Reasons You Need Physician-specific Revenue Integrity Applications

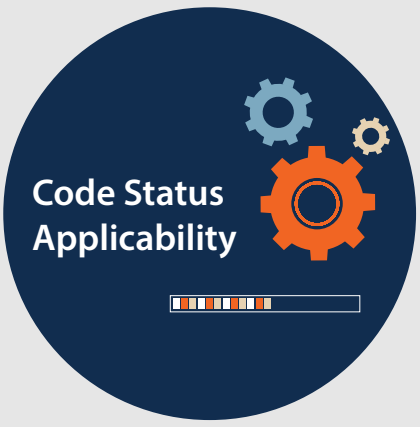
The Medicare Physician Fee Schedule (MPFS) and the Outpatient Prospective Payment System (OPPS) are two separate payment systems and regulatory rule sets. It is important to have access to applications that provide the correct answers and perform the correct analysis for each provider type. Here are a few reasons why:

While hospitals and physicians use the same code sets, codes for the same episode of care may not match. Hospitals code each encounter based on the resources utilized, such as OR time and use of medical equipment, while physicians code each encounter based on time and complexity of the care provided.

Example: A patient presenting with very complex may utilize few hospital resources but may require complex physician management. The hospital may bill at a lower level, while the physician may bill at a higher level or more complex service code for the same patient.

Correct coding guidelines vary greatly between hospitals and physicians. The same CPT® code can have different code pair edits, medically unlikely values, bundling rules and modifier requirements depending on whether it is submitted on a hospital or physician claim. Applying hospital-correct coding principles to professional services and vice versa can create a compliance issue and put reimbursement at risk.

Example: There are a host of services (X-rays, ECGs, blood draws, etc.) that physicians are prohibited from reporting separately in conjunction with critical care CPT codes 99291/99292. However, CMS regulations allow these services to be reported separately on the hospital bill for the same encounter.



A code's "status" which indicates whether the code is billable or not, and/or separately reimbursable, can also differ depending on whether it is billed on a hospital or physician claim.

Example: Routine delivery and postpartum care codes carry a separately billable and payable status when reported on physician claims, however these same codes will be denied if attempted to be submitted on an outpatient facility claim due to their hospital status.

Medicare and many other third-party payors utilize different "payment units" when calculating reimbursement for hospital vs. physician services. Hospital services are reimbursed based on Ambulatory Payment Classification (APC), whereas physician services are reimbursed based on Relative Value Units (RVUs). Physician claims are also subject to place of service (POS) payment differentials depending on whether the service was provided in an office or facility setting.

Example: Procedures may be reimbursed at a higher rate if performed in a non-facility setting. If a physician bills at a lower facility rate for an in-office procedure with a site of service differential instead of the more appropriate non-facility rate, there is a risk of underpayment.

Hospital and physician chargemasters can be maintained by the same team but are often managed separately by subject matter experts in one payment system or another. A professional CDM often contains every CPT Code in the book and is updated once a year by making available the entire code set. This process can create a perception that analysis and regular maintenance of your professional CDM is not required.

Example: While every code may be available in the physician chargemaster, a review of codes being utilized or not utilized can lead to discovery of under- or over-utilized services. Reviewing what modifiers are hard coded or potentially missing from your charges can add integrity to your compliance efforts. RVU updates are key for physician compensation. Analysis of Medicare and especially commercial fee schedules can uncover revenue opportunities.

Guidelines change frequently!

Regulatory changes that occurred in CY2022:

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