Ambulatory Payment Classification (APC) FAQs

As a result of the State Health Plan’s transition to Ambulatory Payment Classification (APC) reimbursement, we have developed this list of frequently asked questions along with a glossary regarding this reimbursement methodology.

Q: What caused the move to the APC methodology?
A: APC reimbursement allows fixed pricing of services to be established at the HCPCS code level. This allows us to base reimbursement on the actual services/procedures provided in an outpatient setting. Fee schedule pricing, as well as APC pricing, has become the industry standard for outpatient reimbursement.

Q: What are the different forms of reimbursement for outpatient services?
A: APC reimbursement includes these components:

- **Established fees for APCs.** Fee schedules for some HCPCS codes (predominantly labs and therapies).
- **Discount off of charges.** Based upon the procedure you file, a claim can have any combination of these three components.

Q: What are incidental services and how are they reimbursed?
A: The Centers for Medicare and Medicaid Services (CMS) defines incidental services within the APC grouper software as services that are normally provided in conjunction with other services. CMS considered all incidental charges when it established the rates with no separate reimbursement allowed for the incidental services.

Q: Since you are updating the grouper annually and updates are done quarterly by CMS and AMA, how will you reimburse for new codes?
A: We base our edits on validations in the version of the CMS grouper used at the time we process the claim. We will accept all valid HCPCS and CPT codes. If the code is too new to be included in the current grouper we use, we will reimburse based on a discount off of charges (as defined in the hospital’s agreement).

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Q: What happens if we have a corrected claim to submit and we increase the number of lines we submit on the claim?
A: We will have to void the original claim, get a refund on that originally processed claim, and process the corrected claim as a new claim. It is important that corrected claims submissions be minimized. We request that you review your volume of corrected claims and make sure your procedures for initial submissions are sufficient to minimize the number of corrected claims.

Q: Regarding status indicators, is it true that "N" and "E" service indicators are not reimbursed?
A: Reimbursement for codes and charges submitted with "N" status indicators are allocated in APC codes (i.e. no separate reimbursement is provided for codes that have an "N" status indicator) and reimbursement for codes and charges submitted with "E" status indicators are based generally on a fee schedule.

Q: Can we charge the patient for incidental services (status indicator = "N") with a zero allowable?
A: No. The service is covered with a zero allowable, so you can not bill the patient.