Chapter A Reimbursement

Medical Coding Mastery

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CPC preparation supplement

Learning objectives

Explain how documented care becomes a paid claim.

Distinguish charges, allowed amounts and patient responsibility.

Describe RVUs, Medicare payment systems and coverage rules.

Identify common claim errors and appropriate corrections.

What reimbursement means

Reimbursement is payment for healthcare services or supplies.

A payer reviews coverage, coding and claim requirements before payment.

Accurate coding supports payment, but a valid code alone does not guarantee coverage.

The coder reports the documented service accurately.

The revenue cycle

Before care: registration, eligibility and authorization checks.

During care: clinical documentation and charge capture.

After care: code assignment, claim review and submission.

After adjudication: payment posting, patient billing and denial follow-up.

Who pays for care?

Medicare: federal health insurance with different parts and plan options.

Medicaid: a joint federal and state program with state-specific requirements.

Commercial plans: employer or individual insurance with contract rules.

Other payment sources include workers’ compensation and self-pay.

Common plan terms

HMO: a plan that generally uses a provider network and may require referrals.

PPO: a plan that usually offers network discounts and some out-of-network benefits.

Eligibility confirms enrollment and benefits for the date of service.

Prior authorization requirements depend on the plan and service.

Patient responsibility

Premium: the amount paid to maintain insurance coverage.

Deductible: the amount the patient pays before specified benefits apply.

Copayment: a fixed amount for a covered service.

Coinsurance: the patient’s percentage of the allowed amount.

Charges and allowed amounts

Charge: the provider’s billed price.

Allowed amount: the amount a plan recognizes for a covered service.

Contractual adjustment: the difference a participating provider must write off under the contract.

Patient responsibility depends on benefits, contracts and applicable rules.

Worked example: allowed amount

Teaching example: charge $200, allowed amount $120.

Assume the deductible is met and the plan pays 80% of the allowed amount.

Payer payment: $120 × 80% = $96. Patient coinsurance: $24.

Contractual adjustment: $200 − $120 = $80. Total accounted for: $200.

Worked example: deductible

Teaching example: allowed amount $150 and remaining deductible $50.

Apply $50 to the deductible. The remaining allowed amount is $100.

With 20% coinsurance on the remainder, the patient owes another $20.

Patient total: $70. Payer payment: $80. Assume no other adjustments.

Codes connect documentation to claims

ICD-10-CM reports the documented diagnosis or reason for care.

CPT and HCPCS Level II describe reportable services, supplies and other items.

Diagnosis pointers connect claim services to relevant diagnoses.

Modifiers describe qualifying circumstances when coding rules support their use.

Professional and institutional claims

Professional claims commonly use the CMS-1500 form or electronic 837P.

Institutional claims commonly use the CMS-1450/UB-04 or electronic 837I.

A hospital encounter may generate separate professional and facility claims.

The claim type and care setting affect reporting and payment rules.

Medical necessity and coverage

Documentation explains why the patient needs the service.

Coverage rules may address indications, frequency and other conditions.

The diagnosis must reflect the record, even when it does not support payment.

A coder queries unclear documentation through the organization’s approved process.

NCDs and LCDs

National Coverage Determination (NCD): CMS coverage policy at the national level.

Local Coverage Determination (LCD): a Medicare contractor’s coverage policy for its jurisdiction.

Related billing articles may list applicable codes and billing instructions.

The Medicare Coverage Database helps locate policies effective on the service date.

Advance Beneficiary Notice (ABN)

For Original Medicare fee-for-service, an ABN may be required when denial is expected in specified situations.

The notice explains the service, reason Medicare may deny and estimated cost before care.

A properly completed notice can transfer liability when Medicare rules permit.

An ABN does not guarantee payment or correct unsupported coding.

Payment methods

Fee-for-service: payment relates to separately reportable services.

Capitation: a contracted payment per member over a defined period.

Prospective payment: a predetermined method tied to a payment classification.

Quality or value programs can adjust payment based on program requirements.

Medicare payment systems

Physician services: Medicare Physician Fee Schedule.

Acute inpatient hospital facility services: IPPS and MS-DRGs.

