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# Assuring Payment under APCs

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*Q: The hospital billing department tells me that it won't be using the new APC codes on bills. Why?*

*A:* The APC codes are payment codes, not service codes. They will be assigned by your fiscal intermediary (FI) based on the service codes (HCPCS) itemized on the bills. The FI will have software that converts the HCPCS codes into the appropriate APCs. So your billing department is correct: it will not be assigning APC codes. It will, however, receive payment information showing the applied APC codes on a line-by-line basis if it uses the current electronic-remittance advice version.

*Q: Not all of the J-codes for drugs have assigned APC codes. What if we use drugs with different J-codes?*

*A:* Payments for APC-included oncology drugs generally will be made for only one unit size of any particular drug. This means that if you administer a 200 mg injection of cyclophosphamide (J9080), your systems need to adjust that to the APC units. Therefore, bill two units of J9070 (100 mg injection of cyclophosphamide), and it should be paid as APC 0815.

*Q: What if we don't administer two whole adjusted units?*

*A:* Always round up to the next whole APC-defined unit. If you give 25 mg of a drug and the APC-defined unit is 10 mg, then you will bill for three units or 30 mg.

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*Q: Isn't it fraud to bill for more than what you give?*

*A:* No, the billing and payment rules state clearly that units will be rounded up. This is true whether you "waste" the remainder of a dispensed vial or you reuse it. HCFA generally chose the lowest available J-code unit for drugs with more than one code, making it very unlikely that there will be substantial usable amounts left over.

*Q: I thought that hospitals are supposed to bill services using HCPCS codes, and CPT codes are for physicians' professional services but there are CPT codes in the APC tables.*

*A:* Actually, hospitals use quite a few CPT codes in addition to HCPCS codes. The most common are those that have both a technical and a professional component for the service. Radiation therapy codes are a good example: A private practice radiation oncologist may bill for the professional component of 77299 Radiation Therapy Planning, and the hospital may bill for the technical component using the same code.

Under APCs, hospitals can also bill for visits (or facility fees) at various levels of complexity just as physicians do (called Evaluation and Management or E&M). The same CPT codes will be used. APC payments for these services will obviously not be the same amount as physicians receive. The rules that guide physicians in determining the level of E&M are defined in terms of his or her actions and complexity of decision-making. For hospitals, this determination will be based on the amount of resources used to provide the service.

*Q: Where are the rules for hospitals for determining the level of the visit?*

*A:* There are none published. Instead, HCFA will require each individual hospital to develop its own "maps" to the five levels. These maps should spell out the factors that would distinguish one level from the next. Those factors should take into consideration all the costs incurred by the hospital in the course of the visit, for instance, staffing, supplies, and equipment, among others.

*Q: Why should we spend the time to itemize our bill even though some items won't be paid under APCs?*

*A:* Items that are considered bundled into the APC payments or that are covered but not paid by Medicare should still be billed. There are three reasons for this. First, the outlier payments for services will be calculated based on the bill. If you don't include charges for all of the services you delivered, HCFA will have no way to know that a particular bill meets the outlier criteria for additional payment. Second, end-of-year cost report reconciliation will be affected if all of your costs are not accounted for in the billing process. And third, remember that APCs are really an experiment. During the next couple of years, HCFA will be using the bills generated to try and determine more accurately the actual costs of care. If you don't show them the costs, they might base future payment rates on grossly understated cost data.