



3M™ Enhanced Ambulatory Patient Grouping System for payers

- Simplifies the ambulatory visit for analysis and reporting
- Identifies the key procedures of an ambulatory visit
- Determines which items are paid within an outpatient prospective payment system (OPPS)
- May be used as the basis for payment or quality assessment

A brief history of Ambulatory Patient Groups (APGs)

Before APGs, outpatient care was difficult to analyze and manage. In response to an increasingly complex outpatient healthcare sector, the Centers for Medicare and Medicaid Services (CMS) contracted with 3M Health Information Systems in 1988 to develop an outpatient prospective payment system (OPPS).

The resulting Ambulatory Patient Groups (APGs) were introduced in 1990, with major updates in 1995 and 2006. The APGs were designed to clearly describe and define each ambulatory visit for both clinical and financial purposes.

Today, several states and third-party payers continue to operate under an OPPS developed using APGs as the classification system.

The benefits of APGs

APGs provide users with a framework for better analyzing and managing the unique complexities of outpatient care. These complexities include:

- Patients receive care in many settings
- Many different procedures may be provided for similar diagnosis codes
- Resource intensity varies for similar diagnosis codes
- Documentation of services is less centralized
- Outpatient volumes are significantly higher compared to inpatient care (about 16:1)

The benefits of the 3M Enhanced APG System

In 2007, 3M Health Information Systems redesigned the APGs to better reflect current clinical care complexities and practices and the current outpatient cost structure. The result of this major modification is the 3M Enhanced Ambulatory Patient Grouping System (3M Enhanced APGS), a proprietary product of 3M Health Information Systems. 3M Enhanced APGS simplifies and streamlines the APG process for better analysis and management of the OPPS environment.

3M Enhanced APGS: Product features and functions

- **Designation of APG types.** HCPCS and ICD-9-CM diagnosis codes are assigned to one of seven broad APG types to help in the ordering and discussion of APGs and services provided by hospitals. The seven types are: Ancillary, DME, Drug, Incidental, Medical Visit, Per Diem, and Significant Procedure.
- **Assignment of APG categories.** In addition to types, APGs are organized into one of 54 clinical categories that provide a framework for product line analysis and reporting. Examples of the categories include: Musculoskeletal System Procedures, Nuclear Medicine, and Diseases and Disorders of the Digestive System.



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- **Grouping assignments.** APGs are defined using ICD-9-CM diagnosis codes and HCPCS level 1 and 2 codes and modifiers. As these coding sets are updated regularly, the “from date” on the claim is used to designate the code and APG versions that are used for a given claim. These codes establish relative weights and determine reimbursement.

Significant procedure APGs are assigned based on the presence of appropriate HCPCS codes. The medical APGs are defined based on the primary diagnosis code. Also required for the determination of a medical APG is an appropriate hospital Evaluation and Management (E&M) CPT® code and the absence of a significant procedure APG. In some cases, where a significant procedure is present in conjunction with the medical visit requirements, and it is appropriate to code a modifier 25 on the E&M code, both a medical APG and a significant APG are assigned.

Ancillary service APGs are assigned based on the presence of the appropriate HCPCS code. The assignment of APGs to several of the service line items may result in multiple APGs being assigned per claim.

- **Significant procedure consolidation.** When a patient has multiple significant procedures, some significant procedures may require minimal additional time or resources. With significant procedure consolidation, multiple APGs are collapsed into a single APG for the purpose of determining payment. When APGs are consolidated, only one of them is paid. However, all APGs are identified to allow for reporting and analysis.

There are two types of consolidation: Same APG and Clinical. Same APG consolidation is where multiple occurrences of the same APG are collapsed. Clinical consolidation is the collapsing of multiple related APGs.

- **Ancillary packaging.** A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. With ancillary packaging, certain ancillary services are included in the APG payment rate for a significant procedure or medical visit. A uniform list of ancillary APGs that are always packaged into a significant procedure or medical visit is also included with the APG system.
- **Multiple visit definition.** A claim for ambulatory care may represent services provided on a single date or over a period of several calendar days. The multiple visit definition allows claims to be treated as a single day claim whether there are multiple dates of service on the claim or not.
- **Per diem payments.** APGs allow the definition of per diem payments for ambulatory mental health and substance abuse services based on the presence of predefined services on the claim.

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