Outpatient Classification Systems and Enhanced Ambulatory Patient Groups (EAPGs)

Presented by Treo Solutions
Presentation Highlights

• Goals of outpatient payment classification systems

• How EAPGs meet these goals

• How EAPGs classify visits/services

• Key EAPG grouper elements

• Questions
Key Goals of Outpatient Classification
Payment Systems

• Be clinically meaningful, comprehensive and flexible, describing every patient in the outpatient setting.

• Be simple and cost-effective to develop, implement and maintain.

• Promote provider incentives that encourage a balance between cost-effective and quality-based provision of services.

• Be flexible in meeting unique community reimbursement goals.

• Provide the ability to report to customers on outpatient services purchased for their employee and dependent populations.

• Increased accountability and transparency.

• Promote equity in payment.
Payment equity is achieved through:

- Pay utilizing one set of payment weights that reflect the relativity of costs for all services in the payment system.

- Cost based weights that utilize the same hospital RCCs for both inpatient and outpatient to ensure payment consistency.

- Base rates that reflect the cost of similar providers, services, and service settings.

- Consistent definition of the ‘unit of service’ to be paid.
EAPGs - The Definition

- Enhanced Ambulatory Patient Groups (EAPGs) is a visit-based patient classification system used to organize and pay services with similar resource consumption across multiple settings.

- EAPGs have the potential to bring about beneficial changes to management, communication, cost accounting and planning within hospitals and hospital systems.
Key Characteristics of EAPGs

- Visit based payment decisions.
- Ambulatory visits reflect similar resource use.
- Patients in each APG have similar clinical characteristics.
- Encompass full range of ambulatory care settings including same day surgery units, hospital emergency departments, outpatient clinics (excluding phone contacts, home visits, nursing home services, inpatient services).
- Use administrative data readily available on claim forms in the classification logic.
- Developed to represent ambulatory patient across entire patient population, not just Medicare.
EAPGs are a similar concept to DRG-based inpatient payments.

- **APR-DRGs**
  - Describes an inpatient admission as unit of service
  - Uses discharge date to define code sets
  - Based only on standard code sets (ICD-9-CM)

  Differences:
  - Each admission assigned only 1 DRG

- **EAPGs**
  - Defines ambulatory visit as unit of service
  - Uses from date to define code sets
  - Based on standard code sets (ICD-9-CM Dx and HCPCS Px)
  - Multiple EAPGs may be assigned per visit
  - Each Line assigned an EAPG
## APCs vs. EAPGs: Key Differences

<table>
<thead>
<tr>
<th>Methodology</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily a payment classification system and fee schedule of individual outpatient procedures/services</td>
<td>Outpatient visit classification system, which places services into clinically coherent groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong> packaging of ancillaries and bundling of procedures</td>
<td><strong>Comprehensive</strong> packaging and bundling—flexible to meet reimbursement goals.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comprehensive- siveness</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excludes</strong> many services, which are then covered under other fee schedules</td>
<td><strong>Covers all</strong> medical outpatient services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Payment Basis</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical APCs pay based on self-reported effort (duration of patient contact)</td>
<td>Medical EAPGs pay based on patient’s condition and service intensity (i.e., diagnosis and procedure)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting and Scope</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicability <strong>limited</strong> to payment for facility cost for hospital based outpatient services and ambulatory surgery centers</td>
<td>Broader applicability to other services and settings (e.g., Mental Hygiene, Physical Therapy, and Occupational Therapy) and to performance reporting</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>Unit of Service</th>
<th>APCs</th>
<th>EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment structure based on utilization of services (volume)</td>
<td>Payment structure based on <strong>visits</strong></td>
<td></td>
</tr>
</tbody>
</table>
## APCs vs EAPGs: grouping

