codes to be used in physician offices for infusions, injection and push techniques.
- These codes provide much more detail as to the type of infusion and the purpose of the infusion than previous codes.
For example:

- CPT code 90780 – IV infusion 1 hr - has been replaced with G0345 – IV infuse hydration, initial
- CPT code 90781 - Each additional hour up to 8 - has been replaced with G0348 – Each additional hour up to 8 hrs and G0349 – Additional sequential infuse
- There is a new code for each additional sequential IV – G0354
- 90408 – Chemo push – has been replace by 2 codes G0357 – IV push single/initial subsequent and G0358 – IV push each additional drug
When new CPT – 4 codes have been issued to replace the physician “G” codes CMS will begin using them in hospitals

CMS believed it would be disruptive to have hospitals use the “G” codes this year and then change to CPT – 4 codes in 2006
Medication Changes

- There are 50 medications with active HCPCS codes in 2004 that are receiving pass-through reimbursement as of January 1, 2005.
- Most hospitals do not add active HCPCS medication codes when there is no associated reimbursement.
Medication Changes Cont.

- For example
  - J1492 – Intraocular Fomivirsen na was not separately reimbursed in 2004
  - Starting January 1, 2005 national average reimbursement is $939.79 under APC 9040
Medication Changes Cont.

- Correct billing of units and charges is key to proper medication reimbursement.
- By having these active codes in the CDM the hospital receives pass-through payment whenever CMS makes a change and begins reimbursing a medication.
- CMS makes medication changes at least quarterly.
- Having all active HCPCS codes in the CDM allows the pharmacy CDM to work for you.
Unlisted Codes

- Unlisted HCPCS codes will be reassigned to the lowest level APC in the clinical grouping in which the unlisted code is located.
- CMS believes this provides incentive to interested parties to secure a code through the AMA’s CPT process.
Example of the cost of using unlisted codes
CPT – 4 code 37799 was used by a hospital 22 time in 2004
Reimbursement for 37799 was $9.23
Correct code was 37785, or other codes paid under APC 0091
Reimbursement for APC 0091 was $1,573.14
Total missed reimbursement $34,406.02
Whenever an unlisted code is used it should be reviewed by the hospital’s Coding Quality Specialist or department manager.

If there are any questions regarding the procedure or the documentation the physician should be queried.

If this procedure will be performed frequently then work with the physician to obtain a code.
ER Levels

- CMS did not publish a national ER level tool for 2005.
- The AHIMA tool was field tested and failed to provide an adequate bell curve and was not uniformly used.
- There are no plans to release national guidelines at this time.
- When guidelines are developed CMS will provide at least 6 to 12 months notice to allow time to educate staff.
ER Levels Cont.

- 2003 January update released on Friday November 1, 2002 addressed the issue of “double – dipping” on page 66791
- One of the few issues CMS has discussed regarding establishing an ER tool is not using separately payable procedures to determine your ER facility level
- The following is from page 66791
ER Levels Cont.

• “...proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as “interventions” or “staff time” in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.”
**ER Levels** Cont.

- Review your current tool to ensure there are no separately reimbursable procedures being used to determine the facility level

- For example:
  - IVP
  - IM or subq injections
  - Assistance with procedure
  - Dressing application following a procedure
ER Levels Cont.

- Also look to see if you make all admissions or observation patients a specific level
- For example:
  - Patient admitted – 99285
  - Patient place in observation – 99285
- You should compare your levels to a national bell curve
ER Levels Cont.

- The Healthcare Financial Management Association (HFMA) has released national bell curve guidelines
- Be sure to break out your Medicare population when doing a bell curve
- Commercial payors may mask a shift to a higher level, especially if admissions are driving you to higher levels
ER Levels Cont.

Medicare HFMA Benchmark Comparison
All Payors - Third Quarter 2004

<table>
<thead>
<tr>
<th>Percent of Total Visits</th>
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<tbody>
<tr>
<td>Low Level</td>
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- Low Level: Example Hospital = 40%, National = 40%
- Mid Level: Example Hospital = 30%, National = 30%
- High Level: Example Hospital = 20%, National = 20%

Legend:
- Black: Example Hospital
- Gray: National
ER Levels Cont.

Medicare HFMA Benchmark Comparison
Medicare Only - Third Quarter 2004

Percent of Total Visits

Low Level  Mid Level  High Level

Example Hospital  National

[Bar chart showing comparison of access to care levels (Low, Mid, High) between Example Hospital and National average across 0 to 70% of total visits]
ER Levels Cont.

Medicare HFMA Benchmark Comparison
Medicare Only - Second Quarter 2004

Percent of Total Visits

Example Hospital
National

Low Level  Mid Level  High Level

0% 10% 20% 30% 40% 50% 60% 70%
When the Example Hospital levels are changed to match the National levels there is an increase of $17,524,904 in reimbursement.
For questions regarding this presentation please contact Dr. Jim Georgoulakis at
210.820.3966
drjim@sprintmail.com

Debbie Sheets at:
614.738.1770
dsheets@navigantconsulting.com