Getting Ready for APCs

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by Rita Scichilone, MHSA, RHIA (formerly RRA), CCS, CCS-P

While most healthcare practitioners support accurate coding, the challenge remains for HIM professionals: how to achieve coding accuracy in a system of imperfect data capture methods and changing reimbursement methodologies. Greater emphasis on coding specificity and completeness for reimbursement places extreme pressure on facilities to engineer processes that minimize coding errors and omissions and improve documentation quality. This makes it easier for third-party payers to clearly see justification for services rendered.

The latest study on Medicare claims, conducted by the Office of the Inspector (OIG), showed an error rate of 8.53 percent for incorrect coding, with insufficient or no documentation errors of 46.76 percent.[1] So it is obvious that there are no quick fixes for these industry-wide problems. However, for those seeking guidance, the OIG created the Compliance Plan for Hospitals. It serves as a guide to avoid problems with government reimbursement and defines risk areas that involve coding. According to the plan, "Upcoding, DRG creep, outpatient services rendered in connection with inpatient stays, teaching physician and resident requirements and duplicate billing"[2] all fall under the responsibilities of health information managers.

According to the March 1999 Medicare Payment Advisory Committee (MEDPAC) Report, "difficulties in coding have been documented since HCFA began requiring HCPCS coding for outpatient reimbursement. Mismatches between hospital and physician coding for the same service have been particularly problematic."[3] It is important to consider the cause of incorrect coding carefully to determine whether the problem is lack of technical expertise by coding professionals or to documentation that creates an inadequate source document for coding decisions.

A Golden Opportunity

Coding is the common denominator for information transfer and decision support, as it provides data on the patient's condition and the treatments provided. This means that accurate codes must be obtained through a documentation improvement plan. To meet the requirements of correct coding in the Ambulatory Payment Classification (APC) environment, both the technical expertise of the coder and the hospital's system of documentation must be examined. So focusing upon coder education may not achieve your organization's goals unless physician education on information required for accurate code selection is also included.

The introduction of the APC methodology for Medicare reimbursement may provide a great opportunity to build relationships between physicians and other clinicians and the HIM department. Data analysis performed to assess the impact of APCs should include a committee representing both medical and coding staff. One of the most important roles of the coding professional in the APC environment: to educate physicians about documentation and coding requirements, in order to optimize payments and keep the facility safe from coding risk areas. See Exhibit 1 for a sample criteria set that provides feedback to physicians who are responsible for outpatient service documentation. According to the Compliance Guide for Hospitals, "accurate coding depends on the quality and completeness of the physician's documentation."[4] This does not necessitate more documentation from overworked physicians. It does, however, mean that we must create better ways to capture coding information required for billing. This may be as simple as devising a form that clarifies terminology for procedures or creating a system in which the physician indicates the codes he will report for surgery or diagnostic procedures—this would clear up any discrepancies before a claim is sent to Medicare.

Why Were APCs Created?

The Balanced Budget Act of 1997 requires the Department of Health and Human Services (HHS) to implement a prospective payment system (PPS) for hospital outpatient services. The original deadline, January 1, 1999, did not provide ample time to meet the requirement.

In the past, distinctions were made between freestanding ambulatory surgery centers (ASCs) and hospital-based outpatient surgical services. ASCs received Medicare reimbursement on the basis of eight selected ASC Groups, in which facility and professional fees by physicians were allowed for approximately 2500 procedures. ASCs are limited to furnishing services in connection with surgical procedures, while hospital outpatient departments include surgery and services.

The comparison of ASC to hospital-based reimbursement for surgery is, as the old saying goes, like comparing apples to oranges. Since the ASC is a prospective payment system with a fixed reimbursement amount, the hospital outpatient payment system is a blend of this fixed payment (58 percent) and a cost-based formula (42 percent). So there could be financial incentives that influence the site of service. For diagnostic services, the hospital cost and the fee schedule portions are each 50 percent.

Medicare payments for hospital outpatient surgery, radiology, and other diagnostic services equal the lesser of the following:

- a hospital's reasonable costs or its customary charges (whichever is lower), net of deductible and coinsurance amounts
- a blended amount comprising a cost portion and a fee schedule portion, net of beneficiary cost sharing

A hospital may bill the patient for the coinsurance amount owed for the outpatient service. This coinsurance is based on 20 percent of the hospital's submitted charges for the service, while Medicare usually pays based on a blend of hospital costs and the amount paid in other settings for the same service. The results: the patient pays a coinsurance amount that does not equal 20 percent of the Medicare allowance for the service and provides an incentive for hospitals to increase charges for outpatient services. Under the PPS, the hospital will know the amount of the Medicare payment since there is no cost-based adjustment. Thus, the patient will know ahead of time what the coinsurance will be. Each patient visiting a particular hospital for a certain service will pay the same coinsurance amount for the procedure. In the current system based on charges, the payment could vary from patient to patient for the same procedure.