<table>
<thead>
<tr>
<th>Category</th>
<th>APC</th>
<th>EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groupings</td>
<td>838 APC Groups:</td>
<td>505 EAPG groups:</td>
</tr>
<tr>
<td></td>
<td>• 394 significant procedures</td>
<td>• 229 significant procedures</td>
</tr>
<tr>
<td></td>
<td>• 17 medical groups</td>
<td>• 183 medical groups</td>
</tr>
<tr>
<td></td>
<td>• 336 drug groups</td>
<td>• 12 drug (for chemotherapy/pharmacotherapy)</td>
</tr>
<tr>
<td></td>
<td>• 39 ancillary</td>
<td>• 66 ancillary</td>
</tr>
<tr>
<td>Editing</td>
<td>Extensive OCE edits</td>
<td>Limited editing for code validation and gender validation</td>
</tr>
<tr>
<td>Modifiers</td>
<td>Extensive use in editing</td>
<td>Smaller subset &amp; purpose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 25 separate E&amp;M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 27 multiple E&amp;M on same day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 52 reduced services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 73 discontinued service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 59 distinct procedural service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 50 bilateral procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Therapy</td>
</tr>
</tbody>
</table>
According to CMS, APCs have moved from packaged encounter-based payment to inefficient service-level payment

- “… over the past 7 years, significant attention has been concentrated on service specific payment for services furnished to particular patients, rather than on creating incentives for the efficient delivery of services through encounter or episode-of-care-based payment.”

- “Overall packaging included in the clinical APCs has decreased, and the procedure groupings have become smaller as the focus has shifted to refining service-level payment.”

- “Specifically, in the CY 2003 OPPS, there were 569 APCs, but by CY 2007, the number of APCs had grown to 862, a 51 percent increase in 4 years.”
• “Packaging and bundling payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility...”

• “In many situations, the final payment rate for a package of services may do a better job of balancing variability in the relative costs of component services compared to individual rates covering a smaller unit of service without packaging and bundling.”

• CMS’s new Composite APCs will bundle and package more services:
  - “… it would be more appropriate to establish a composite APC under which we would pay a single rate for the service reported with a combination of HCPCS codes on the same date of service ... than to continue to pay for these individual services under service specific APCs.”
EAPG CLASSIFICATION
EAPG Key Features

- Utilize UB-04 Data
- Processes claims with multiple Dates of Service
- Eligible sites of service can be customized
Other user customized features are:

- Packaging

- Use of consolidation algorithms
  - Same EAPG
  - Clinically similar

- Per Diem Identification for MHSA

- Inpatient Only procedure list
  (additions only)

- Use of discounting algorithms
  - Multiple procedure
  - Repeat Ancillary
  - Bilateral procedure
  - Terminated procedure

- Direct Admission for Observation
• Supports 5 years of codes using ‘from date’ lookup logic

• Codes will be updated October and January of each year
EAPG unit of service

- The unit of service for EAPG is the visit.
- User actions are required to define what constitutes a visit.

DECISION: More than 1 calendar day?

- Keep as one day
- Split to multiple claims*

DEFAULT

*Note: recent enhancements to EAPGs allow for exceptions to emergency department and direct admit for observation claims.
Assigning APGs

Each line on a claim is assigned an APG. Based on the grouper ‘rules’ certain paths are followed and a final overall visit type is assigned.

The Unassigned APG (999) can result for any of the following reasons:

- User Ignored
- Inpatient Procedure
- Invalid Procedure Code
- Code not used by APGs
- Invalid Dx for Medical Visit
- E-code Dx for Medical Visit
- Non-covered care or settings
- Invalid date (out of range)
- Invalid Procedure
- Direct Per Diem code w/o qualifying Pdx
- Observation condition error
- DAO condition error
- Gender Unknown
- Home Management
EAPG Types (classify services in a visit)

- Significant Procedures, Therapies, Tests
- Ancillary Services (test and procedures)
- Incidental Procedures
- Medical Visits
- Drugs
- Durable Medical Equipment
- Per Diem
- Unassigned
How Classification Work?

- Significant procedures or therapies present
  - NO
  - YES: Type of procedure or therapy
    - NO: Medical visit indicator APG present
      - NO: Ancillary tests or procedures present
        - NO: Primary dx code
          - NO: Types of ancillary tests or procedures
            - NO: Error EAPG
            - YES: Ancillary only visit EAPG
          - YES: Major SSF EAPG
        - YES: Medical visit EAPG
      - YES: Medical visit EAPG
    - YES: Major SSF EAPG
  - YES: Significant procedure or therapy visit EAPG
Significant Procedures

- Procedural service that constitutes the reason for the visit.

