



Medical Coding

Essential guidelines & tips to core coding procedures & practices, including: ICD-10-CM, CPT-4 & HCPCS Level II

General Coding & Legal Guidelines

Medical Care + Preventative Care = Health Care

- Health care is a comprehensive system that focuses on establishing and maintaining each individual's good health.
- Third-party payer is the person or organization not involved in the health care relationship except for their obligation to pay for the encounter and services involved.

Party #1: The health care provider

Party #2: The patient

Party #3: The insurance carrier (third-party payer)

ICD-10-CM stands for International Classification of Diseases, 10th Revision, Clinical Modification

ICD-10-CM used to code diagnoses

ICD-10-PCS contains codes used to bill for inpatient (hospital) procedures

CPT stands for Current Procedural Terminology, and is used to code procedures

HCPCS stands for Health care Common Procedural Coding System

HCPCS Level II is a book containing codes used to bill for dental procedures, durable medical equipment (DME), drugs, and other services and supplies; codes are used to report services, procedures, and supplies not included in CPT

Advanced Life Support (ALS) is a level of service provided by ambulance personnel

DMEPOS: Durable Medical Equipment, Prosthetic, and Orthotic Supplies

Durable Medical Equipment (DME): medical supplies that either can be used by several individuals or that last a long time, such as a cane or a wheelchair

Outpatients: an individual provided health care services without an overnight stay in the facility

Inpatients: an individual staying overnight in an acute-care or other health care facility

Legal Guidelines

HIPAA: Health Insurance Portability and Accountability Act, a federal law

TIP If you don't know, you don't code!
Don't assume! Don't guess! Don't suppose!

- HIPAA's Privacy Rule is about protecting the patient's privacy; this law simply assures each and every person coming to any health care facility that his/her personal and private information will be protected and treated with respect.
- Coding for coverage means that a code is chosen to fit what the insurance company will pay for rather than accurately reflecting the procedure that was performed.
- Medical necessity (medically necessary) is the determination that the provider was acting according to standard practices in providing this procedure for an individual with the diagnosis; use of ICD-10-CM Diagnosis Codes establishes a medical reason (medical necessity) for providing the services and/or procedures claimed.
- Mutually exclusive codes report conditions that cannot be in the same patient at the same time.
- Supporting documentation refers to the paperwork in the patient's file that corroborates the codes presented on the claim form for that particular encounter.
- Unbundling means that individual parts of a specific procedure were used rather than a combination or bundle that includes all those components.
- Upcoding means that a code is used on a claim form indicating a higher level of service than was actually performed.

Rules of Legal & Ethical Coding

- The codes indicated on the claim form **must** represent the services actually performed, and are supported by the notes and other documentation in the patient's health record.
- Coding for coverage—using codes not chosen for the best, most accurate code available, but rather, with regard to what procedures the insurance company will pay for (i.e., "cover")—is dishonest and is considered **fraud**.
- Upcoding—using a code that indicates that a higher level of service was provided than was actually performed—is unethical and **illegal**.
- Submitting a claim for services that have already been billed for is called **double billing** and constitutes **fraud**.
- Unbundling—using individual (also known as

component) service codes when a comprehensive or combination (bundled) code is available—is **illegal**.

- The use of **mutually exclusive codes**—codes identified as not permitted to be used on the same claim form—is considered **unethical**.
- Separating codes relating to a single encounter and placing them on several claim forms over the course of several days is **not legal or ethical**.

Definitions

TIP

6 Steps to Accurate Coding:

- Read through the Superbill and the physician's notes.
- Abstract physician's notes.
- Query the health care provider if details are missing or unclear.
- Code the diagnosis(es).
- Code the procedure(s).
- Link every procedure code to at least one diagnosis code to document medical necessity.



