

# Preparing for Ambulatory Patient Groups

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**A**s most healthcare professionals know, the advent of ambulatory patient groups (APGs) is not far off. This payment method for Medicare outpatient hospital services will likely become effective in 1993. Although most providers know that this methodology is an outpatient version of diagnosis-related groups (DRGs), many fail to remember how significantly hospitals changed their outlooks and management styles after the introduction of DRGs. And the ramifications inherent in the introduction of any ambulatory grouping schema far outweigh those which resulted from the introduction of DRGs.

Hospitals had a fairly good understanding of the kinds of patients they were seeing before the introduction of DRGs. A number of factors contributed:

- Hospital staffs abstracted and coded all inpatient charts, thus obtaining statistics on all the diseases and conditions the facility was encountering.

- Facilities generally subdivided medical staffs by specialty. Managers therefore better understood the relative strengths and weaknesses of various services.

- Generally, limited numbers of inpatient admissions were made in a given year.

These factors, which helped facilities understand inpatient services in light of DRGs, do not exist in the outpatient realm. In many instances facilities register all outpatient encounters only as services of a given ancillary department. Hospitals that require patients to reregister at each department will not have a comprehensive record of services rendered. In addition, many hospitals do not require diagnostic information before rendering outpatient services; they merely perform the tests ordered and send the results to the requesting physician.

APGs will require hospitals to summarize the services they render to a patient for a particular condition. In addition, APGs by definition require the grouping of all outpatient encounters



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into a limited number of classes. The logic has a similar basis to that of DRGs. The problem is, however, that no equivalent to ICD-9 coding exists for most outpatient services. The best alternative is CPT-4 coding, which does not apply to all outpatient services and does not apply exclusively to outpatient services. Finally, medical records departments may be unfamiliar with the CPT-4 coding schema, adding to the complexity of implementing an APG system.

## PREPARING FOR APGs

What must hospitals do to prepare for the APG payment system? First, each institution must learn about the outpatients it serves. The objective is not to learn any more about the *services* provided to outpatients, but rather to learn about the *patients who receive the services*.

To better understand this concept, facilities should group outpatients into a number of logical sectors for analysis: outpatient surgery, emergency room, observation stays, repetitive therapy, single diagnostic, multiple diagnostic, and other groups. Each sector has specific characteristics that distinguish it from the others.

Outpatient surgery is the easiest sector to understand because it is most like inpatient services. Hospitals can and should abstract and code surgeries, with ICD-9 and DRG codes resulting.

Emergency room patients have the same intake point and therefore share certain likenesses. In addition, emergency room records should include thorough patient histories and diagnostic evaluations, as well as medical records that note all tests patients receive. The records make it possible to group emergency room patients into similar categories. This, however, requires emergency room staff to gather consistent information and correctly code and abstract *all* emergency room charts.

The most problematic cases are one-time admissions because little information is collected about the patient other than that necessary for

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# Healthcare providers must establish a new vision of the outpatient market and how best to serve it.

billing. A hospital needs to know *why* the patient is in the facility, not just the services he or she is seeking.

### NEW RELATIONSHIPS

The advent of APGs will require different relationships between the hospital and the medical staff, between the patient and the physician, and between the patient and the hospital. Hospitals will have to alter the manner in which they schedule outpatients and the manner in which they receive outpatients into the facility. They no longer can require a patient to reregister at each department. Rather, hospitals must standardize the intake process for all outpatients. They will also have to make the data analysis and billing functions consistent for all outpatients served.

At first glance, these procedural changes appear to be simple; however, before they can be implemented, hospitals must redefine the roles of the clinical and ancillary departments. Just as facilities have rewarded these departments for doing only necessary tests and therapies under the DRG payment system, facilities will also need to reward them for wise and prudent selection of only necessary outpatient services under the APG payment system. And just as hospitals have learned to view the inpatient stay as a unitary encounter, they must now view the disparate outpatient encounters in the same manner. The multiplication of services is disadvantageous under APGs, and it cannot be rewarded.

Medical records departments, which in many instances have had little experience with outpatient records, will now be required to understand outpatient services as well as they understand inpatient services. Relationships will need to be strengthened, therefore, between

medical records, the clinical and ancillary departments, and outpatient admitting and billing. Medical staff must work to understand physician interactions with these departments. Accurate diagnostic procedural information will lead to the appropriate APG assignment and Medicare payment.

### SERVING THE OUTPATIENT MARKET

The challenges of managing outpatient care will increase because the knowledge base is poorer and the number of transactions is significantly greater for outpa-

tient services than for inpatient services. Healthcare providers must establish a new vision of the outpatient market and how best to serve it before they can complete the transition to the APG payment methodology. Hospitals will then have to translate this outlook into new ways of collecting information and relating to their constituent groups. The transition will not be easy, but it is essential if hospitals are to succeed in serving all patients under the Medicare APG methodology and to receive the requisite, deserved payments. □

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