Types of Outpatient Coding

Outpatient Coding Systems

Medical coding systems are used according to explicit guidelines to ensure consistent and reliable translation and compression of medical information into manageable codes. Outpatient coding constitutes the majority of coding done in healthcare today. This includes coding for physicians and other outpatient settings such as facility outpatient services (including outpatient surgery). For outpatient medical services, the procedure or service rendered determine the reimbursement from an insurance company or other payer.

Physician’s Office Coding

If you work in a physician’s office or a clinic, you will be coding for the physician’s reimbursement, regardless of where the physician performs the medical, surgical, or diagnostic service. The driving forces for physician reimbursement are the services and procedures that they perform. These are documented using CPT/HCPCS Level II codes. It is extremely important that the physician’s office coders be well-versed in these coding systems. It is also important for them to know basic information concerning ICD-10-CM as these codes are also necessary to establish medical necessity.

Note: Physician payment from Medicare is based on the Outpatient Resource-Based Relative Value Scale (RBRVS). This complicated system is based on the “Physician Fee Schedule.” This schedule sets a payment limit for virtually every CPT/HCPCS Level II code available.

Physician coding includes services, procedures, and diagnostic tests performed by the physician in both the office, and the outpatient and inpatient facility settings. The coder selects the CPT/HCPCS Level II codes based on these services and the ICD-10-CM code based on the patient’s diagnoses and/or symptoms. In the office setting, the coder uses the documentation in the office medical record, if the physician performs services in an outpatient facility or inpatient setting then the documentation usually comes from the facility, however it is still the
responsibility of the physician’s office and coders to send in the claim form for physician reimbursement of these services.

**Outpatient Facility Coding**

If you work as an outpatient facility coder your codes will be used to reimburse hospitals and other outpatient facilities for the use of their resources. Payment is made based on the Outpatient Prospective Payment System (OPPS). This system is based on APCs (Ambulatory Payment Groups). APC payments apply to Outpatient Surgery, Outpatient Clinics, Emergency Department Services, and Observation Services. APC payments are based on CPT/HCPCS Level II codes with the addition of ICD-10-CM codes needed for the determination of medical necessity. As with physician office coding, it is important that you be well-versed in CPT/HCPCS Level II codes as well as ICD-10-CM codes.

**Example**

A patient presents to a hospital outpatient surgery department for arthroscopy of the right knee. The orthopedic surgeon indicates in the operative report that the patient has condromalacia patellae (abnormal softening of the cartilage under the patella) and that a chondroplasty is also performed.

The CPT code 29877 is assigned along with a ICD-10-CM code of M22.41
Applying the Coding Systems

Recognizing the distinct applications of the three coding systems is a critical first step to accurate coding. Consider this example, which demonstrates this distinction:

Example

Consider a patient who goes to the doctor with a significant nosebleed. The patient doesn’t need to be admitted to the medical facility for treatment. The medical coder reviews this encounter in the patient’s medical record and identifies the diagnosis *epistaxis* and applies the *ICD-10-CM code R04.0*. The treatment is *simple packing to control nasal hemorrhaging* and applies the *CPT code 30901*. Had the patient been provided with medication, an HCPCS J code would be used.