



PPS and Misc Topics

A Practical Reference for Medical Coders

CODING DECODED

1. Prospective Payment System (PPS)

The Prospective Payment System (PPS) is a Medicare reimbursement method where healthcare providers are paid a fixed, predetermined amount for services based on a classification system, rather than actual costs incurred. It was introduced by CMS (Centers for Medicare & Medicaid Services) to control costs, improve efficiency, and standardize payments for healthcare services.

Under PPS, payment rates are set in advance, and hospitals must manage costs within these fixed rates. The payment is based on factors like diagnoses, procedures, severity of illness, and facility location.

2. Inpatient Prospective Payment System (IPPS)

Definition: The Inpatient Prospective Payment System (IPPS) is a Medicare payment system used for inpatient hospital services. Hospitals receive a fixed payment per patient admission, based on the MS-DRG (Medicare Severity Diagnosis-Related Group) assigned to the patient's case.

Key Features

- Applies to inpatient hospital services (patients admitted to the hospital).
- Payments are based on MS-DRGs (Medicare Severity Diagnosis-Related Groups).
- Encourages cost control by paying a predetermined amount per hospital stay, regardless of the actual length of stay or services provided.
- Hospitals receive a single lump-sum payment per admission rather than itemized charges.

Payment Adjustments Made Under IPPS

- Severity of illness or patient's condition
- Procedures performed
- Complications (CC/MCC) — if the patient has additional diagnoses that increase complexity, the hospital receives higher reimbursement
- Hospital location (Rural or Urban) — rural hospitals receive additional payment adjustments
- Teaching status of hospital — hospitals training doctors receive additional payment adjustments

Example of IPPS Payment Process

- A patient is admitted for heart failure.
- The hospital assigns MS-DRG 291 (Heart Failure & Shock without CC/MCC).
- Medicare pays a fixed amount (e.g., \$10,000), regardless of actual costs.

If the hospital's cost is \$8,000, they keep the surplus; if \$12,000, they absorb the extra cost.

Hospital-Specific Factors Affecting Payment in IPPS

These factors account for hospital characteristics, location, and patient population.

A. Hospital Base Rate

- **Definition:** The predetermined rate paid to a hospital for a standard case under IPPS.
- **Impact:** The DRG relative weight is multiplied by the hospital's base rate to calculate the total payment.
 - Example: DRG 192 Relative Weight: 1.000; Hospital Base Rate: \$6,000; Reimbursement: $\$6,000 \times 1.000 = \$6,000$.

B. Wage Index Adjustment

- **Definition:** Adjusts the hospital's payment to account for geographic differences in labor costs.
- **Impact:** Hospitals in high-cost areas (e.g., urban regions) receive higher adjustments.
 - Example: A hospital in New York City will have a higher wage index than one in rural Texas.

C. Teaching Status

- **Definition:** Hospitals with teaching programs receive additional reimbursement for training residents.
- **Impact:** Higher payment adjustments are provided to teaching hospitals.

D. Disproportionate Share Hospital (DSH) Adjustment

- **Definition:** Hospitals serving a high proportion of low-income or uninsured patients receive additional payments.
- **Impact:** DSH adjustments increase the total reimbursement for qualifying hospitals.

E. Indirect Medical Education (IME) Adjustment

- **Definition:** Additional payments to teaching hospitals to account for the higher costs associated with residency programs.
- **Impact:** Hospitals with higher IME factors receive greater reimbursement.

Case Complexity Factors

These factors consider the complexity and intensity of care provided to the patient.

A. Case Mix Index (CMI)

- **Definition:** Represents the average severity and resource intensity of a hospital's patient population.
- **Impact:** A higher CMI indicates more complex cases and leads to higher overall reimbursement.

B. Length of Stay (LOS)

- **Definition:** The number of days the patient stays in the hospital.
- **Impact:** Although DRG payments are fixed, outlier payments may be triggered for exceptionally long stays.

C. Outlier Cases

- **Definition:** Cases with unusually high costs compared to the DRG payment may qualify for outlier payments.
- **Impact:** Outlier payments increase reimbursement to account for resource-intensive cases.
 - Example: A patient requiring prolonged intensive care.

Policy-Driven Adjustments (Penalties)

Reimbursement under the DRG system is influenced by specific policies:

A. Readmission Policy

- **Definition:** Hospitals may face penalties for high readmission rates for certain conditions (e.g., heart failure, pneumonia).
- **Impact:** Reduced payment for hospitals with excessive readmissions.

