

Hospital APC Pricing Webinar

- Historical Perspective
- Provider Contract Payment Exhibits
- Pricing Rules
- APC Line Level Remits
 - Remit line allowed amount versus line priced amount.

Hospital Outpatient Line Level *Historical Perspective*

- Medicare created APC (Ambulatory Payment Classification) pricing to match costs (not charges) with services.
- The APC system establishes groups of covered services so that the services within each group are clinically similar in terms of resources/costs required.
- Multiple APCs can be assigned on an outpatient claim.

Hospital APC Pricing

- Claims process through software called the APC/Outpatient Code Editor (OCE).
- The APC/OCE applies CCI (Correct Coding Initiative) edits and assigns APCs, Service Indicators and discount factors when multiple procedures are performed.
- APCs are assigned based on the HCPCS (Healthcare Common Procedure Coding System) codes filed on the claim.

APC Service Indicators

APC Service Indicator	Description
A, E	Not paid under OPPS APC. Usually paid by HCPCS fee schedule.
G	Drug biological pass-through.
K	Non-pass-through drug/biological or device.
N	Incidental/packaged services. Not payable.
S	Significant procedures.
T	Significant procedures subject to discount.
V	ER or clinic visit.
X	Ancillary services. Priced either based on APC, HCPCS or discount.

Pricing the Services

- Refer to correct provider payment exhibit, Preferred Blue[®] or State Health Plan, or participating contract and correct payment exhibit effective date.
- Basic APC pricing is a combination of three pricing methods: APCs, an HCPCS fee schedule and charge discount.
- The allowance for Incidental Services (Service Indicator = “N”) is included in the allowance for valid APC and HCPCS services. (Does not generate separate reimbursement.)

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Pricing Methodology

- APC's price is based on the APC Fee Schedule.
- HCPCS code's price is based on the HCPCS Fee Schedule.
- APC and HCPCS codes that do not have established fees and are not incidental, price is based on a discount.

Provider Payment Exhibit

- A.7 To determine the outpatient reimbursement amount, the claim will be processed to determine if there are one or more valid APC codes to describe the services. Hospital shall accept the lower of Covered Charges or the APC reimbursement (see Attachment #1) for claims that meet this criteria. The APC groupings and edits will be updated at least annually. Charges determined to be for “incidental” services (as determined by CMS and/or PLAN) are not paid separately. In order to calculate APC reimbursement the charges for incidental services on which the grouper assigns a service/payment indicator of “N9,” are allocated to the APC codes billed on the same claim. However, “N9” services billed without a valid APC are not reimbursable.

Provider Payment Exhibit

- A.8 If Covered Charges on a claim do not price according to the APC methodology in A.7, then the services will be subject to the HCPCS code fee schedule (see Attachment #2). INSTITUTION shall accept the lower of Covered Charges or the HCPCS code reimbursement for claims that meet these criteria.
- A.9 If the claim is not priced according to the APC methodology or the HCPCS code fee schedule as described above, then INSTITUTION shall accept 61 and 6/10 percent (60%) of Covered Charges for such services.

Provider Payment Exhibit

APC Reimbursement Rates: Attachment 1			
Conversion Factor = \$332.42 Default = 61.6% of Covered Charges			
APC	Group Title	Relative Weight	Payment Rates
00343	Level II Pathology	0.4617	\$153.48
00252	Level II ENT Procedure	6.4469	\$2,143.08
HCPCS Fee Schedule: Attachment 2			
HCPCS	Description	Allowance	
36415	venipuncture	\$0.00	
82247	Bilirubin, total	\$29.06	
82248	Bilirubin, direct	\$29.06	
Example only. Refer to your provider contract payment exhibit for actual rates.			

Provider Outpatient

Line Level Remit

- The claim level allowance is populated to each line based on ratio of line charge to total charge.
- On the remit, the line allowed amount is not the priced amount for that line.
- The line allowed amount is simply the portion of claim allowed amount allocated to each line.

APC Reimbursement Methodology

Example 1

Services price by HCPCS. Claim allowance less than charge.

