10 Steps to Better Billing under APCs

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If you've been working with ambulatory payment classifications (APCs) for the past year and believe the reimbursement system is difficult and inflexible, you're not alone. Although the Health Care Financing Administration (HCFA) continues to make minor changes quarterly, system glitches still have not been fixed, and rules have not been fully clarified or routinely implemented.

APC payment itself has been difficult to implement. Many hospitals have seen substantial reductions in the percentage of charges collected from Medicare, and oncology service lines at some hospitals are losing money in underreimbursement. Because Medicare payment itself is not sufficient to cover the costs of some treatments, copayment collection has become critical to the bottom line. In some oncology treatments, copayments make up about 60 percent of the total dollars received. Furthermore, many hospitals have been harmed by the cap placed on co-payments.

While all hospital outpatient payments used to be driven solely by the charge and the revenue code associated with the service, Medicare APCs have changed the keys for payment. All services provided must be billed using a descriptor of service, HCPCS code, and date of service, as well as a revenue code and charge. Each payable service must be stated in allowed units and placed on a separate line on the bill to show its HCPCS code and the date delivered. A radiation series patient, for example, might have a bill 40 to 50 lines long, showing treatment for each day, multiple physics QA, multiple port films, and multiple visit facility fees.

Moreover, all pass-through drugs and high-level visit services are targeted for intense Medicare audit review. Expect your cancer center to have frequent audits.

While APCs have changed hospital management, some of the new reimbursement processes are actually better than the ones they replaced. For example, HCFA has better defined how and when a visit should be billed. Also on the plus side, new coding changes and additions make providing brachytherapy and intensity modulated radiation therapy (IMRT) services feasible in the hospital outpatient setting. To prepare for APCs, HCFA had used single-procedure bills to calculate group weights that were used ultimately to make payment determinations for radiation oncology services. This action led to inadequate payment for certain procedures and a misclassification within specific APCs. HCFA responded by adding new codes to cover brachytherapy needles and seeds and IMRT planning and treatment. The IMRT payments account for the cost of capital equipment, software, and physician and staff training, plus the cost of providing each service. Still, radiation departments must monitor the pass-through pool reductions, since some payments, such as those for brachytherapy supplies, may be decreased. Brachytherapy supplies are currently paid at cost.

Sadly, many hospitals actually think everything is fine despite the fact that they lack an adequate system to record all revenues, track denials, and speed these claims to review. Following are 10 steps to help hospitals receive the reimbursement to which they are entitled under APCs.

1 Know Your Charges, Revenues, and Expenses.

Problem. Too many hospitals set their charges inadequately. They do not know how to price oncology services and often miss many cost items. In one hospital we found department cost-to-charge ratios of .97 with private insurance discounts of 10 to 15 percent. Not only is the department losing money on Medicare under APCs, but it is losing money on its private insurers as well.

Solution. Make sure your charges cover your costs. Know what is billable. Then either bundle everything to those codes or bill every item to show cost, even those for which you expect no payment. Make certain you include all direct and indirect costs. Use a benchmark of local charges to ensure that you capture the market rate.

Properly record all revenues. Know what the rules are and learn what patient accounts, medical records, finance, and information services departments are doing to

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help you in sending out clean and appropriate bills to insurers. Is the data interface working optimally between billing and the radiation and pharmacy clinical systems? Are proper ICD-9-CM codes being added? Are modifiers being used properly?

Most of all, act like an independent business. Track trends and make projections. Identify potential problems and solve them before they cause trouble.

2 Bill for Each Service to Which You Are Entitled.

Problem. If hospitals do not bill for everything to which they are entitled, they will not stay financially viable. Moreover, HCFA will never receive the data it needs to justify raising the APC rates. HCFA knows that hospital cost report data are inaccurate, especially by department; so, to establish a payment rate for each procedure, HCFA uses the hospital's average cost-to-charge ratio. Under APCs, departments with low-cost services and procedures become profit generators, and departments with high-cost services (such as cancer centers) become profit losers. HCFA projects that, while hospital outpatient services may break even or see up to a 4.7 percent increase, cancer centers may experience up to 29.7 percent in losses.