3. 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.

4. 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.

5. Electronic Health Records (EHRs)

Electronic Health Records (EHRs) are digital versions of patients' paper charts, providing real-time, patient-centered records accessible to authorized users across various healthcare settings. They enhance clinical workflow efficiency, improve patient care coordination, and ensure data accuracy for coding and billing.

Types of EHRs

1. Physician-Hosted EHRs:
 - Stored on local servers within a physician's practice.
 - Offers direct control over data security but requires maintenance.
2. Remotely-Hosted EHRs:
 - Data is stored off-site and managed by a third-party vendor.
 - Reduces internal IT burden but may pose security concerns.
3. Cloud-Based EHRs:
 - Accessed via the internet with real-time data synchronization.

- Cost-effective and scalable, allowing multiple users to access data remotely.
- 4. Enterprise EHRs:
 - Used by large hospitals and healthcare systems.
 - Integrates multiple departments and ensures seamless data sharing.
- 5. Hybrid EHRs:
 - Combination of paper-based and electronic records.
 - Often used during the transition from paper to digital systems.

Role of EHRs in Medical Coding

- **Accurate Code Assignment:** Provides structured documentation that assists in the proper assignment of ICD-10-CM, CPT, and HCPCS codes.
- **Improved Documentation:** Enhances clarity in physician notes, reducing ambiguity in diagnosis coding.
- **Query Support:** Facilitates Clinical Documentation Improvement (CDI) by allowing coders to query providers efficiently.
- **Audit Trails:** Tracks documentation edits and code changes for compliance purposes.
- **Better Compliance & Security:** Adheres to HIPAA guidelines for protecting patient information.
- **Data Security & Privacy Risks:** Protection against unauthorized access and cybersecurity threats.
- **Leverage EHR Reporting Features:** Utilize built-in reports to track coding trends and reimbursement patterns.

6. Encoding Software

Encoding software are essential tools in medical coding, assisting healthcare professionals in accurately assigning diagnosis and procedure codes. These tools ensure proper reimbursement, streamline workflow efficiency, and maintain compliance with regulatory standards.

Functions of Encoding Software

1. Code Lookup & Selection:
 - Provides a search function to find appropriate diagnosis and procedure codes.
 - Includes built-in coding guidelines and reference materials.
2. Code Validation:
 - Ensures assigned codes comply with the latest ICD, CPT, and HCPCS guidelines.
 - Flags incorrect or outdated codes before finalizing claims.
3. Automated Code Suggestions:
 - Uses natural language processing (NLP) to recommend codes based on provider documentation.
 - Reduces manual errors and speeds up the coding process.
4. Coding Edits and Compliance Checks:
 - Integrates with National Correct Coding Initiative (NCCI) edits to prevent bundling errors.
 - Ensures codes align with payer policies and medical necessity guidelines.

Importance of Encoding in Medical Coding

- **Ensures Coding Accuracy:** Reduces human errors in code selection and reimbursement classification.
- **Enhances Compliance:** Adheres to CMS guidelines, NCCI edits, and payer-specific regulations.
- **Speeds Up Coding Workflow:** Automates repetitive tasks and increases coder productivity.
- **Improves Financial Outcomes:** Ensures hospitals and providers receive correct reimbursement based on DRG/APC assignments.

7. Computer-Assisted Coding (CAC)

Computer-Assisted Coding (CAC) is a technology-driven solution that uses Natural Language Processing (NLP) to analyze clinical documentation and suggest appropriate medical codes.

CAC systems assist medical coders by automating part of the coding process, improving efficiency, and enhancing accuracy.

How CAC Works

1. **Data Extraction:** CAC software scans electronic health records (EHRs) and extracts relevant clinical terms.
2. **Code Suggestion:** The system identifies diagnosis and procedure codes from ICD-10-CM, ICD-10-PCS, CPT, and HCPCS.
3. **Code Validation:** Coders should review and validate the suggested codes to ensure compliance and accuracy.
4. **Integration with EHR & Billing Systems:** The final verified codes are sent to billing systems for claim submission.

Benefits of CAC in Medical Coding

- **Increases Efficiency:** Reduces manual work by automating code assignment.
- **Enhances Accuracy:** Identifies potential errors and improves documentation.
- **Improves Compliance:** Aligns with regulatory standards such as NCCI and CMS guidelines.
- **Optimizes Workflow:** Reduces turnaround time for coding and billing.