- Dominates the time and resources expended during the visit.

- Examples:
  - Echocardiography
  - Bone/Joint Manipulation
  - Hernia Repair
  - Cat Scans
  - Stress tests
  - Pacemakers
• EAPG payment includes an algorithm for consolidation (optional)
  - Multiple Same Significant Procedure Consolidation
  - Clinical Significant Procedure Consolidation

• Modifier 59 overrides consolidation

• Modifier 50 for an eligible service will trigger bilateral payments.

• Includes packaging algorithms
  - Optional
  - Can be modified at the EAPG level
  - Incidentals are always packaged (EAPG 490)
• Discounting options include:
  - Multiple significant procedures on same day
  - Repeat ancillary APGs
  - Bilateral with Modifier 50
  - Terminated procedures (Modifiers 52 or 73)
Medical Visits

• Describe patients who receive medical treatment but do not have a significant procedure performed during the visit.

• Development was based upon the following variables: (not EAPG distinctions, but considerations in development)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etiology</td>
<td>Pregnancy, Poisoning, etc...</td>
</tr>
<tr>
<td>Body System</td>
<td>Respiratory, Digestive, etc...</td>
</tr>
<tr>
<td>Type of Disease</td>
<td>Acute or Chronic</td>
</tr>
<tr>
<td>Medical Specialty</td>
<td>Ophthalmology, Gynecology, etc...</td>
</tr>
<tr>
<td>Patient Age</td>
<td>Pediatric, Adult, etc...</td>
</tr>
<tr>
<td>Patient Type</td>
<td>New or Old</td>
</tr>
<tr>
<td>Complexity</td>
<td>Time needed to treat patient</td>
</tr>
</tbody>
</table>
• Assigned based on principal diagnosis code

• Requires a medical visit indicator code = E&M CPT code

• The medical visit EAPG is assigned to the E&M code
  Examples:
  - Chest Pain
  - Headaches
  - Fracture of Femur
  - Hernia

• Significant Procedures and medical visits are allowed on the same day with the presence of Modifier 25.
• Final Medical visit EAPG relies on principal diagnosis for assignment.
  - Multiple medical visits indicators on the same day will be assigned the final EAPG associated with the principal diagnosis.
  - Multiple medical visit indicators with separate dates will result in the same final EAPG associated with the principal diagnosis.

• All other lines with a medical visit indicator will receive the same final EAPG and get packaged.
Ancillary Tests and Procedures

- Ordered by the primary physician to assist in patient diagnosis or treatment

- Examples:
  - Immunizations
  - Plain films
  - Laboratory tests
  - Pathology Tests

- Basic ancillaries are eligible for packaging

- Repeat ancillaries are eligible for discounting
Mental Health and Substance Abuse Per Diem

- Full day or half day

- Establishes ‘criteria’ for per diem payments
  - Direct Assignment (full or half day)
  - Indirect Assignment (full day only)

- Both types of assignments require the presence of an associated Pdx code
Direct Assignment

- Assigned based upon the HCPCS code
- Optional
- Packaging of related services may apply
- Direct assignment HCPCS codes without qualifying diagnoses are given a final APG assignment of *Unassigned* (999)
Indirect Assignment

- Need to develop qualifying lists A and B
- List A are always significant procedures
- List B can be the procedurally based or diagnosis based
- Establish counts of items from A and B and qualifying Pdx
- If counts meet criteria, claim is labeled per diem
- List A 1st line establishes EAPG, others are packaged
Observation

- Direct Admit or Ancillary observation is assigned based upon the HCPCS code.

- Payment for direct admit requires a medical visit indicator or code indicating direct admission from MD office or emergency department.

- Final EAPG depends on principal diagnosis: maternity and all other.
• Packaging applies to observation on per diem and significant procedure visits.

• Ancillary observation will be paid separately only on Medical Visits unless user applies option to add to packaged list.
EAPG GROUPER FUNCTIONS
Three Key Elements

- Consolidation
- Ancillary packaging
- Discounting
Consolidation

• Refers to the collapsing of multiple related significant procedure EAPGs into a single EAPG for the purpose determining the payment.

• Applies to Significant Procedures only.

