

Medical Coding

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

general & 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 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 diagnoses.
- **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 or component 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]

• Steps to Accurate Coding

1. Enter enough the patient's and the provider's notes
2. Obtain a complete code
3. Check for any exclusions, inclusions, or modifiers
4. Check for sequencing
5. Code every procedure code (a bill)
6. Add any codes with the correct modifier



• Methods of Administering Medications

- **IA**: Intradermal (into the arm)
- **ID**: Intradermal (skin test)
- **IM**: Intramuscular (into the muscle)
- **INH**: Inhaled 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.
- **HCPLA**: Health Professional Licensure Area
- **License Transfer**: a physician that life in, temporarily, for another physician

[TIP]

- Enter codes from the Alphabetic Index.
- Always check the code in the Tabular List before writing the claim.

[TIP] Enter codes from the Alphabetic Index

Coding from the Alphabetic Index	Never, Never, NEVER code out of the Alphabetic Index!
Back Coding	After coding a patient's encounter from the physician's notes, make certain you back code to double-check yourself; wait a little while, then go into the ICD-9-CM volume 1 and into the CPT-4 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. • Give and legible identity of observer or provider.
Who = The Patient	• Why did the patient come to see the provider?
Why = Diagnostic Codes	• What did the provider do for in response to the WHY?
What = Procedure Codes	• How did the injury or procedure happen?
How/Where = D-Codes	• Where did it happen?

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Medical Coding Shelley C. Safian, 2017-11 Updated for 2018 ICD 10 guidelines this 6 page laminated guide covers core essentials of coding clearly and succinctly Author Shelley C Safian PhD RHIA CCS P COC CPC I AHIMA approved ICD 10 CM PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages designed so that answers can be found fast with color coded sections and bulleted lists A must for students seeking coding certification and a great desktop refresher for professionals 6 page laminated guide includes General Coding Legal Guidelines Coding Tips Conditions Diagnoses Diagnosis Coding Pathology Laboratory Reimbursement Billing Tips Coding Evaluation Management Services ICD 10 Terms Notations Symbols Wounds Injuries Important Resources Anesthesia Surgery Radiology Diagnostic Coding Medical Coding: Icd-10-Pcs BarCharts, Inc, Shelley C. Safian, 2012-05-31 The health care industry is moving toward a major change in the code set or language used to report the reasons why a physician or health care professional provided care to a patient Since 1978 the industry has used codes from ICD 9 CM volume 3 to report the procedures services and treatments provided to inpatients in acute care facilities Within the next few years the transition will be made to ICD 10 PCS The transition from ICD 9 CM volume 3 to ICD 10 PCS will only affect those health information management professionals and those getting ready to enter this profession working on hospital inpatient procedure coding but it will require even the most seasoned professionals to learn how to accurately report what has been provided to patients With the use of tabular examples and color coded text this QuickStudy guide helps make the transition smoother and promote better understanding and greater comfort with the new code set *Medical Coding (Speedy Study Guides* LLC Publishing, Speedy Publishing LLC, 2014-05 When you are studying something as intricate involved and structured as medical coding it's worth your time to invest in every study aid you can possibly employ to that end Since studying is just a way of working to ensure that you can better retain and recall information a pamphlet is a great way to help you quickly decode various medical codes While a deck of flash cards may seem useful using them for a practice such as deciphering medical coding means that you will need a very thick stack a pamphlet form study guide takes less space and similar information

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Mastering Medical Coding - E-Book Marsha Diamond, 2006-06-02. Expansion of ICD 9 CM information. Sample patient charts include explanatory notes. A simulated medical practice identified as Godfrey Regional lets you study in a real world scenario. Key Terms lists highlight the most important vocabulary and content. More exercises. **Medical Coding** Shelley C. Safian, 2006-10-06. Essential guidelines and tips to core coding procedures and practices including ICD 9 CM CPT 4 HCPCS. **Medical Coding** Shelley C. Safian, 2017. Medical Coding ICD-10-PCS Shelley C. Safian, 2017-11. Updated for 2018 ICD 10 PCS International Classification of Diseases Procedure Coding System guidelines. This 6 page laminated guide covers core essentials of coding clearly and succinctly. Author Shelley C. Safian PhD RHIA CCS P COC CPC I AHIMA approved ICD 10 CM PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages designed for you to find answers fast with color coded sections and bulleted lists. A must for students seeking coding certification and a great desktop refresher for professionals referencing procedural codes that track various health interventions taken by medical professionals. 6 page laminated guide includes Inpatient Procedure Coding Selection of Principal Procedure ICD 10 PCS Coding Conventions ICD 10 PCS Sections Subsections Medical Surgical Section Guidelines Obstetrics Section Guidelines New Technology Section Guidelines ICD 10 PCS Terms. **Medical Coding: Icd-10-Cm Speedy Study Guides** Speedy Publishing, 2014-07-16. Every known illness, disease, and condition has a specific number that goes along with the word describing the person's medical problem. Every physician and their office staff must know medical codes for the sake of billing purposes. If the doctor and office staff does not code a specific illness, condition, or disease correctly, the insurance company may not pay for treatment, medication, in hospital stays, outpatient treatment, and a number of surgical and other procedures performed for the patient, making it impossible for the patient to receive the proper treatment. Common illnesses, diseases, and conditions listed in a pamphlet would enable the medical student to become familiar and able to memorize with the more common medical codes. The bottom line for using proper ICD codes is money reimbursement for the medical community and patient. **Medical Coding: Icd-10-Pcs Speedy Study Guides** Speedy Publishing, 2014-07-16. ICD 10 PCS is a kind of medical coding that is used to identify what kinds of treatment a patient received and used for billing a patient. Medical coding requires a person to get an education and there is a huge amount of information a person needs to know in order to get a coding certification. One great way to learn the information is with the use of a study pamphlet. The pamphlet can be used to learn the basic information and can keep a student focused on what

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