Challenges of CAC Implementation

- **Reliability of NLP:** CAC systems depend on NLP accuracy, which may misinterpret ambiguous documentation.
- **Coder Oversight Required:** Human validation is essential to prevent errors and ensure correct code assignment.
- **Integration Issues:** CAC must seamlessly interact with EHR and revenue cycle management systems.
- **Compliance Risks:** Automated coding must adhere to payer-specific rules and regulations.

8. Grouper Software

In medical coding and billing, groupers are software applications used to classify and assign patients to specific payment categories or groups based on coded clinical data such as diagnoses, procedures, and demographic information. These groupers are essential for determining reimbursement under various prospective payment systems (PPS) and ensuring proper resource allocation.

| Types of Groupers Used in Healthcare

1. Diagnosis-Related Group (DRG) Grouper:
 - Used primarily for inpatient hospital reimbursement under the Medicare Inpatient Prospective Payment System (IPPS).
 - Assigns a DRG based on factors such as principal diagnosis, secondary diagnoses, procedures performed, patient age, and discharge status.
 - Example: A patient with pneumonia might be grouped under DRG 193 (Simple Pneumonia and Pleurisy).
2. Ambulatory Payment Classification (APC) Grouper:
 - Used for outpatient hospital reimbursement under the Outpatient Prospective Payment System (OPPS).
 - Groups procedures and services into APCs for payment purposes.
 - Example: A colonoscopy procedure might be grouped under a specific APC for gastrointestinal endoscopic procedures.
3. Resource Utilization Group (RUG):
 - Used for skilled nursing facility (SNF) reimbursement based on patient characteristics and resource needs.
 - Factors considered include therapy needs, nursing care, and functional status.

There are more Groupers, but they are not required from the exam standpoint.

| Functions of Grouper Software

1. Assigning DRGs & APCs:
 - Groups cases based on diagnosis codes, procedures, and patient demographics.
 - Ensures accurate reimbursement based on hospital resource utilization.
2. Calculating Relative Weights and Payment Rates:
 - Uses CMS algorithms to determine the appropriate reimbursement amount.
 - Helps healthcare facilities project revenue based on case mix.
3. Identifying Coding Errors & Documentation Gaps:
 - Alerts coders to missing or incompatible diagnoses/procedures that affect DRG assignment.
 - Assists in Clinical Documentation Improvement (CDI) efforts.
4. Integration with EHRs and Billing Systems:
 - Works seamlessly with Electronic Health Records (EHR) and revenue cycle management software.
 - Ensures coded data is correctly transmitted to billing systems for claim submission.

9. Advance Beneficiary Notice (ABN)

Definition: An Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is a written notice that a physician, provider, or supplier gives to a Medicare Fee-for-Service beneficiary before furnishing an item or service, when the provider believes Medicare may not pay for it.

The ABN allows the beneficiary to make an informed decision about whether to receive the item or service, knowing they may be financially responsible if Medicare denies the claim.

The current ABN form is valid through March 31, 2029. Providers should confirm they are using the most recent OMB-approved version from the CMS ABN webpage, since older versions are phased out after their transition deadline.

Purpose of the ABN

- **Transfers Financial Liability:** Shifts potential payment responsibility from the provider to the beneficiary when Medicare denies a claim.
- **Informed Consent:** Ensures the beneficiary understands why Medicare may not pay and what the estimated cost will be.
- **Protects Providers:** Without a valid, properly executed ABN, providers generally cannot bill the beneficiary for a denied service.
- **Supports Compliance:** Documents that proper notice was given in accordance with CMS guidelines.

When is an ABN Required?

An ABN must be issued when a provider believes Medicare is likely to deny payment because the item or service:

1. Is not considered reasonable and necessary under Medicare coverage rules.
2. Exceeds a Medicare utilization or frequency limit.
3. Is being provided as custodial care rather than skilled care.
4. Does not meet the criteria for the level of care billed.

When an ABN is NOT Required

- **Statutorily Excluded Services:** Items or services Medicare never covers by law (e.g., cosmetic surgery, routine eye exams) do not require an ABN, though one may be issued voluntarily.
- **Emergency or Urgent Care:** ABNs cannot be used to shift liability for medically necessary emergency services.
- **Medicare Advantage Plans:** ABNs are a Fee-for-Service (Original Medicare) notice; Medicare Advantage and other payers may require their own waiver or predetermination forms.