The objective of the APC system is to eliminate the apples-to-oranges comparison by expanding the fruit basket. Rather, the hospital will include all outpatient services not currently subject to a fee schedule or prospective reimbursement allowance. It is a classification system based on grouping of procedures by CPT/HCPCS codes that have similar clinical characteristics with similar costs or resource inputs. The proposed system has 346 groups, with 134 surgical groups—compared to the current eight. In addition, there are 46 significant procedure groups, 121 medical visit groups, and 44 ancillary groups in the system.

HCFA is proposing to use the same grouping system to set rates for ASCs and hospital outpatient surgical services. However, this does not mean that the rates will be the same. The coding rules remain the same, despite different statutory requirements for setting rates for hospitals and ASCs. Which could leave hospital-based surgery centers experiencing more drastic cuts in payments than ASCs. HCFA indicated the reimbursement amounts should eventually be more equitable, preventing financial issues from driving patient care choices. Initially, the common factor will be that the groups of CPT/HCPCS codes for surgical procedures will be the same. In some cases, the rate of payment may be different because the basis for rate setting is different for ASCs and hospitals. At this point, it would be premature to speculate on gains or losses under this system, but it is not too early for facilities to analyze their case mix and compare their current and proposed reimbursement. (See "Assessing the Impact of APCs")

The NCCI's Role in APCs

The National Correct Coding Initiative (NCCI) is a set of edits used by Medicare part B carriers to identify coding patterns resulting in overpayment to providers. NCCI's edits are expected to be applied to hospital outpatient claims upon implementation of APCs, or possibly sooner. This event is not something coding professionals need to fear, but rather become familiar with. The edits primarily apply CPT coding guidelines and prohibit unbundling of procedures that are integral to other procedures. Many hospital information systems/encoding software packages are including NCCI edits to assist coders and billers.[5]

Examples of NCCI Edits[6]

CPT Codes

- 29877 (chondroplasty)
- 29875 (synovectomy, limited) (separate procedure)
- 11403 (excision, benign lesion)
- 12002 (simple repair) (mutually exclusive procedure)
- 45380 (colonoscopy with biopsy)
- 94760 (pulse oximetry) (clinically correlated, medically included)

The second code in each pair would not result in an additional APC, since the NCCI edits consider them to be bundled or integral to the larger procedure.

Units of service in field location (FL) 46 are entered in the UB-92 with all HCPCS codes reported in FL 44. For example, if a patient has cataract surgery, CPT code 66984 is entered in FL 44 and a unit of one is reported to show that one procedure was performed. Laboratory and radiology procedures may have more than one unit listed. CPT code 11720 (nail debridement) is listed with a unit of one, since the code description states "one to five" and code 11721 states "six or more." On the other hand, code 19126 (each additional breast lesion identified by a radiological marker) would have as many units listed as were appropriate for the situation. In the APC environment all abstracted codes must correctly transfer to the UB-92 billing fields so that additional procedures performed receive proper payment. For fingers and toes, HCPCS level two modifiers help designate separate procedures on individual digits, that may have the same CPT code.

Each CPT code listed in the APC system has a status indicator that determines reimbursement:

- T = surgical services subject to discounting. 100 percent of allowance is paid for the highest weight procedure, and 50 percent of the allowance is paid for all subsequent procedures
- S = significant procedures not subject to discounting. 100 percent of allowance is paid, even when performed with other procedures at the same time or on the same date of service
- X = no discounting applies to these ancillary procedures
- N = no separate payment is made for these procedures, since they are considered incidental to another procedure or service
- V = visit APCs where separate reimbursement is furnished for the X (ancillary) APCs in addition to the visit APC for emergency room or clinic visits.

