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Cancer Centers Tackle the Complexities of APCs

Swedish Cancer Institute in Seattle, Wash.

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In preparation for implementation of ambulatory payment classifications (APCs), initially scheduled to start on July 1, 2000, Swedish Medical Center developed an action plan earlier this year that involved a task force with representatives from all key departments within the institution. Membership on the task force included representatives from general finance, patient financial services, key operating departments such as surgery, emergency room, laboratory, pharmacy, rehabilitation services, outpatient clinics, and the cancer services of medical oncology and radiation therapy. Supporting the task force effort was a consulting group that was to fully analyze the hospital's current charge-master database for compliance with the new APC billing and payment process. A leadership team headed up the Swedish APC task force, and through a series of subcommittees, linked all departments throughout the hospital that would be affected by APC implementation.

The main focus of preparation and study was the hospital's charge-master. It was reviewed for those items under APCs that were identified as inpatient-only services and to judge the appropriate matching of all current outpatient services with an appropriate APC code.

A second major area of planning and concern was the need to discharge all hospital series account outpatients at the time of the APC billing cut-off, and the re-registration of these patients for services on or after July 1. In the case of Swedish Cancer Institute, more than 750 outpatient series accounts needed to be closed. More than two-thirds of these accounts were in the cancer center departments. The task force sorted through these accounts to ensure that only patients under active care would be reinitiated after the APC cut-off.

Third, we drafted a form letter to notify all Medicare patients under care at the hospital that APCs would be implemented and that this implementation might affect their co-payment portion of their bills in the future. The letter provided each patient with a 1-800 Medicare phone number that could be called to request a booklet explaining how the new outpatient prospective payment system works and how it affects patients.

Specifically in the Cancer Institute, a number of issues were studied and addressed:

- The appropriate use of Q codes for chemotherapy services was reviewed and information provided to all coding personnel about their appropriate use.
- Appropriate ICD-coding to accompany both outpatient service bills and specifically chemotherapy drugs was reviewed, and information resources, such as tables, were prepared for the use of billing coders.
- Coders were also provided with the most current approved-indication lists for specific chemotherapy agents to ensure that denials would not be made based on unapproved uses.
- Charging and coding procedures were reviewed, and daily audits were reinforced to ensure all charges are posted within 24 hours.

The generation of charges for care throughout Swedish Medical Center is quite decentralized; service departments in many areas initiate the charges onto a centralized billing system. To be familiar with newly APC-revised charges, individuals in many of the hospital's departments were trained in all procedures that had been modified.

A key area reviewed in pharmacy services was proper use of J code units, which must match the drug and dosage administered with payment for the service. High-use oncology drugs were reviewed to make sure that appropriate J code units were being charged and that the charging procedures were upgraded and revised to meet this requirement. A specific process was established for pass-through drugs—those not yet assigned to an APC. These drugs must have specific ICD-9 codes associated with them for Medicare payment. At Swedish, ICD-9 coding will be placed on the paper-based drug orders and processed through to appear on the bill.

Swedish has reviewed the processes used on returned claims and intends to regularly sample the early APC bills to identify trends and respond to problems as they are identified. Service departments will be responsible for correction of billing errors and supplying missing data and information.

Swedish Medical Center has analyzed APCs for the whole institution, and a specific analysis has been run for both radiation therapy and medical oncology within the Cancer Institute. The initial information on Swedish as a total organization indicates that Medicare payment under APCs will not significantly decrease during the final months of 2000 or through 2001. Within the specific areas of the medical oncology chemotherapy service and radiation therapy, the negative impact is

estimated to be a 5 to 10 percent reduction in the compensation received by the hospital.

The financial impact of APCs on Swedish Medical Center may not necessarily result in a major decrease in financial reimbursement. APCs, however, have caused a fair amount of administrative expense and time in preparation for this new payment methodology. As the Health Care Financing Administration (HCFA) moves forward and potentially reduces the compensation for cancer services in the estimated range of 5 to 10 percent, APCs could have a long-term negative impact on the ability to gain resources and investment in the cancer area.

