CODEX

CODING DECODED

OPPS, APC & Medical Billing Edits

A Practical Reference for Medical Coders

CODING DECODED

1. Outpatient Prospective Payment System (OPPS)

Definition: The Outpatient Prospective Payment System (OPPS) is a Medicare reimbursement system for outpatient hospital services.

Under OPPS, hospitals are paid a fixed amount per service or procedure, classified using Ambulatory Payment Classifications (APCs).

Key Features of OPPS

- Applies to outpatient services, including ER visits, diagnostic tests, minor surgeries, and therapy.
- Reimbursement is based on APCs (Ambulatory Payment Classifications).
- Hospitals are paid per procedure or service, not per admission like IPPS.
- Some services are bundled (e.g., anesthesia, surgical supplies).
- Discounting applies for multiple procedures performed in the same visit.

Payment Adjustments

- **Packaged Services:** Some services (e.g., anesthesia, supplies, drugs) may be bundled into the payment.
- **Multiple Procedures Discounting:** If multiple procedures are performed in one visit, Medicare reduces payment for secondary procedures (refer to edits like NCCI edits, MUE's edits).
- **Hospital Outpatient Quality Reporting (OQR) Program:** Hospitals must meet quality standards to avoid payment reductions.

Example of OPPS Payment Process

- A Medicare patient visits the hospital for an MRI scan without contrast.
- The CPT code for MRI without contrast is 70551.
- This has a Medicare-set payment rate of $300.

Hospital Cost Scenario: If the hospital's cost for the MRI is $250, it earns a $50 surplus. If the cost is $350, the hospital loses $50. So, under OPPS, hospitals must manage costs efficiently because Medicare pays a fixed amount per service, rather than reimbursing based on actual expenses.

2. Ambulatory Payment Classification (APC) — Outpatient Setting

Ambulatory Payment Classification (APC) is a prospective payment system (PPS) used by Medicare and other insurers to reimburse hospitals and outpatient facilities for outpatient services. It is part of the Hospital Outpatient Prospective Payment System (OPPS) and is used for services such as surgeries, emergency department visits, imaging, and other outpatient treatments.

Key Features of APCs

Covers outpatient services	Used for hospital outpatient departments (HOPDs), emergency rooms (ERs), and other outpatient settings.
Prospective payment model	Hospitals are paid a fixed amount based on the APC group assigned to the procedure.
Bundled payments	A single APC payment covers facility services, nursing care, and certain ancillary services but does not include physician services (paid separately under the Medicare Physician Fee Schedule).
Multiple APCs per encounter	Unlike Diagnosis-Related Groups (DRGs), which assign one DRG per inpatient stay, multiple APCs can be assigned in a single outpatient visit.

3. RBRVS and Physician Fee Schedule

What is the Resource-Based Relative Value Scale (RBRVS)?

RBRVS is a standardized payment system developed by Medicare to establish fair and consistent reimbursement rates for physician services. It assigns a value to each medical service based on the resources required to provide that service.

The Relative Value Unit (RVU) assigned to a procedure is associated with providing that service. These units are issued by CMS.

Medicare Physician Fee Schedule (PFS)

The Physician Fee Schedule (PFS) is a list updated annually by Medicare that sets payment rates for Medicare Part B services based on the RBRVS system.

Services Covered Under PFS

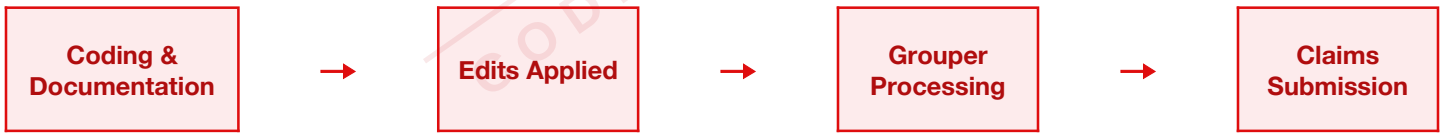
- Physician visits and procedures
- Anesthesia services
- Diagnostic tests (e.g., imaging, lab tests)
- Physical and occupational therapy
- Preventive services (e.g., screenings, vaccinations)
- Durable Medical Equipment (DME)

How PFS Works

- **The Centers for Medicare & Medicaid Services (CMS)** releases yearly updates to the PFS.
- **Many private insurers** use the Medicare PFS as a benchmark.
- **The PFS outlines** billing rules, modifiers, and global periods for procedures.

4. Medical Coding and Billing Process Flow

From Documentation to Claims Submission



A systematic approach ensures accurate medical billing from initial coding through final submission.

5. Edits in Medical Coding and Billing

In medical coding and billing, edits are automated checks and validations applied to claims before submission to ensure compliance with payer policies, coding guidelines, and regulatory standards. Edits help detect and correct potential errors that could lead to claim denials, underpayments, or legal penalties.

Purpose of Edits

1. Error Prevention:
   - Detects coding inaccuracies before claims reach the payer.
   - Reduces the chances of claim rejection or denial.
2. Compliance Assurance:
   - Ensures adherence to coding guidelines (e.g., ICD-10-CM, CPT, HCPCS, NCCI, payer-specific rules).
   - Complies with federal and state regulations, such as Medicare and Medicaid policies.
3. Financial Accuracy:
   - Prevents undercoding or overcoding that could affect reimbursement.
   - Ensures correct claim submission for maximum allowable reimbursement.
4. Efficiency Improvement:
   - Reduces administrative work related to claim corrections and resubmissions.
   - Speeds up the reimbursement cycle by submitting clean claims.