There are three methods under consideration to determine visit APCs. The first uses only the ICD-9-CM diagnosis code. The second method is called a hybrid method, since it uses a combination of the major diagnostic category (MDC) group determined by the ICD-9-CM code and the CPT code to create a unique APC. A five-digit code (a combination of the MDC and APC) is used in the proposed regulations for clarity. If this method is selected, a three-digit unique APC is expected to take the place of the five-digit version. For example:

Table 1—MDCs for the Proposed APC System[7]

Multiple Diagnosis Code	Description Table
11	Well care and administrative
18	Skin and breast diseases
24	Musculoskeletal diseases
31	Ear, nose, mouth, and throat diseases
32	Respiratory system diseases
36	Cardiovascular system diseases
41	Digestive system diseases
53	Kidney, urinary tract, and maile genital diseases
56	Femal genital system diseases

Coding professionals know that it is important to code wounds as complicated when there is delayed healing, delayed treatment, a foreign body involved, or a major infection present. Cellulitis and osteomyelitis sometimes occur as a complication of an open wound, so sequencing of diagnosis codes will depend on the circumstances of the encounter. In a patient who presented for outpatient surgery for treatment of osteomyelitis of the hand from an injury occurring six weeks ago, the osteomyelitis is reported in first position, followed by the complicated open wound code. In a patient presenting with cellulitis attributed to a minor puncture wound not requiring treatment at the time, only the cellulitis would be reported. When the organism that causes the infection is identified, it should be reported as a secondary code.

57 Pregnancy and neonatal care
63 Nervous system diseases
68 Eye diseases
72 Trauma and poisoning
78 Major sign, symptoms and findings
82 Endocrine, nutritional, and metabolic diseases
86 Immunologic and hematologic diseases
88 Malignancy
91 Psychiatric disorders
97 Infectious diseases
99 Unknown cause of mortality

In general, lacerations are assigned to MDC 72, while cellulitis places the patient in MDC 18. In an ER situation, the laceration code would result in an APC payment. This is a mid-level ER visit represented by a 99283 assignment that, combined with the laceration diagnosis code, results in APC 95318 for a proposed payment of $97.18. The cellulitis as a diagnosis code, combined with the same CPT, results in APC 95372 and a payment of $103.87. Osteomyelitis designation (when appropriate) would result in a payment of $91.53, even though the evaluation and management CPT code are the same.

For a patient presenting to the ER with a respiratory infection, the MDC assignment is 33 for acute bronchitis, while unspecified bronchitis or upper respiratory infection is MDC 31. COPD code 496 is assigned to MDC 33 as well, but chronic obstructive asthma with status asthmaticus is MDC 78. A mid-level ER visit for MDC 33 (APC 95333) is $98.21, compared to $92.56 for MDC 31, which results in APC 95378. The acuity and resource use of the patient in status asthmaticus is recognized by a reimbursement of $157.86 for MDC 78. See Table 1 for an illustration of the 20 categories resulting from collapse of MDCs into categories. Dollar amounts are taken from Addendum A in the June 30, 1999, Federal Register.

The third method involves using CPT codes from the evaluation and management series to determine the level of service. It has not been determined which method will be used.

Effects on Hospital Coding and Documentation

The changes in coding procedures will not be significant. The impact on revenues, however, will be apparent if coding accuracy problems are not identified and corrected. The use of hospital modifiers have been required since July 1, 1998, and it is expected that more modifiers may be used in the APC system as it develops.

Modifier -50

The bilateral modifier is required to receive 150 percent of the Medicare allowance and avoid having a second CPT code rejected as a duplicate procedure. For example code 28292-50 would result in a payment of 100 percent of APC 276 which has a proposed amount of $976.98, with an additional 50 percent allowance ($488.99) paid for the other foot.

Modifier -73 and Modifier -74

These modifiers are reported to indicate those circumstances where surgery was planned, but had to be terminated before conclusion. Modifier -73 is used for circumstances causing termination before anesthesia is administered; modifier -74 is selected when anesthesia has already been given. Full payment (100 percent of APC) is received for a procedure that gets to this point, while 50 percent of the APC allowance is given when surgery is intended, but procedures are terminated before anesthesia is administered. Prior to the change, no service was coded unless it was performed. So there is a critical need for clear documentation in both of these instances (due to the difference in reimbursement) but often, documentation is not completed when the patient's procedure is terminated before anesthetic is given.