Solution. Bill for each service you provide and for each service to which you are entitled because the figures on your cost report have the potential to affect your payment rates later on.

If the hospital staff provides physician support services, the hospital may bill for a visit service, whether or not the physician sees the patient. If a medical oncology patient is seen by the nurse, nutritionist, and social worker, the aggregate visit level should be billed. A patient seen by multiple physicians could have multiple billable visits on a single day, but a patient seen by one physician can have only one billable visit on one day.

Each hospital must define and write its own standards for outpatient visit services. The emergency room is the only department allowed its own rule set. Escalating visit levels must correspond to greater use of hospital resources. Ordinarily, there are five visit levels. Oncology, however, has an additional level, used for interdisciplinary team visits if at least three staff members work with the patient and at least one is a physician. Critical care visits (99291) may be billed if a patient meets the definition of critically ill, as described in the American Medical Association coding manual. This code would most likely be used in the infusion area if a patient has a severe reaction to the drugs being administered.

All billable visits must be medically necessary and documented by the hospital staff. These visits can be billed by the staff of both the medical oncology and radiation oncology departments when they are supporting a physician. Since HCFA uses the physician E&M codes, there are Correct Coding Initiative (CCI) edits that prohibit billing a basic visit while a patient is receiving radiation treatment. This may be unintentional, and the result of HCFA's lack of understanding about how many staff members are needed to support a physician's professional service during radiation treatment. Since HCFA accepted comments until June 25, 2001, many hospitals have written HCFA and asked the agency to either eliminate this CCI edit, or add a code for supportive care during treatment. (Radiation oncologists do not bill regular visit codes during treatment because they were given a special higher professional visit code to bill.)

Anytime more than one visit (facility charge associated with visit service) is provided on the same day (visit to multiple clinics, or clinic & ER), the condition code G0 must be used on each claim other than the first claim. The logistics of applying condition code G0 are tricky at best. (Usually, the G0 code is entered by the billing department.)

You can bill for a patient assessment pre- or post-hydration, chemotherapy by multi-technique, and injections on the same day if all were medically necessary. Use a 25 modifier on the visit code, a Q0081, a Q0085, and 90784 or appropriate injection code(s). Many other combinations of services can be given on the same day as well. Injections are paid as ancillary services and can be billed in multiple units if appropriate.

Ask for and review your denials daily.

3 Track Denials and Speed Claims to Review.

Problem. In today's APC environment, most hospital staff members think that filing appeals is too burdensome and denials are just a minor problem. Some mistakenly believe that HCFA and the Medicare fiscal intermediaries (FIs) are always right; denials are hospital mistakes. Most hospitals do not have an adequate system to track denials and speed these claims for review, despite the fact that HCFA gives providers 45 days to appeal a denied service claim.

Solution. Department managers must take a strong role in collection and assist patient accounts with the resubmission of any returned claims. Ask for and review your denials daily. Attach the documentation and appeal paperwork and give them back to the proper location for appeal in a timely manner.

Staff in the patient accounts department should be just as concerned with making sure that every charge gets collected as they are with correct billing and days in accounts receivable.

4 Keep Up with Coding and Billing Changes.

Problem. HCFA is constantly changing and updating regulations, coding, and billing procedures. If you are out of the loop, you may be out of business. Here is just one example. Although many hospitals are using "claims scrubbers" (claims editors) in their billing process, if the claim does not make it through the scrubber, patient accounts believes the service is not billable. The flaw in this belief is that the hospitals are not updating their scrubber rule sets every time HCFA or the FI makes a change. The results are inaccuracies and lost revenue.

Solution. Every cancer center should have a task force that evaluates the impact of rule and coding changes and alerts senior administration to potential threats to the program. This task force should include the medical and radiation oncology managers, the pharmacy manager, and the patient accounts manager at the very least.