Line	HCPCS Code	APC Code	Service Indicator	Payment Indicator	Discount Indicator	Units	Charge	Rate	Rate*Units	Allowance
1	82247	00000	A	2	1	1	\$52.00	\$29.06	\$29.06	\$29.06
2	82248	00000	A	2	1	1	\$52.00	\$29.06	\$29.06	\$29.06
3	36415	00000	A	2	1	1	\$29.70	\$0.00	\$0.00	\$0.00
Total							\$133.70		\$58.12	\$58.12

HCPCS code 36415 has \$0.00 allowance.

Example 1: Electronic Remittance Advice

Services priced by HCPCS. Claim allowance less than charge.

PreProv	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS	Summary
001	HC:82247	52.00	22.61			29.39	22.61	CO A2	29.39
002	HC:82248	52.00	22.60			29.40	22.60	CO A2	29.40
003	HC:36415	29.70	12.91			16.79	12.91	CO A2	16.79
Remittance Summary		133.70	58.12			75.58	58.12		

Example 1: My Insurance ManagerSM BlueCross Remit Services priced by HCPCS. Claim allowance less than charge.

Rev Cd	APC#	Procedure Code	Days/ Units	S I	P I	D I	RB MTH	Submitted Charge	Covered Charge	Allowed Amount	Discount	Patient Liability	Payment
300	00000	82247	1	A	2	1	APC	52.00	52.00	22.61	29.39	0.00	22.61
300	00000	82248	1	A	2	1	APC	52.00	52.00	22.60	29.40	0.00	22.60
300	00000	36415	1	A	2	1	APC	29.70	29.70	12.91	16.79	0.00	12.91
								133.70	133.70	58.12	75.58	0.00	58.12

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APC Reimbursement Methodology

Example 2 — Services priced by APC * 2.

Line	HCPCS Code	APC Code	Service Indicator	Payment Indicator	Discount Indicator	Units	Charge	Rate	Rate*Units	Allowance
1	88305	00343	X	1	1	2	\$514.72	\$153.48	\$306.96	\$306.96
2	88312	00433	X	1	1	1	\$126.68	61.6% disc	\$78.04	\$78.04
Total							\$641.40			\$385.00

Because neither APC code 00433 nor HCPCS code 88312 are listed on either APC or HCPCS fee schedule, **and** because SI/PI is NOT N9, these services price at default discount.

APC Reimbursement Methodology

Services priced by HCPCS Fee schedule.

Line	HCPCS Code	APC Code	Service Indicator	Payment Indicator	Discount Indicator	Units	Charge	Rate	Rate* Units	Allowance
1	36415	00000	A	1	1	1	\$4.00	\$5.00	\$5.00	\$5.00
2	80048	00000	A	1	1	2	\$100.00	\$40.00	\$80.00	\$80.00
3	86349	00000	A	1	1	1	\$90.00	\$110.00	\$110.00	\$110.00
4		00000	N	9	1	4	\$12.00	\$0.00	\$0.00	\$0.00
Total							\$206.00		\$195.00	\$195.00

Because lower of charge or allowance is calculated at the claim level, the fact that the rate on line 1 is more than the charge for that service does not impact the pricing of the claim.

Example only. Refer to your provider contract payment exhibit for actual rates.

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

HCPCS FEE SCHEDULE

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Rate* Units</u>	<u>Allowed</u>
1.	36415	00000	A	1	1	4.00	5.00	5.00	4.00
2.	80048	00000	A	1	2	85.00	40.00	80.00	85.00
3.	86359	00000	A	1	1	90.00	110.00	110.00	90.00
4.		00000	N	1	4	12.00	0.00	0.00	12.00
TOTAL						191.00		195.00	191.00

Claim prices at charge when Total Charge is lower than Total of Rate*Units.

