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Outpatient Facility Coding Alert

Coding Update: Heads Up: Some Outpatient Codes Are Ready to Bundle Up as 'Mini DRGs'

Your reporting could change drastically in 2015, thanks to comprehensive APCs including associated smaller services.

In an attempt to streamline the Medicare payment system, CMS has introduced new bundled codes for outpatient services that will put the outpatient coding system in sync with inpatient diagnosis-related groups (DRGs). According to CMS' proposed outpatient payment rule, the "comprehensive APCs" will be implemented starting Jan. 1, 2015.

At present, the basic payment unit on which providers are reimbursed in Medicare's outpatient prospective payment system is the ambulatory payment classification, or APC. Some coding experts feel these new comprehensive bundled codes are like "mini-DRGs" because of their structure. The list includes larger bundles of services with no separate payment for additional items or services. The list of 28 "device dependent" comprehensive APCs covers procedures that include costly devices, such as orthopedic implants, implantable cardio-defibrillators, and stents.

The proposed payment rates differ for each proposed bundle. For example, pacemaker procedures will vary from $7,000 to $17,000, depending on the resources used. The more complex claims would reimburse providers more than $32,000, while reimbursement for intensive orthopedic surgeries, excluding those on the hands and feet, will pay about $11,000.

Know the Provider's Perspective

"If the (bundled) payment rate is appropriate for all those itemized things sitting on the claim, people will feel OK with the notion of a comprehensive APC," said **Jugna Shah**, president and founder of Nimitt Consulting, a firm that works with hospitals and providers on inpatient and outpatient payment issues.

But there are some concerns as well. According to **Pam Kassing**, senior economic adviser for the American College of Radiology, two comprehensive APCs that involve endovascular revascularizationa procedure to clear artery blockagesrepresent 85% of all imaging services that would be packaged under the new codes. "There is a lot of imaging involved in those APCs," she said, and radiologists should not be skimmed off the top.

Pay Heed to the Exceptions

There are some exceptions to the comprehensive APC policy. For example, Medicare will make separate payments for certain outpatient claims including ambulance services, pass-through drugs and devices, preventive services like cancer screening tests and diabetes tests, and self-administered drugs, likely because they are covered under other CMS benefits or are reimbursed under other payment methodologies.

Plan for Both Approaches to Payments in the Future

The drive for bundled outpatient services is not likely to ease up. As CMS sources confirmed in the Proposed CY 2015 Policy for Comprehensive APCs, "We may extend comprehensive payments to other procedures in future years as part of a broader packaging initiative."

However, as the American Hospital Association and other groups analyze and submit comments to CMS, Shah suggests providers still annotate every outpatient service on their claimseven as bundled payments become part of the normal payment schedule.

"From an operational perspective, if we fast forward and all is finalized, there's not a lot to do other than continue

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reporting every single service that you've rendered," Shah said. "The second you stop reporting those line items, they don't exist on the claims anymore. That is the absolute worst thing that providers could do."

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