All institutions and cancer programs must monitor billing and reimbursement under the APC program. Administration must monitor any updates or further changes to the APC system and stay in touch with its fiscal intermediaries for the system to maximize any potential reimbursement that is available and justified under APCs.

Forsyth Medical Center in Winston-Salem, N.C.

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Forsyth Medical Center, a member of the Novant Health System, began preparing for APCs on May 26, 2000, with a Task Force Committee kick-off meeting. The task force is composed of representatives from health information management resources, billing, finance, admitting, information technology, outpatient services, physician services, and case management. The task force meets weekly, and members participate in various subcommittees, which meet more often. In addition to forming the task force, we also hired a clinical, billing, and coding expert.

Next, we made sure that coders from health information management resources were trained using HCFA guidelines. We also purchased new software systems—one to assist with the grouping of APC payment and another to help us with the Correct Coding Initiative and the Outpatient Code Editor.

Our implementation plan also called for our pharmacy to update its charge-master to include appropriate J codes. Staff continuously reviews the pass-through list, which provides additional codes associated with new pharmaceuticals. Pharmacy also changed its system charge file to convert medication dosages into J codes and APC code increments. For example, a 50 mg vial is now written as 5 to 10 mg units. Forsyth Medical Center's pharmacy dispenses approximately 3.2 million doses annually.

Changes have also been made in the billing office, which is logging and analyzing every denial and rejection received to determine if there are any trends. The denials and rejections have not been significant, averaging only three to five a day. HCFA explained that it has been experiencing difficulties in billing, and many of the errors we have discovered may be related to those difficulties.

In addition, our hospital has performed a financial analysis. Early this fall we will begin to review many of our patient accounts to determine the effect of APCs.

After analyzing the new APCs, we believe there are both benefits and drawbacks. The impact at Forsyth's Cancer Center will not be as large as other cancer centers may experience because our patients have always received chemotherapy treatments in a private medical oncologist's office. The APCs will have an impact on our radiation oncology outpatients; however, with a payer mix of only 25 percent Medicare, we do not expect this impact to be significant. The total volume of patients seen annually in radiation therapy at our cancer center is more than 1,000. Clearly, the impact of APCs will be greater on smaller cancer centers that administer chemotherapy and serve a majority of Medicare patients.

Our experience has been that the new APCs demand clear and concise communication among all members of the health care team. Each staff member must understand the APCs and the new regulations. In addition, Novant Health recommends designating an individual who has the clinical, coding, and billing expertise to focus only on APCs. We have hired an APC coordinator who analyzes denials and rejections regarding APCs and follows all regulations to ensure appropriate billing and coding.

Baptist Hospital East in Louisville, Ky.

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We began planning for the implementation of APCs in fall 1999. We started by hiring an outside consulting firm to review our charge-master and procedural CPT-4 codes for the five hospitals and their departments in the Baptist Healthcare System (BHS). Since the CPT-4 codes drive reimbursement under APCs, our codes had to be accurate.

Next we assigned team leaders for the various product lines and departments, including oncology, cardiology, respiratory therapy, pharmacy, surgery, laboratory, radiology, and materials management. Each team leader is a department head at one of the sister hospitals. The team leaders' tasks included coordinating new service item master (SIM) requests, working with the charge coordinator on CPT-4 code updates, and disseminating pertinent information to their counterparts systemwide.

APCs ushered in the use of HCPCs Level II modifiers, which are essential in many cases for a hospital to be reimbursed properly. Modifiers exist for procedures that are 1) repeated in the same day by

the same or a different physician, 2) aborted prior to or after the administration of anesthesia, 3) involve the left or right side of the body, or 4) done during an emergency room visit, or other outpatient department visit, along with a separate evaluation and management (E&M) visit.