Key Components of the ABN Form

Notifier Information	Name, address, and contact information of the provider or supplier.
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Patient Information	Beneficiary's name and Medicare number.
Item or Service (Blank A)	Description of the specific item or service that may not be covered.
Reason Medicare May Not Pay (Blank B)	Plain-language explanation of why coverage may be denied.
Estimated Cost (Blank C)	A good-faith estimate of what the beneficiary may owe if Medicare denies payment.
Beneficiary Options (Blank D)	The patient selects one of three options — (1) receive the item/service and want it billed to Medicare, (2) receive it without billing Medicare, or (3) do not receive the item/service.
Signature and Date	The beneficiary or authorized representative must sign and date the form before the service is furnished.

ABN Modifiers

When billing Medicare for services connected to an ABN, coders append one of four HCPCS modifiers to indicate the ABN status and who is financially liable.

Modifier	Meaning	ABN Signed?	Who Is Liable?
GA	Waiver of liability statement issued as required by payer policy (mandatory ABN on file)	Yes	Patient — claim denies and patient may be billed
GZ	Item/service expected to be denied as not reasonable and necessary; no ABN issued	No	Provider — claim denies and patient cannot be billed
GX	Notice of liability issued, voluntary, under payer policy (voluntary ABN for excluded service)	Yes (voluntary)	Patient — informational, claim denies automatically
GY	Item/service statutorily excluded or does not meet the definition of any Medicare benefit	No (not required)	Patient — informational, claim denies automatically

- **GA:** Use when a mandatory ABN was issued and signed because the service may be denied for medical necessity.
- **GZ:** Use when a denial for medical necessity is expected but no ABN was obtained — the provider absorbs the cost.
- **GX:** Use when a voluntary ABN was issued for a service that is statutorily excluded from coverage; may be combined with GY.
- **GY:** Use for statutorily excluded items/services; an ABN is not required and liability automatically falls to the patient.

Mandatory vs. Voluntary ABNs

Mandatory ABN

Issued when a service is usually covered by Medicare but may be denied in this specific instance (e.g., exceeding frequency limits, lacking medical necessity documentation). The beneficiary must be notified before the service is provided.

Voluntary ABN

Issued as a courtesy for items or services that are always excluded from Medicare coverage (statutorily excluded) or are not a Medicare benefit at all. Not required, but recommended so the beneficiary is informed of financial responsibility in advance.

Special Considerations

- **Qualified Medicare Beneficiary (QMB) Program:** Federal law prohibits billing QMB-enrolled patients for Medicare Part A and Part B deductibles, coinsurance, or copayments — verify QMB status before attempting to collect any balance.
- **Timing:** The ABN must be delivered far enough in advance for the beneficiary to consider the options and make an informed choice — not at the point of service or after.
- **Blank Forms Prohibited:** An ABN cannot be signed with blank fields (such as cost estimate) left for the provider to complete later.
- **Refusal to Sign:** If a beneficiary refuses to sign, the notifier should have a witness annotate the refusal; modifier GA may still apply.
- **Skilled Nursing Facilities (SNFs):** Must use the ABN for items/services excluded from the SNF Part A benefit as well as Part B services expected to be denied.

Worked Example

1. A physical therapist plans to provide additional therapy visits beyond what Medicare typically covers as medically necessary for the patient's diagnosis.
2. The therapist issues an ABN, explaining that Medicare may deny the extra visits and providing a cost estimate.
3. The patient signs the ABN, choosing to receive the therapy and have it billed to Medicare.
4. The coder appends modifier GA to the claim line for the additional visits.
5. Medicare denies the claim as expected, and financial responsibility shifts to the patient per the signed ABN.

Common Coding and Compliance Errors

- **Using GA without a signed ABN on file:** Improper use can result in denied claims and inability to collect from the patient.
- **Forgetting to issue an ABN, then billing with GA:** Should be billed with GZ instead, since no valid ABN exists — the provider becomes liable.
- **Leaving the cost estimate blank:** Invalidates the ABN; a good-faith estimate is required.
- **Applying ABNs to Medicare Advantage members:** ABNs apply to Original Medicare (Fee-for-Service) only.
- **Billing QMB patients directly:** Violates federal balance-billing protections regardless of ABN status.