CHCPP NEWS
COMMISSION ON HEALTH CARE POLICY AND PRACTICE

HCFA's Prospective Payment System for Hospital Outpatient Services

With growing concern over increased costs of hospital outpatient services, Congress required the Health Care Financing Administration (HCFA) to develop a prospective payment system for hospital outpatient services. In 1990, HCFA contracted with 3M/HIS to develop such a proposal. To date, 3M has developed the Ambulatory Patient Groups (APGs), version 2.0. In the Spring of 1995, HCFA submitted a report to Congress on APGs. Legislation is required to implement this system. To date, there has been no congressional action on this issue although HCFA officials indicate that the 105th Congress may consider this issue.

An APG task force headed by Kenneth McKusick, MD, chair of the Society of Nuclear Medicine (SNM) coding and reimbursement committee, was recently convened and includes members from the SNM, the SNM-Technologists Section, the American College of Nuclear Physicians and the Council on Radionuclides and Radiopharmaceuticals. Members of this task force met with HCFA officials on December 9 to provide education on the practice of nuclear medicine and its distinctions and uniqueness compared to other specialties, and to discuss some initial concerns with the APG system as it currently exists.

Ambulatory Patient Groups, Version 2.0

Fundamental to the design of any outpatient prospective payment system (PPS) is the determination of the basic unit of payment. The inpatient PPS uses the hospital discharge as the basic unit of payment, while the visit was selected as the basic unit of payment for the outpatient PPS. A visit represents a contact between the patient and the health care professional. The visit could be for a procedure, for a medical evaluation or for an "ancillary service" such as a bone scan. For each type of visit a prospective price is established that includes all the routine services (e.g., blood tests, chest x-rays, etc.) associated with the visit. Since the cost of the routine services rendered during a visit is included in the payment for the visit, hospitals have the financial incentive to control the amount of services rendered.

In order to have a visit based outpatient PPS, it was necessary to develop a classification system that could serve as the basis of payment. A classification system for outpatients would serve the same function as the Diagnosis Related Groups (DRGs) in the inpatient PPS. A new ambulatory classification system was developed by 3M which is referred to as Ambulatory Patient Groups. The APGs are designed to explain the amount and type of resources used in an ambulatory visit. Patients in each APG visit should have similar clinical characteristics, similar resource use and similar costs.

The assignment of multiple APGs to a patient is in contrast to DRGs, which always assigns a patient to a single DRG. In the outpatient setting, the diversity of sites of service, the wide variation in the reasons patients require outpatient care and the high percentage of cost associated with ancillary services, necessitates a classification scheme that can reflect the diversity of services rendered to the patient. The APGs are intended to address the diversity within the outpatient system by assigning patients to multiple APGs.

In an outpatient PPS, each APG would have a standard payment rate, and the payment for a patient would be computed by summing the payment rates across all the APGs assigned to the patient. However, to provide incentives for cost control and to minimize opportunities for upcoding of APGs, not all APGs assigned to a patient are used in the computation of the final payment. The APG system uses three techniques for grouping different services provided during the same visit into a single payment unit.

- Significant Procedure: By definition this is a procedure or study that has been scheduled and is a reason for the patient being seen in the outpatient setting. When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the determination of payment. For example, if both a simple incision and a complex skin incision are coded on a patient bill, only the complex skin incision will be used in the APG payment computation.
- Ancillary Packaging: A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. Ancillary packaging refers to the inclusion of certain ancillary services into the APG payment rate for a significant procedure or medical visit. For example, a chest x-ray would be packaged into the payment for a pneumonia visit.
- Multiple Significant Procedure and Ancillary Discounting: When multiple unrelated significant procedures are performed or when the same ancillary service is performed multiple times, a discounting of the APG payment rate is applied. Discounting refers to a reduction in the standard payment rate for an APG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure itself.

In general, a visit-based PPS has three components: the classification scheme (i.e., APGs), a significant procedure consolidation and ancillary packaging process and a payment computation with discounting. The combination of the APGs and the rules for procedure consolidation, ancillary packaging and discounting are referred to as the APG payment model.

Nuclear Medicine Concerns

- Lack of Homogeneity in the Nuclear Medicine APG Classification: In version 2.0 of the current APG system, over 150 nuclear medicine CPT codes are collapsed into 4 APGs: therapeutic; simple diagnostic; intermediate diagnostic; and complex diagnostic. All nuclear medicine codes are located within Radiology.

The task force expressed concern on the lack of homogeneity in each of the four classes, in relation to the resources (time, equipment and complexity) used. One alternative to make the nuclear medicine APGs more homogeneous is to create additional classifications or sub-classifications.