Example of an Edit in Medical Billing and Coding

Scenario

A patient visits a healthcare provider for a routine check-up, and the coder assigns the following codes for billing:

- ICD-10 Code: Z00.00 (Encounter for general adult medical examination without abnormal findings)
- CPT Code: 99214 (Office or other outpatient visit for the evaluation and management of an established patient, typically 25 minutes)
- Modifier: None applied

Potential Edit Triggered

In this case, a medical necessity edit is triggered because the diagnosis code Z00.00 (general adult medical exam) is not appropriate for CPT code 99214, which is used for a more detailed office visit typically involving a problem-focused evaluation.

Edit System Response: "Diagnosis code Z00.00 is inconsistent with procedure code 99214. Please review and correct."

Resolution Process

1. Verify Medical Documentation:
   - Determine if the visit was indeed a routine check-up or a problem-focused evaluation.
2. Correct the Coding:
   - If preventive, use a more appropriate CPT code (e.g., 99396 – Preventive visit, established patient).
   - If problem-focused, use a more appropriate ICD-10 code related to the patient's condition (e.g., R10.9 for abdominal pain).
3. Resubmit the Claim:
   - Once corrected, resubmit the claim for processing.

6. National Correct Coding Initiative (NCCI) — PTP Edits

Modifier Indicator

- **Modifier Indicator 0:** Codes are always bundled — no modifiers allowed to unbundle them.
- **Modifier Indicator 1:** Codes may be unbundled if proper documentation supports the use of a modifier.
- **Modifier Indicator 9:** The edit no longer applies — codes can be billed together without modifiers.

Modifiers Used in NCCI PTP Edits

Modifiers used in NCCI Procedure-to-Procedure (PTP) edits are categorized into Anatomic modifiers, Global surgical modifiers, and Other relevant modifiers. These modifiers help distinguish services as separate and distinct, ensuring compliance with coding guidelines.

Example — PTP Edit Pair

Code 1	Code 2	Modifier Indicator	Edit Rationale	Modifier Guidance
99213	93000	1	E/M service and ECG can be billed separately if the E/M is unrelated to the ECG.	Use modifier -25 on the E/M service (99213) if the services are distinct.

7. Medically Unlikely Edits (MUEs)

Definition: An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service.

- Limits the number of times a procedure or service can be billed for a patient on a single date of service by the same provider.
- These are updated quarterly.
- Maintained by the Centers for Medicare & Medicaid Services (CMS) and available on the CMS website.

Example: Billing for 10 chest X-rays (CPT 71046) in a single day.

Solution: Review documentation and resubmit with appropriate quantities.

8. Medical Necessity Edits

Medical necessity edits verify whether a procedure or service is appropriate and justified for the reported diagnosis, based on CMS or payer policies.

- **Example:** A claim for an MRI (CPT 70553) submitted with an ICD-10 code for a minor headache (R51.9) might be denied for lack of necessity.
- **Solution:** Ensure the diagnosis matches clinical criteria for an MRI (e.g., brain tumor suspicion).

Example: Medicare covers a screening mammogram (CPT 77067) once every 12 months. Submitting a second mammogram within the same period would trigger an edit.

- **Resolution:** Review coverage guidelines to ensure compliance with frequency limits.

9. Local & National Coverage Determinations

LCDs	Local Coverage Determinations (LCDs) are policies issued by Medicare Administrative Contractors (MACs) that define whether specific medical services, procedures, or items are covered under Medicare in a specific geographic region.
NCDs	National Coverage Determinations (NCDs) are policies established by CMS that define whether a particular medical service, procedure, or item is covered nationwide under Medicare. NCDs apply to all Medicare beneficiaries and provide uniform coverage criteria.

Difference Between LCDs and NCDs

Feature	Local Coverage Determinations (LCDs)	National Coverage Determinations (NCDs)
Issued by	Medicare Administrative Contractors (MACs)	CMS (Centers for Medicare & Medicaid Services)
Scope	Regional (specific states or areas)	Nationwide (applies to all Medicare beneficiaries)
Policy Differences	Varies by MAC and region	Same across the U.S.
Example	Coverage of a specific lab test in a state	Coverage of a national screening (e.g., mammograms)
Flexibility	Can be adjusted based on regional needs	Standardized nationally

10. Revenue Codes

A Revenue Code is a 4-digit numeric code used on institutional/facility claims to identify the department, accommodation, or category of service that generated the charge.

Code	Description
0250	General Pharmacy
0270	Medical/Surgical Supplies
0300	Laboratory
0320	Diagnostic Radiology
0350	CT Scan
0360	Operating Room
0370	Anesthesia
0420	Physical Therapy
0430	Occupational Therapy
0450	Emergency Room
0510	Clinic
0610	MRI
0636	Drugs requiring detailed coding (HCPCS required)
0710	Recovery Room
0761	Treatment Room

Example

A hospital outpatient claim shows:

- Revenue code: 0450
- CPT: 99284
- Diagnosis: R10.31

Here, 0450 tells you that the service was provided through the Emergency Department.

For medical coders: Recognizing revenue codes alongside CPT and diagnosis codes helps confirm which department or service line generated a charge — an essential cross-check for accurate, compliant claim submission.