Impact on Record Analysis and Encoder/Grouping

Diagnosis coding must be completed only when all pertinent information, including pathology reports, is available. For instance, Medicare has special coverage requirements for removal of skin lesions that make ICD-9-CM code accuracy important in the outpatient setting. CPT coding for lesion removal is contingent on the size and the pathology of the lesion. Malignant lesion removal is consistently grouped to ASC group 2 while some of the benign lesions remain at group 1. Definitive information must be obtained before reporting. Coders should never assign codes from the 238.x category unless the subject is designated by the pathologist as a neoplasm of uncertain behavior. The term "mass" in a record is not to be interpreted as a neoplasm, but should be coded to a symptom when no further information is available, not to category 239. These are common diagnosis errors that may have an impact on payment or cause denials when the APC system is implemented. The size of lesions also

makes a difference, so documentation must be clear and available from the operative record, before shrinkage has occurred from laboratory processing.

Skin ulcers may be decubitus, neurogenic, trophic, or chronic and are often due to diabetes or peripheral vascular disease where the code for that diagnosis should be placed in first position. Varicose ulcers are classified to 454.0 or 454.2 (MDC 36) rather than the 707.x category (MDC18). It is important to utilize the ICD-9-CM index correctly when classifying skin ulcers, since the MDC categories are not all the same, and their assignment may influence the APC group. When record documentation suggests that a condition has a specific etiology, but the diagnostic statement is not clear, contact the physician to clarify the cause of the ulcer. Do not code the condition as not otherwise specified.

Table 2—APC Impact on Lesion Measurement

CPT Code and Size	APC Assignment	Rate Proposed
11603, 2.1 - 3.0 cm	161	$176.37
11604, 3.1 - 4.0 cm	162	$287.44
11606 > 4.0 cm	163	$538.88

Encoders should be used with care to assure correct crosswalk between ICD-9-CM and CPT procedure coding to optimize APC assignments. It is also important to review chargemaster assigned codes with codes assigned after record review. This enables the HIM department to perform an analysis for APC grouping before the claim form is generated. Any facility not investing in grouping software will be at a distinct disadvantage in optimizing payment through correct coding and sequencing of services. Use of built-in coding edits, reminders, and tips help keep the complex array of coding requirements manageable.

The selection of diagnosis code in the visit APGs may also affect documentation practices and require consideration if the hybrid model is used. Whether or not the presenting symptom or the established diagnosis is recorded may drive the resulting APC and corresponding payment. According to UB-92 guidelines for diagnosis reporting in field location 67, hospitals are to report the diagnosis "to your highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (786.2). If during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), report the definitive diagnosis."[8]

Since reporting screening codes versus diagnostic codes results in different APC groups, be aware of the covered preventive services for Medicare beneficiaries (outlined in the Balanced Budget Act of 1997). It is also important to assign the appropriate HCPCS code and recommended diagnosis codes per local Medicare review policies for screening. For example, bone density screening is now a covered service for a number of patients at high risk for bone disease. And screening colonoscopy is covered for high-risk patients every 24 months. When the reason for the service is screening, the diagnosis code selected will be a V code with additional codes reported to describe the high-risk conditions. Bone density screening is reported with HCPCS codes G0130, G0131, or G0132 and the high-risk colonoscopy code is G0105. APC 426 results in a proposed payment of $346.57. Code G0121 is used to report an individual with a screening colonoscopy who is not at high risk. Without APC code results, the patient will be responsible for this non-covered service.

Cardiac rehab procedures in the APC system are designated by CPT codes 93797 - 93799. APC 948 (proposed payment of $41.65) results from CPT 93797 and 93798, but 93799 (unlisted cardiovascular service or procedure) groups to APC 967 with a proposed payment of $87.41. It is inappropriate to maximize reimbursement for cardiac rehab services by assigning the unlisted code when the definitive codes describe the procedure rendered.

CPT code 65205 is assigned for superficial removal of foreign body from the external eye conjunctiva. Removal of foreign body currently must be intraocular to make the ASC list (reported with codes 65235 in group 2, 65260 in group 3, and 65265 to Group 4). The superficial code groups to APC 681 with a projected allowance of $84.84. The intraocular procedures group to APC 652 for code 65235 ($840.72) and APC 676 for codes 65260 and 65265 ($301.84). This means a variance of more than $500 occurs between the two procedures. Whereas procedures that were previously paid more are lower in reimbursement under the new methodology.

If coders do not have adequate documentation to discern what was performed, reimbursement in the APC system will not be accurate for nervous system procedures, such as spinal injections for pain management, or for carpal tunnel release procedures common in ASC facilities and hospital outpatient surgical departments. Endoscopic release of carpal tunnel is coded 29848 (APC 281 = $1150.27), compared to open release code 64721, which groups to APC 631 with a reimbursement projected to be $653.03. Miscoding this procedure would result in a loss of more than $500.