• When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Therefore, these procedures require no additional payment.

• Types of consolidation
  - Same EAPG Consolidation
  - Clinically Similar EAPG Consolidation
### Arthroscopic Knee Surgery

<table>
<thead>
<tr>
<th>PROC_CODE_1</th>
<th>APG</th>
<th>APG Description</th>
<th>Payment Element</th>
<th>Payment Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>29876</td>
<td>37</td>
<td>LEVEL I ARTHROSCOPY</td>
<td>Significant Procedure</td>
<td>Full Payment</td>
</tr>
<tr>
<td>29877</td>
<td>37</td>
<td>LEVEL I ARTHROSCOPY</td>
<td>Significant Procedure</td>
<td>Consolidated</td>
</tr>
<tr>
<td>28881</td>
<td>37</td>
<td>LEVEL I ARTHROSCOPY</td>
<td>Significant Procedure</td>
<td>Consolidated</td>
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</table>

Different procedures, but all fall into the same APG

Visit EAPG = 037 - Level I Arthroscopy
### Arthroscopic Knee Surgery

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<tbody>
<tr>
<td>29851</td>
<td>38</td>
<td>LEVEL II ARTHROSCOPY</td>
<td>Significant Procedure</td>
<td>Full Payment</td>
</tr>
<tr>
<td>29877</td>
<td>37</td>
<td>LEVEL I ARTHROSCOPY</td>
<td>Significant Procedure</td>
<td>Consolidated</td>
</tr>
<tr>
<td>12017</td>
<td>13</td>
<td>LEVEL II SKIN REPAIR</td>
<td>Significant Procedure</td>
<td>Consolidated</td>
</tr>
</tbody>
</table>

Different APGs, but they are clinically related to EAPG 038 - Level II Arthroscopy

**Visit EAPG = 038 Level II Arthroscopy**
Multiple Significant Procedure (MSP) Discounting

- MSP Discounting refers to a reduction in the standard payment rate for a significant procedure.

- When multiple, un-related significant procedures or therapies are performed, a discounting of the EAPG payment is applied.

- 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 by itself.
### Example MSP Discounting

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<tr>
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<td>Consolidated</td>
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<tr>
<td>12017</td>
<td>35</td>
<td>LEVEL I FOOT PROCEDURE</td>
<td>Significant Procedure</td>
<td>Discounted</td>
</tr>
</tbody>
</table>

Unrelated Significant Procedure is discounted instead of consolidated.

Visit EAPG = 038 Level II Arthroscopy
Ancillary Packaging

• Refers to the packaging of certain, routine ancillary services when they occur with a significant procedure or medical visit.

• Payment for routine ancillary services is built into the payment of a significant procedure or medical visit for which they are routinely associated.

• If ancillary services are not done as part or a significant procedure or medical visit, they do not package and are paid, but multiple ancillary discounting may apply.
### Uniform Packaging List

<table>
<thead>
<tr>
<th>EAPG</th>
<th>EAPG Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>380</td>
<td>ANESTHESIA</td>
</tr>
<tr>
<td>390</td>
<td>LEVEL I PATHOLOGY</td>
</tr>
<tr>
<td>394</td>
<td>LEVEL I IMMUNOLOGY TESTS</td>
</tr>
<tr>
<td>396</td>
<td>LEVEL I MICROBIOLOGY TESTS</td>
</tr>
<tr>
<td>398</td>
<td>LEVEL I ENDOCRINOLOGY TESTS</td>
</tr>
<tr>
<td>400</td>
<td>LEVEL I CHEMISTRY TESTS</td>
</tr>
<tr>
<td>402</td>
<td>BASIC CHEMISTRY TESTS</td>
</tr>
<tr>
<td>406</td>
<td>LEVEL I CLOTTING TESTS</td>
</tr>
<tr>
<td>408</td>
<td>LEVEL I HEMATOLOGY TESTS</td>
</tr>
<tr>
<td>410</td>
<td>URINALYSIS</td>
</tr>
<tr>
<td>411</td>
<td>BLOOD AND URINE DIPSTICK TESTS</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>EAPG</th>
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</tr>
</thead>
<tbody>
<tr>
<td>412</td>
<td>SIMPLE PULMONARY FUNCTION TESTS</td>
</tr>
<tr>
<td>413</td>
<td>CARDIOGRAM</td>
</tr>
<tr>
<td>423</td>
<td>INTRODUCTION OF NEEDLE AND CATHETER</td>
</tr>
<tr>
<td>424</td>
<td>DRESSINGS AND OTHER MINOR PROCEDURES</td>
</tr>
<tr>
<td>425</td>
<td>OTHER MISCELLANEOUS ANCILLARY PROCEDURES</td>
</tr>
<tr>
<td>426</td>
<td>PSYCHOTROPIC MEDICATION MANAGEMENT</td>
</tr>
<tr>
<td>427</td>
<td>BIOFEEDBACK AND OTHER TRAINING</td>
</tr>
<tr>
<td>471</td>
<td>PLAIN FILM</td>
</tr>
</tbody>
</table>