A corporate-wide APC committee dealt with the issue of modifiers and identified the operational approach each facility should take, for example, whether the modifier would be entered by the applicable department or by medical records, and how these patients would be identified. An outside consultant was brought in to provide training to medical records on modifiers and evaluation and management coding.

Baptist Health System obtained the 3M APC grouper, a software package from the 3M company that groups procedures into APC categories, and is approved by HCFA.

Because of frequent changes by HCFA, the pharmacy has had to complete multiple revisions of its charge-master and coding. Codes had to be added or changed, and drugs on the pass-through list had to be re-identified. The appropriate charging methodology based on dosing units was identified and reworked. Disease codes had to be identified along with the itemization of each drug and dose unit. The complexity of the behind-the-scenes work with the order entry and charging systems is indescribable. Nurses are concerned about dosing and billing errors associated with these changes (especially with utilization of automatic medication dispensing systems) because many are unfamiliar with the new requirements. We must be constantly vigilant in overseeing these processes.

The costs associated with consultation, review, analyses, restructuring of systems, education, and the phenomenal number of man-hours to accomplish APC implementation has been staggering. The finalized grouper software was received only five days prior to the August 1 implementation date. Additional delays in management reporting have occurred because our software vendor needed to write an interface between the grouper (which provides an edit report *before* the bill is dropped) and our decision support system application from which reporting will be done. The interface is in the testing phase, and if all goes well, reporting on the final impact of APCs will follow shortly. Based on a manual review of Medicare remittance advices received to date, a reduction in reimbursement appears likely. However, until we have reporting capability, the extent of that reduction cannot be estimated.

The complexity of coding requirements and use of modifiers in conjunction with the new billing requirements are so mind-boggling that we may have overlooked crucial modifications to the systems. From an oncology perspective, the new APC system may stifle new technologic developments for radiation therapy and new drug development for chemotherapy. Our fear is that the tremendous strides made in oncology care over the years may be eroded. Programs and services offered in many specialties in what has been a more cost-efficient outpatient model may be disbanded.

Some recommendations we have for other hospital administrators in their preparation for APCs include sharing every available piece of information—whether it has been obtained from HCFA, from the professional societies, or from telephone conversations—with colleagues. Be sure that communications with multiple departments in a network are open and regular in order to implement changes with clear delineation of responsibilities. Ongoing communication with elected officials is also necessary to assure an understanding of the ramifications of the changes brought by APCs on the provision of health care to our Medicare population.

Is Your Oncology Program Ready for APCs?

Here is a sampling of what the oncology consultants are seeing when they review oncology programs for APC readiness and projected reimbursements.

- *Billing systems.* Many systems are not able to handle multiple diagnosis codes for medical necessity edits. Rejected or denied bills under APCs will cost one institution about $1.4 million each year if its billing system is not fixed. Pharmacy and billing staff don't have requisite knowledge.
- *Pharmacy systems.* Some systems do not communicate well with other computerized systems. Good communication among systems is now vital because pass-through drugs in oncology must be billed with their assigned J-codes.
- *Accountability.* Oncology administrators often don't have responsibility and accountability for drugs. Pharmacy administrators have more than just oncology to worry about, thus they are often not able to spend the time necessary to address the issues.
- *Drug unit sizes.* Conversion of drugs from acquisition units to APC billable units is a serious problem in many institutions. One drug may be purchased in multiple sizes, but can be billed only in one unit size.
- *Co-payments.* Not only is the calculation of co-payments complicated, but many hospitals simply do not have the staff or the mechanisms in place to collect.
- *Charge-masters.* In one large institution, more than $2 million dollars were being lost each year because the charge-master was out of date.
- *"Lost" charges.* Millions of dollars are being lost because charge capture is incomplete or data transfer is problematic. This loss is particularly true in programs where the charges are entered into one system in the clinical area but are then rekeyed into another computerized system for actual billing. In one program, the radiation department system doesn't "talk" to the hospital system. The result: half the charges are erroneously dropped.

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