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

APC and HCPCS PRICING

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Rate*Units</u>	<u>Allowed</u>
1.	87070	00000	A	1	1	56.00	45.00	45.00	45.00
2.	87186	00000	A	1	1	67.00	50.00	50.00	50.00
3.	31645	00076	T	2	1	1149.00	1000.00	1000.00	1000.00
4.		00000	N	1	1	211.00	0.00	0.00	0.00
5.		00000	N	1	2	39.00	0.00	0.00	0.00
TOTAL						1522.00		1095.00	1095.00

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

APC , HCPCS and DISCOUNT PRICING

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Rate*Units</u>	<u>Allowed</u>
1.	87070	00000	A	1	1	56.00	45.00	45.00	45.00
2.	87186	00000	A	1	1	67.00	50.00	50.00	50.00
3.	31645	00076	T	2	1	1149.00	1000.00	1000.00	1000.00
4.	Q9949	09161	K	1	1	200.00	60% **	12 0.00	120.00
5.		00000	N	1	2	39.00	0.00	0.00	0.00
TOTAL						1511.00		1215.00	1215.00

** Line 4 prices at a discount because there is no rate for HCPCS Q9949 or APC 09161.

Multiple Procedure Discounting

- The APC/OCE software assigns each service a Discount Indicator that determines how discounts will be applied when multiple procedures (with a Service Indicator = “T”) are performed.
- Only services with Service Indicator “T” are subject to multiple procedure discounting.

Multiple Procedure Discounting

- Generally speaking, the primary procedure allows 100% and other procedures allow 50%.
- The APC/OCE software determines which is the primary procedure (not the charge amount or fee schedule amount).
- The software also determines when bilateral pricing is applicable and assigns a Discount Indicator to price the service accordingly.

Multiple Procedure Discounting

These are the eight Discount Indicators:

1. Service prices at 100%.
2. Prices first unit at 100% and additional units at 50%.
3. Service prices at 50% (reduced/terminated procedure).
4. Service prices at 150% (bilateral).
5. Service prices at 50% (secondary procedure).
6. Service prices at 25% (reduced/terminated secondary procedure).
7. Service prices at 75% (secondary bilateral procedure).
8. Service prices at 200% (bilateral not subject to discount).

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

MULTIPLE PROCEDURE DISCOUNTING — MULTIPLE UNITS

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Rate*Units</u>	<u>Allowed</u>
1.	76005	00000	N	1	1	100.00	0.00	0.00	0.00
2.	62282	00207	T	2	3	1600.00	700.00	1400.00	1400.00
3.	J0130	00000	N	1	1	40.00	0.00	0.00	0.00
TOTAL						1740.00		1400.00	1400.00

1. The Discount Indicator on Line 2 causes the first service to price at 100% and the secondary procedures to price at 50%.
2. Pricing for the three units on this line is $700 + 350 + 350 = 1400$.

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

MULTIPLE PROCEDURE DISCOUNTING — MULTIPLE CODES FILED

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Rate*Units</u>	<u>Allowed</u>
1.	45380	00143	T	2	1	1300.00	1000.00	1000.00	1000.00
2.	43239	00141	T	5	1	1000.00	900.00	450.00	450.00
TOTAL						2300.00		1450.00	1450.00

1. The Discount Indicator on Line 1 causes the service to price at 100%.
2. The Discount Indicator on Line 2 causes the service to price at 50%.

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

MODIFIER 50 — MULTIPLE PROCEDURE DISCOUNTING

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Allowed</u>
1.	64475-50	00207	T	4	1	2000.00	1000.00	1500.00

1. The Discount Indicator 4 causes the procedure to price at 150% (bilateral pricing).
2. Correct billing for bilateral procedures is to file appropriate procedure code with the 50 modifier, file one line with one unit. If using a bilateral code, do not use the 50 modifier. File one line with one unit.

APC Reimbursement Methodology

Example only. Refer to your managed care contract payment exhibit for actual rates.

MODIFIER 50 FILED ON A PROCEDURE THAT CANNOT BE BILATERAL

	<u>HCPCS</u>	<u>APC</u>	<u>SI</u>	<u>DI</u>	<u>Units</u>	<u>Chrg</u>	<u>Rate</u>	<u>Allowed</u>
1.	58661-50	00131	T	2	1	5000.00	4000.00	4000.00

1. Discount Indicator 2 results in the service pricing at 100%.
2. The Discount Indicator determines the pricing, not the modifier.