Table 3—APC Comparisons

Cough due to acute bronchitis as reason for visit in the ER = difference in reimbursement

Cough
Low level = APC 95131 = $57.08
Mid level = APC 95331 = $92.56
High level = APC 95531 = $132.15

Acute bronchitis
Low level = APC 95133 = $59.13
Mid level = APC 95333 = $98.21
High level = APC 95533 = $160.94

Chest pain compared to angina as reason for visit in the ER = no difference in reimbursement

Chest pain
Low level = APC 95136 = $64.79
Mid level = APC 95336 = $103.87
High level = APC 95536 = $160.94

Angina
Low level = APC 95136 = $64.79
Mid level = APC 95336 = $103.87
High level = APC 95536 = $160.94

Chest pain compared to esophagitis as reason for visit in the ER = difference in reimbursement

Chest pain
Low level = APC 95136 = $64.79
Mid level = APC 95336 = $103.87
High level = APC 95536 = $160.94

Esophagitis
Low level = APC 95141 = $66.85
Mid level = APC 95341 = $103.87
High level = APC 95541 = $148.60

Abdominal pain due to UTI = difference in reimbursement

Abdominal pain
Low level = APC 95141= $66.85
Mid level = APC 95341 = $103.87
High level = APC 95541 = $148.60

UTI (urinary tract infection)
Low level = APC 95153 = $73.53
Mid level = APC 95353 = $105.93
High level = APC 95553 = $147.58

Fever due to otitis media

Fever
Low level = APC 95197 = $63.76
Mid level = APC 95397 = $102.33
High level = APC 95597 = $142.95

Otitis media
Low level = APC 9513 1= $57.08
Mid level = APC 95331 = $92.56
High level = APC 95531 = $132.15

Note: All dollar amounts are taken from the June 30 Federal Register. *This document corrects technical and typographical errors that appeared in the September 8, 1998,* Federal Register*, which contained the proposed rules for APCs.*

Creating a system that results in accurate and concise coding will pay off in correct reimbursement, so any deficiencies in documentation practices or coding education should be corrected before APC reimbursement becomes standard practice. The stakes will be high. Coding has always played a role in outpatient reimbursement for hospitals, but with APC methods, it becomes the vehicle to correct payment. Are you prepared? To find out, test yourself against the APC readiness report card in Exhibit 3.

Exhibit 1—Documentation Checklist for ASC Coding Adequacy

Record Number		DOS	Physician Number	Surgical Service
	Facility-specific criteria samples			
	History and physical present - performed no more than 30 days prior to service			
	Indications for the procedure			
	Current medications			
	Any known allergies			
	Pulse, blood pressure and respiration (local anesthesia) temp (general anesthesia)			

	Pre-procedure risk assessment of sedative administration			
	Informed consent			
	Name of surgeon and assistant(s)			
	Operative report			
	Pre-operative diagnosis or referring diagnosis			
	Post-procedure diagnosis(es)			
	Size of lesion removed or length of repair recorded			
	Description of procedure in detail including approach, prosthetics used, etc.			
	Complications including blood loss			
	Medical stability before, during, and post procedure			
	Anesthesia report			
	Type recorded (local - regional - IV sedation - general)			
	Anesthesiologist or anesthetist name			
	Time and agents used (monitored anesthesia care indicated)			
	Additional procedures recorded such as central lines, etc.			
	Discharge status			
	Instructions to patient or family			
	Record Adequate for Coding Yes No Comments:			

Exhibit 2—Comparison Chart for Current Outpatient Procedures versus APC Method for Medicare

CPT Code	Current reimbursement based on cost/ASC blend		Hospital amounts (APC payment proposed from June 30, 1999, *Federal Register)*		ASC amounts (APC-based payment proposed from June 12, 1999, *Federal Register*)	Variance	
		ASC	*Allowance*	*Copay*	*Allowance 20% Copay*	*Hospital*	*ASC*
66984	**$1,120**	$928	**$1,132.27**	$617.21	**$863**	**+12.27**	**-65**

Exhibit 3—APC Readiness Report Card

	Not evaluated or not available—unsatisfactory	**Satisfactory but needsd further development**	**Very satisfactory—excellent work**

Data quality review for coding accuracy			
Chargemaster review			
Physician documentation education			
Record processing assessment			
Grouper investigation and budgeting			
Software edit and UB-92 interface testing			
Staff education and remittance review			
HIM and patient accounts			

Notes

1. Department of Health and Human Services. "Improper Medicare Payments for Nonphysician Outpatient Services under the Prospective Payment System." A-01-95-00508. Available at www.hhs.gov/progorg/oas/reports/region1/19500508.htm.