A few radiation codes and billing rules have changed since APC implementation. Port films should be reported as only one charge per week of therapy (regardless of the number of films required during the week), and films may be obtained via electronic imaging. Also, 3-D simulation includes teletherapy isodose planning, and therefore only the 3-D simulation should be billed.

Stay current. Use the HCFA web site to get timely information: *www.hcfa.gov* or *www.hcfa.gov/medlearn/listserv.htm.*

5 Ensure Communication and Coordination among Departments.

Problem. Lack of coordination and lack of incentives for system well-being are common in hospitals, and occur in more than one department. During one recent hospital visit, the director of patient accounts reported that, "Days in accounts receivable are my problem, not whether all charges were properly entered and billed." No wonder the collection rate was 37 percent!

Solution. To succeed under APCs, hospitals must change their internal operations. Patient accounts must work more closely with other departments that provide services. The patient accounts department will require help to handle oncology returns/denials, since their staff is not trained to answer improper diagnosis or medical necessity questions. Meet with the supervisor and arrange a schedule (daily or perhaps weekly, depending on the size of your program) to pick up all cancer-related returned/denied bills. Spend some time with the supervisor to learn how to read the reasons for return/denial so you can review them easily and correct them quickly. For example, note corrected service dates or check for mismatches between ICD-9-CM diagnosis codes and drug codes. Work with the departments that made the errors, so they are clear about your corrections. If the bill requires appeal, you may need to involve your medical director, especially if the issue is medical necessity.

In every successful hospital outpatient program, each service department is responsible for working with patient accounts, information services, medical records, and managed care. Every support department is accountable for working with the service departments.

6 Update Your Information Systems.

Problem. The information systems in most hospitals are notoriously antiquated and dysfunctional. Problems include clinical systems that don't interface with billing systems, patient registration programs that need 17 data entry screens, and ICD-9-CMs that can't be added or removed without damaging historical files. Recently, a pharmacist described the interface between the pharmacy system and the hospital billing system "as a fire hose meeting a garden hose." He was receiving a daily, six-inch thick error report showing that more than 10,000 of the 40,000 or so charges going into billing from the pharmacy every night were *not* being entered into the system at all. Another 10,000 or so were being processed to the wrong account or had some other defect. Our audit found about $10 million in net patient revenue missing from the pharmacy's budget! Although your pharmacy's billing problems may not be as extreme as this example, it is still likely that your pharmacy is missing 10 percent or more of charges.

Solution. Hospitals should invest in updating the information systems (IS) department by replacing or updating what they already have, or improving the interface among other departments to ensure that all charges are reaching the claim. Hospitals must establish an efficient system for reviewing error reports and enforce whatever rules they already have in place for follow-up. Each error report requires follow-up!

7 Build a Perfect Charge Master.

Problem. In many hospitals, the charge master is too complicated and incorrect. All too often the existing charge master is not suited for medical oncology, the infusion center, and pharmacy services and procedures. We have seen too many generalist consultants give hospitals incorrect information, resulting in inadequate charge masters and lost revenue.

Solution. Building a charge master cannot be accomplished in a financial vacuum. Each service department must understand the new rules, have guidance from the compliance and managed care departments, and then build a charge master with the finance department that makes every service or procedure billable. Each service department must also work with IS and patient accounts to build encounter screens that make clinical sense so that data entry is accurate and complete.

To make sure your charge

master is perfect, check charges, revenue codes, descriptions, and HCPCS codes. Revenue and HCPCS code requirements may be different for different payers. Make certain all are correctly loaded for claims processing. Only one charge description needs to show on charge master or data entry screens.

It is better to start from scratch than to try to adapt an old charge master for APCs. Building efficient oncology charge masters requires a specialist in oncology billing.

8 Use Modifiers Correctly.

Problem. Most hospitals have IS systems that cannot enter modifiers. In fact, many hospitals still add modifiers by hand in the patient accounts department.