• Payment of Radiopharmaceuticals: In the current proposed APG system, radiopharmaceuticals are included (bundled) in the payment for the procedure. This would depart significantly from HCFA's current policy of reimbursing radiopharmaceuticals separately and on the basis of the radiopharmaceuticals reasonable costs. The cost of the radiopharmaceutical is a major cost component of many nuclear medicine procedures. Moreover, the costs of radiopharmaceuticals can vary considerably. There is often no or only minimal correlation between procedure costs and radiopharmaceutical costs. In a similar situation involving chemotherapeutic agents, HCFA's APG proposal has created five separate APGs on the basis of costs. Likewise, the task force may recommend that HCFA's refined APG proposal enable radiopharmaceuticals to be paid separately, or that separate APGs for radiopharmaceuticals be created. This would contribute to selection of those radiopharmaceuticals and procedures which provide the Medicare patient with the most appropriate clinical value.

• Discounting for Multiple Procedures: The definition of a significant procedure or therapy is a procedure which is normally scheduled, constitutes the reason for the visit and dominates the time and resources expended during the visit. An ancillary test is a procedure which is ordered by the primary physician to assist in patient diagnosis or treatment. Radiology, laboratory and pathology constitute ancillary tests. An ancillary procedure is a procedure that does increase the time and resources expended during a visit, but does not dominate the time and resources expended during the visit. Examples of ancillary procedures are immunizations, and insertion of an IUD.

Under version 2.0 of the APG system, the therapeutic nuclear medicine APG is classified as a "significant procedure and therapy," while the three diagnostic nuclear medicine APGs are classified as "ancillary tests and procedures." The task force believes that there are many problems associated with the discounting of multiple procedures and the issue of classifying a procedure as an ancillary incident versus classifying it as a significant procedure. The task force feels that all nuclear medicine procedures should be treated as significant procedures. Dr. McKusick explained that if a patient has a CT and a bone scan on the same day, there are different personnel, equipment and supplies, resources, etc. that are involved and that there are no economies of scale that will allow for discounting of one of the two procedures. He stated that nuclear medicine procedures are stand-alone procedures.

During the meeting, HCFA officials reported that they have continued to collect data since the development of version 2.0 of the APGs in 1995 and noted that many of the current policies may require rethinking and revision.

They were receptive to learning about the specialty of nuclear medicine. After discussing concerns related specifically to nuclear medicine, HCFA officials encouraged the task force to submit in writing our issues of concern in detail. They also requested that we make specific recommendations to resolve these concerns, such as developing a revised system of classification for nuclear medicine procedures and radiopharmaceuticals. The task force will develop an action plan and submit it's comments to HCFA in January 1997.

If you would like more information on APGs, including a definitions manual or an executive summary of version 2.0, please contact Wendy Smith at (703) 708-9000, ext. 242 or via e-mail at wsmith@snm.org.

Coding Alert: How to Code for Bone Densitometry in 1997

HCFA has created new HCPCS codes that are to be used in lieu of existing CPT codes for bone mineral density studies furnished on or after January 1, 1997. The HCPCS code for peripheral bone densitometry is G0062 and G0063 for central bone densitometry. You should no longer use CPT codes 78350 or 76075, as these existing codes will no longer be recognized for Medicare reporting purposes. The relative value units (RVUs) for these codes are comparable to the new G codes.

HCFA has assigned 0.22 work RVUs and 0.82 practice expense RVUs to HCPCS code G0062, based on the RVUs assigned to CPT code 78350, which was used to report single-photon absorptiometry bone mineral density studies. G0062 is the only code to be used for reporting peripheral bone mineral density studies.

HCFA has assigned 0.30 work RVUs and 3.07 practice expense RVUs to HCPCS code G0063, based on the RVUs assigned to CPT code 76075, which was used to report dual-energy x-ray absorptiometry studies (DEXA). DEXA is to be coded as G0063

Under Medicare's coverage policy:

• Single-photon absorptiometry (CPT code 78350) is covered when used in assessing changes in bone density of patients with "osteodystrophy or osteoporosis when performed on the same individual at intervals of 6 to 12 months." Under this coding change, HCPCS code G0062 would be used to report single-photon absorptiometry on the peripheral skeleton and HCPCS code G0063 would be used to report the procedure on the central skeleton.

• The coverage of DEXA bone mineral density studies (CPT 76075) is a matter of individual carrier discretion. If covered, HCPCS G0062 would be used to report a peripheral skeleton study and HCPCS G0063 would be used to report the procedure on the central skeleton.

• Dual-photon absorptiometry (CPT code 78351) remains a noncovered service under Medicare and may not be reported under HCPCS codes G0062 or G0063. Dual-photon absorptiometry should be reported with CPT code 78351.

HCFA views these codes as temporary and has assigned interim values. They plan to forward these codes to the CPT Editorial Panel. An application is pending with the CPT for a new code for pDEXA, which the SNM has commented upon unfavorably since pDEXA appears to be of secondary value to central bone density studies.

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