APC Filing Guidelines

- File the same codes as for Medicare.
 - File in UB format (837-I).
 - Follow Medicare protocol and use valid HCPCS codes and modifiers.
- Important to file claim correctly first time.
 - Corrected claims problematic for APC.
 - Cannot add lines to processed claim.
 - Will request refund and reprocess new claim.

APC Filing Guidelines

- Professional fees on HCFA (Healthcare Financing Administration) 1500 claim form.
- Emergency room.
 - Use -25 modifier on HCPCS code when filed with other significant procedures.
- Require valid HCPCS for revenue services requiring HCPCS.
 - File same revenue service and HCPCS on one line with multiple DUTs.
 - Some HCPCSs have DUT (Days, Units, or Time) limits.
 - Limits are listed in the DUT quantity limit table.
 - HCPCSs not on table have no limit.
 - DUT updates sent via e-mail to hospitals when updated and as needed.

“OBSERVATION” SERVICES

“Observation” services **only** pay to the hospital when **all** of the following circumstances are true:

- Diagnosis is either “chest pain,” “heart failure” or “asthma.”
- Billed code G0378 with eight units (hours) or more.
- ER or clinic visit code *OR* code G0379 (direct request by physician for observation) billed on claim.
- No surgery (“T” service indicator) on claim.

APC Status Codes

Entire Claim – No Payment

- 2907 - Only incidental services reported.
- 2904 - Revenue center requires HCPCS.
- 2903 - Service unit out of range for procedure.
- 2971 - One or more lines has DUTs that exceed max allowed.

APC Status Codes

Claim Line – No Payment

- 2921 - Component of a comprehensive procedure not allowed by NCCI (National Correct Coding Initiative).
- 2922 - Component of a comprehensive procedure that is not allowed by NCCI.
- 2901 - Multiple codes for same service.
- 2923 - Mutually exclusive procedure not allowed by NCCI.
- 2924 - Mutually exclusive procedure allowed by NCCI.

Miscellaneous Information

- APC grouper edits are determined by several factors:
 - Codes may process and pay differently for different dates of service (e.g., claims may group differently after a new version of the grouper is installed).
 - Combination of codes and quantity units may cause a claim to deny or disallow another line.

Miscellaneous Information

○ DUT Limit Table

- Entire claim will deny if any DUT out of range
- Lines out of DUT range will be indicated on remit (posted with R7023).

○ Common DUT Errors:

- Time units for ER visits or surgical procedures.
- Omission of appropriate condition code.

APC Q&A

- Q: How will BlueCross look at codes that are not yet set up/recognized?
- A: If the claim is filed with a valid code, but it is not a code listed in the grouper version used by BlueCross, that code will pay at a discounted percentage of the covered charge.
- Q: If a change/update is made on how a code is “grouped” after the BlueCross grouper is installed, how will providers be reimbursed?
- A: Providers are reimbursed according to the APC/OCE software in place at the time the claim is processed (or re-processed).

APC Q&A

Q: How does BlueCross handle CCI (Correct Coding Initiative) edits and medical edits?

A: BlueCross recognizes the CCI edits for our current version of the grouper. (The “timing” of when a claim is processed can change how a claim is paid).

APC Pricing Issues

Common mistakes when calculating pricing:

- Incorrectly pricing services that rejected.
- Incorrectly pricing incidental services (SI = N).
- Incorrect application of discounting multiple procedures.
 - Designating the wrong procedure as primary.
 - Calculating bilateral pricing when not applicable.
- Using the wrong APC assignments.
- Using incorrect contract-effective data.

APC Pricing Issues

Common misconceptions about APC pricing:

- APC claims are manually priced.
- Modifier 50 does not guarantee service to price at 150% (bilateral).
- They believe the APC assignments might be wrong.
- The service with the highest allowance is not always the primary procedure when applying discounting.
- Inappropriate and overuse of modifier 59.