Solution. The use of modifiers for certain services and condition codes is critical if hospitals are to eliminate claim returns or denials. The largest impact on oncology comes from requirements for modifiers 25 and 59, and condition code G0. Modifier 25 must be used any time a visit facility fee is charged and a significant service is provided on the same day. For example, this modifier should be used every time an assessment visit and chemotherapy are provided on the same day, or radiation treatment and the weekly management visit are provided on the same day.

Modifiers are now required for many radiation therapy and medical oncology procedures provided on the same day of service. A 59 modifier is attached to the code for the lesser service and indicates that the lesser service is separate and distinct and was not done as part of the greater procedure. A 25 modifier is attached to the visit service code any time a visit service is provided in addition to a major procedure such as chemotherapy or blood administration. If ancillary services (such as port films or injections) are provided with a major service, no modifier is needed. If two or more radiation treatments are provided with a distinct break in therapy sessions on the same day, use modifier 76 to indicate that the sessions are distinct treatments by the same physician. Remember to put each treatment on a separate line on the claim, and do not use units of more than one.

Have a Billing Question?

On July 30, 2001, if you have a billing question about APCs, your charge master, or how to speed claims to review, check out ACCC's web site at www.accc-cancer.org. Click on the Newsgroup button. Your password is oncologyteam. Ask your question...then consultant Mary Lou Bowers will respond with an answer. It's easy...it's free...it's July 30.

9 Verify and Update Diagnosis Codes.

Problem. Because APCs require that medical necessity be identified for each pass-through drug, every drug must have an ICD-9-CM to support its use. Unfortunately, most hospital billing systems are not prepared for series accounts with changing ICD-9-CMs. Some systems are not capable of adding or removing ICD-9-CMs from patient accounts without changing the entire history of patient care. To produce a correct bill, the hospital has to produce a paper claim and correct it by hand. Handbills create mistakes. Paper claims slow payment and cash flow.

Solution. We recommend that physicians add an ICD-9-CM code to every drug order. Doing so will help pharmacists verify coverage for that use and add the information to the patient's claim. Oncology infusion outpatients are likely to have a high volume of ICD-9-CM code additions and deletions. Medical records must be notified about any coding changes if the authority for making such changes on the bill rests with this department.

Diagnosis codes must be updated at each visit as appropriate. Improper diagnosis codes or lack of specific diagnosis codes will create denials. All cancer center directors should immediately review the process for adding diagnosis codes to single entry and series accounts at their hospitals.

10 Educate and Keep Close Tabs on Your Pharmacy.

Problem. All pass-through drugs (and high-level visit services) are targeted for intense Medicare audit review. Expect your cancer center to have frequent audits. If the wrong J code is used, you will *not* be paid.

Solution. In the APC system, drugs must be billed in J code units, which identify units of use. Some drugs have multiple J codes. Usually only one J code is paid. (Exceptions include filgrastim and reteplase, which have two payable codes.)

All pharmaceutical doses should be rounded up to whole units. If the code is stated per 500 mg, for example, but 1,100 mg were given, the correct number of units is 3. Never use decimal points.

Make sure your pharmacy system adds waste to patient dose for correct billing, and create a written policy that identifies any drugs that the pharmacy will waste once the vial is opened. Bill for all waste, as long as the patient received some of the drug. If the vial contains 100 mg and 80 mg were used and 20 mg wasted, 100 mg is billed. No billed product should ever be used on another patient.

New drugs will not be paid until the pharmacy has assigned both a C code and an APC payment amount. HCFA has agreed to use C codes as a temporary measure for the time between Food and Drug Administration (FDA) approval and assignment of a J code. C codes reduce, but do not eliminate, the time during which hospitals will not be paid for drugs that the FDA has approved for use with Medicare patients. It may take as long as six months for APC payment rates to be set after FDA approval, depending on the timing of the FDA approval date.