

Medical Coding

Essential guidelines & tips to ease coding procedures & practices, including: ICD-9-CM, CPT-4 & HCPCS

General & Legal Principles

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 other than by their obligation to pay for the encounter and services provided.
 - Party #1: The health-care provider
 - Party #2: The patient
 - Party #3: The insurance carrier (third-party payer)
- ICD-9-CM** stands for International Classification of Diseases - 9th Revision - Clinical Modification.
- ICD-9-CM volumes 1 and 2** are used to code diagnosis.
- ICD-9-CM volume 3** contains codes used to bill for inpatient hospital procedures.
- CPT-4** stands for Current Procedural Terminology - 4th edition, and is used to code procedures.
- HCPCS** stands for Healthcare 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 services 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.
- HIPAA Privacy Rule** requires providers' information so it is available to those who should see it while protecting that information from people who should not.

- HIPAA Privacy Rule** is about protecting the patient's privacy; this law simply ensures each and every person coming to any health-care facility that their personal and private information will be protected and treated with respect.
- Coding for coverage** means that a code is changed to to what the insurance company will pay for rather than accurately reflecting the procedure that was actually performed.
- Medical necessity (medically necessary)** is the determination that the provider was acting according to standard practices in providing the procedure for an individual with this diagnosis; use of ICD-9-CM **Diagnosis Codes** establishes a medical reason (medical necessity) for providing the service and/or procedure claimed.
- Mutually exclusive codes** are those identified in the coding book as not permissible to be used on the same claim form with other codes.
- 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 three components.
- Upcoding** means that a code is used on a claim form indicating a higher level of service than that which 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 procedure 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 that which 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 bills known as components) 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**.

[TIP]

1. Steps to Accurate Coding
2. Enter enough the patient's and the provider's notes
3. Assign diagnosis code
4. Check for exclusions
5. Assign procedure code
6. Check for exclusions
7. Code any procedure code as bill
8. Add any codes for supplies and services



Methods of Administering Medications

- IA**: Intradermal (into the arm)
- ID**: Intradermal (skin test)
- IM**: Intramuscular (into the muscle)
- INH**: Inhalant solutions (breathed in by the patient)
- IO**: Introsseous (into the bone)
- IP**: Intraperitoneal (into the abdominal wall)
- IT**: Intrathecal (into spinal fluid)
- IV**: Intravenous (into the vein)
- ORAL**: orally (by mouth)
- OTH**: other—includes suppositories, catheter injections, etc.
- SC, SubQ**: subcutaneous (below the surface of the skin)
- VAS**: venous—includes intravenous into veins, arteries, tissues or topical applications

Definitions

- CLIA**: Clinical Laboratory Improvement Amendments, federal legislation created for the monitoring regulation of clinical procedures.
- EPSCOT**: Early and Periodic Screening, Diagnostic and Treatment services, a Medicaid preventive health program for children under 21 years of age.
- HCFA**: Health Care Financing Agency
- Local Tenets**: a physician that life is, temporarily, for another physician.

[TIP]

- 1. Enter codes from the Alphabetic Index
- 2. Verify that the code in the Tabular List meets coding rules in the book code

[TIP] Enter codes from the Alphabetic Index

Coding from the Alphabetic Index	
Back Coding	Never. Never, NEVER code out of the Alphabetic Index.
IC	Chief Complaint: concise statement about the reason for the encounter.
Medical Record Documentation	The records for each patient encounter should include: - 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. - Why did the patient come to see the provider? - What did the provider do for in response to the why? - How did the injury or poisoning happen? - Where did it happen?
Who = The Patient	
Why = Diagnostic Codes	
What = Procedure Codes	
How/Where = S Codes	

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