Hospital outpatient facility services: OPPS and APCs, with packaging rules.

Other settings have their own payment systems or fee schedules.

RBRVS and relative value units

RBRVS means Resource-Based Relative Value Scale.

Work RVUs reflect the clinician’s work involved in a service.

Practice expense RVUs reflect resources used to furnish the service.

Malpractice RVUs reflect professional liability expense.

The physician fee schedule formula

Payment basis = [(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × conversion factor.

GPCI means Geographic Practice Cost Index.

Teaching example: adjusted RVUs 3.00 × hypothetical conversion factor $35 = $105.

Actual payment also depends on the applicable year, setting and payment adjustments.

MS-DRGs and APCs

MS-DRGs classify acute inpatient hospital cases for facility payment.

Diagnoses, procedures and other case information influence classification.

APCs classify hospital outpatient services, with rules that package some services.

Professional services follow their applicable payment rules separately.

NCCI edits and bundling

Procedure-to-procedure edits identify code pairs that generally should not be paid together.

Medically Unlikely Edits address units of service under the applicable edit rules.

A modifier may resolve an eligible edit only when documentation supports the circumstances.

Unbundling separately reports components that a comprehensive code already includes.

Rejections and denials

A rejection commonly occurs when a claim fails submission or processing requirements.

A denial occurs when the payer adjudicates a claim and declines payment.

Read the payer’s reason before deciding on correction, resubmission or appeal.

Examples include missing data, coverage limits, authorization issues and coding edits.

Remittance review and follow-up

An EOB explains benefit decisions. An ERA communicates electronic remittance information.

Compare billed charges, allowed amounts, payment and adjustments.

Use reason codes and payer instructions to identify the next action.

Track deadlines and retain documentation supporting corrections or appeals.

Case discussion: coverage denial

A payer denies a service because the reported diagnosis does not meet coverage criteria.

The coder finds that the claim diagnosis accurately matches the medical record.

What should happen next? Discuss the policy, documentation and appeal options.

Coding decisions must remain supported by the record.

Case discussion: a bundled service

A claim contains a comprehensive procedure and a component procedure.

An NCCI edit identifies the pair, and the record shows one service at the same site.

What should the coder review before changing the claim?

Discuss code instructions, edit rules and documentation for any distinct service.

Review questions

1. What amount forms the basis for coinsurance in our examples?

2. Name the three RVU components.

3. Which system uses MS-DRGs for acute inpatient facility payment?

4. Does prior authorization guarantee payment? Explain why.

Review answers

1. The allowed amount, after any applicable deductible calculation.

2. Work, practice expense and malpractice.

3. The Inpatient Prospective Payment System (IPPS).

4. No. Coverage, eligibility, documentation and claim rules still apply.

Case discussion answers

Coverage denial: review the effective policy and record. Use the payer’s correction or appeal process when appropriate.

A diagnosis change requires documentation support. Query genuine ambiguity through approved channels.

Bundling: follow code instructions and the applicable edit.

Use a modifier only if the edit permits it and the record supports a distinct reportable service.

Official reference sources

CMS: Medicare Payment Systems and Physician Fee Schedule guidance.

CMS: Medicare Coverage Database for NCDs, LCDs and billing articles.

CMS: Medicare NCCI edits and fee-for-service ABN guidance.

Source links appear in the following slides and in PowerPoint speaker notes.

Reference links: payment

CMS Medicare Payment Systems
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/html/medicare-payment-systems.html

CMS Physician Fee Schedule quick reference
https://www.cms.gov/help/pfs-quick-reference-search-guide

CMS fee schedule documentation
https://www.cms.gov/medicare/physician-fee-schedule/search/documentation

Reference links: coverage

CMS Medicare Coverage Database
https://www.cms.gov/medicare-coverage-database/search.aspx

CMS Medicare NCCI
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits

CMS fee-for-service ABN
https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn

Reference links: insurance and claims

HealthCare.gov: health coverage glossary
https://www.healthcare.gov/SBC-GLOSSARY/

CMS: Medicare claim companion guides
https://www.cms.gov/medicare/coding-billing/electronic-billing/medicare-fee-for-service-compainion-guides