2. The Office of Inspector General's Compliance Program Guidance for Hospitals, OIG Web site. Available at www.hhs.gov/progorg/oig.

3. MEDPAC (Medicare Payment Advisory Committee) Web site. Report available at www.medpac.gov.

4. The Office of Inspector General's Compliance Program Guidance for Hospitals, OIG Web site. Available at www.hhs.gov/progorg/oig.

5. A copy of the edits is available from the National Technical Information Service (NTIS), Springfield, VA, at (800) 553-NTIS or www.ntis.gov.

6. Ibid.

7. Department of Health and Human Services. "Medicare Program; Prospective Payment System for Hospital Outpatient Services; Proposed Rule." *Federal Register* 64, no. 125 (June 30, 1999): 35278-35483.

8. Health Care Financing Administration. *Medicare Hospital Manual Publication* 10, Section 460. Completion of Form HCFA 1450 for Inpatient and/or Outpatient Billing. Available at www.hcfa.gov/pubforms/10_hospital/ho00.htm.

Assessing the Impact of APCs

How will APCs affect your reimbursement? Here's how to assess the impact of this new system.

1. Run a printout (six months to one year) of dates of service for outpatient services in which the reimbursement may be affected by APCs. Limit the list to Medicare patients and include the following patient types:

    - outpatient surgeries
    - radiology
    - radiation therapy
    - clinic visits in any clinics that may be designated as provider based
    - emergency department visits
    - ancillary diagnostic testing except for laboratory services
    - partial hospitalization for mental health

- psychiatric services
- surgical pathology
- cancer chemotherapy administration and drugs

2. Order by CPT code, making sure to include Medicare payment allowance and patient coinsurance amounts if possible. Structure the report with extra columns to record the proposed APC reimbursement amount, patient coinsurance, and the resulting variance. Take advantage of any opportunities to download this information to a computer spreadsheet. This will make it easier to perform data analysis and make adjustments if the proposed amounts change before implementation.

3. If a manual process is required, create a table similar to that in Exhibit 2.

4. If you work at a critical access hospital or an integrated delivery system, relax. APCs will not be used for your Medicare reimbursement.

5. Do not include the following services as they are not subject to APCs:

   - durable medical equipment (DME)
   - prosthetic devices, implants, and supplies
   - end-stage renal dialysis services
   - services to SNF patients covered under SNF PPS furnished "under arrangements" and billable only by the SNF. (This does not apply to outpatient surgery or other selected diagnostic procedures excluded from this requirement.) This includes diagnostic tests or other services rendered by the hospital for skilled nursing facilities and billed by the SNF due to inclusion in the SNF's prospective payment.
   - inpatient services and procedures
   - allied health professional training costs
   - diabetes education

6. Keep in mind that the following services will be considered "packaged" in the APC system. Thus, they will not receive additional payment over and above the services with which they are associated.

   - operating room charges
   - recovery room charges
   - anesthesia charges
   - medical and surgical supplies
   - pharmaceuticals
   - observation services (post procedure)
   - blood
   - intraocular lenses
   - casts and splints
   - donor tissue
   - incidental procedures such as venipuncture

7. Use the June 30, 1999, *Federal Register*[1] to record the proposed payments. Compare them to current payments and compute the difference. More than one APC group may result from a single patient encounter.

8. When APCs are actually implemented, a geographic adjustment will be taken. For initial analysis, you can use non-adjusted amounts taken directly from Addendum B.

9. You may also use the list of patient types (as described in Step 1) as a pick list to select cases for coding review for accuracy. Since this represents all potential APC cases, a 5 percent sample of each patient type would suffice for a comprehensive assessment of coding accuracy. This basis can function to identify deficiencies and as a base for future examination or focused review. If 5 percent of your facility's cases results in too many, adjust the procedure to reduce the cases to a valid sample (30 cases) per patient type.

Note

1. Department of Health and Human Services. "Medicare Program; Prospective Payment System for Hospital Outpatient Services; Proposed Rules." *Federal Register* 64, no. 125 (June 30, 1999): 35278-35483.

Rita Scichilone *is a coding practice manager at AHIMA. She can be reached at ritascic@ahima.org.*

Article citation:
Scichilone, Rita. "Getting Ready for APCs." *Journal of AHIMA* 70, no.8 (1999): 84-92.