EAPG 490, *Incidental to Medical Visit, Significant Procedure or Therapy*, is always packaged.
**Example of Ancillary Packaging**

<table>
<thead>
<tr>
<th>PROC_CODE_1</th>
<th>APG</th>
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<th>Payment Element</th>
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<tbody>
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<td>35</td>
<td>LEVEL I FOOT PROCEDURE</td>
<td>Significant Procedure</td>
<td>Discounted</td>
</tr>
<tr>
<td>82800</td>
<td>400</td>
<td>LEVEL I CHEMISTRY TEST</td>
<td>Ancillary</td>
<td>Packaged</td>
</tr>
<tr>
<td>01220</td>
<td>380</td>
<td>ANESTHESIA</td>
<td>Ancillary</td>
<td>Packaged</td>
</tr>
</tbody>
</table>

Routine ancillaries package only when there is a medical visit or significant procedure EAPG.

**Visit EAPG = 038 Level II Arthroscopy**
Ancillary Discounting

- Ancillary Discounting refers to a reduction in the standard payment rate for multiple, non-routine ancillaries.

- When the same, unpackaged ancillary is performed multiple times on the same visit, a discounting of the EAPG payment is applied.

- Discounting recognizes that the marginal cost of providing a second ancillary to a patient during a single visit is less than the cost of providing the ancillary by itself.
### Ancillary Discounting Example

#### Arthroscopic Knee Surgery and Foot Procedure with clotting tests, blood test, and anesthetic

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<tr>
<th>PROC_CODE_1</th>
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<td>380</td>
<td>ANESTHESIA</td>
<td>Ancillary</td>
<td>Packaged</td>
</tr>
<tr>
<td>85220</td>
<td>407</td>
<td>LEVEL II CLOTTING TEST</td>
<td>Ancillary</td>
<td>Full Payment</td>
</tr>
<tr>
<td>85230</td>
<td>407</td>
<td>LEVEL II CLOTTING TEST</td>
<td>Ancillary</td>
<td>Discounted</td>
</tr>
</tbody>
</table>

The first non-packaged ancillary pays in full. The second procedure that falls into the same EAPG is discounted, even if it is a different procedure.

Visit APG = 038 Level II Arthroscopy
EAPG Process Review

1. Claim is submitted.

2. Claim split into visits based on date of service.

3. Each line assigned an EAPG based on the CPT or HCPCS present on the line = Line EAPG

4. Lines are flagged for consolidation, discounting, and packaging based on the mix of other services included during the visit.

5. After line flags are applied, visit is described by the most resource intense procedure provided during the visit = Visit EAPG

6. Visits can further aggregated by service line, summary service line, category, or Visit Type.
**Arthroscopic Knee Surgery and Foot Procedure with clotting tests, blood test, and anesthetic**

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3. **Visit APG = 038 Level II Arthroscopy**
4. **Service Line = Orthopedic Surgery**
5. **Summary Service Line = Surgery**

1. Claim is submitted.
2. Claim split into visits based on date of service
3. Each line assigned an EAPG based on the CPT or HCPCS present on the line = Line EAPG
4. Lines are flagged for consolidation, discounting, and packaging based on the mix of other services included during the visit.
5. After line flags are applied, visit is described by the most resource intense procedure provided during the visit = Visit EAPG.
6. Visits can further aggregated by service line, summary service line, category, or Visit Type.