Methods of Administering Medications

IA	Intra-arterial (into the artery)
ID	Intradermal (skin test)
IM	Intramuscular (into the muscle)
IR	Intradermal (breathed in by the patient)
IO	Intravenous (into the bone)
IP	Intrapertitoneal (into the abdominal wall)
IT	Intrathecical (into spinal fluid)
IV	Intravenous (into the vein)
ORAL	Orally (by mouth)
OTH	Other—includes suppositories, catheter injections, etc.
SC	Subcutaneous (below the surface of the skin)
SubQ	Subcutaneous (below the surface of the skin)
VAR	Various—includes administration into joints, cavities, tissues, or topical applications

- CLIA: Clinical Laboratory Improvement Amendments; federal legislation created for the monitoring and regulation of clinical procedures.
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services; a Medicaid preventive health program for children (under 21 years of age).
- HPSA: Health Professional Shortage Area.
- Locum Tenens: a physician that fills in, temporarily, for another physician.

TIP

- Use a medical dictionary to ensure you know what the terms mean.
- Always check for symbols and notations to guide you to the correct code.

CODING TIPS

ABC123	Never code out of the Alphabetical Index!
Back Coding	After coding a patient's encounter from the physician's notes, make certain you back code to double-check your work; wait a little while, then go into the ICD-10-CM Tabular List and into the CPT numerical listing, and look up the codes you found earlier; match the descriptions you see to the key words from the physician's notes; this may help you find any errors.
CC	Chief Complaint: concise statement about the reason for the encounter
Medical Record Documentation	The records for each patient encounter should include: <ul style="list-style-type: none"> Reason for encounter and relevant history, physical exam findings, and prior diagnostic test results. Assessment, clinical impressions, and/or diagnosis. Plan for care. Date and legible identity of observer or provider.
Who = The Patient Why = Diagnosis Code(s) What = Procedure Code(s) How = External Cause Codes	<ul style="list-style-type: none"> Why did the patient come to see the provider? What did the provider do in response to the why? How did the injury or poisoning happen? Where did it happen?

Medical Coding 2 Study Guide

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Medical Coding Study Guide Speedy Publishing, 2014-11-26 Individuals who are preparing to take medical coding exams should note that study guides can help them earn the competitive score they want. This is the case for several reasons including the fact that these study guides tend to incorporate a lot of helpful material including medical and anatomy terminology reviews testing techniques for the exam questions that parallel the CPC certification exam practical examples review questions designed to test the student's knowledge of important coding concepts and many more.

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pain management It will prepare the reader for passing the Certified Anesthesia and Pain Management Coder CANPC exam as well as improving their professional practice The book goes beyond the concepts and applications that are required to pass the exam It provides critical insights into actual scenarios faced by coders in the real world 70 unique cases are presented that will highlight the correct coding method These give the reader practice in applying principles to actual patient cases The author's unique formula allows the reader to arrive at the best coding decision for the most complex patients Each case is discussed from a clinical viewpoint to explain the coding rational This book is both an invaluable asset for anyone working towards a CANPC exam but also serves as a useful reference for those currently holding the certificate Workbook to Accompany Step-by-Step Medical Coding 2005 Carol J. Buck, 2004-12 Original source documents provide real world experience to prepare for employers expectations and to practice with actual medical record documentation The workbook provides more than 1 000 questions and terminology exercises as well as over 80 original source documents A Directory of Computerized Data Files & Related Technical Reports, 1980

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2007 Coding Workbook for the Physician's Office Alice Covell,2007-04 This workbook contains coding exercises that reference each section of the CPT 4 and ICD 9 CM coding manuals Exercises requiring HCPCS Level II codes are also provided Condition and procedure statements in the exercises reflect the current annual editions of the coding manuals By completing the exercises learners will expand their medical vocabulary and increase their coding skills for the physician s office and will learn to code only what the documentation supports Also included are the Center for Medicare and Medicaid Services CMS guidelines for diagnosis coding and reporting by physicians Learners need current CPT 4 ICD 9 CM and HCPCS coding manuals to complete the exercises

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