



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 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** are individual provided health-care services without an overnight stay in the facility.
- Inpatients** are 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**
 1. Enter enough the patient and the encounter notes
 2. Obtain diagnosis code
 3. Check the ICD-9-CM code book for the correct code
 4. Check the HCPCS code book for the correct code
 5. Code any procedure code (if any)
 6. Code any supply code (if any)



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 Professional Shortage Area
- Learn To Live**: a program that life is, temporarily, for another physician.

[TIP]

- 1. Enter codes from the encounter notes.
- 2. Always check the code in the ICD-9-CM code book, starting with the first code.

[TIP] Easy way to find your code

Coding Steps ANDT3	Notes: Never, 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 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. Date and legible identity of observer or provider.
Who = The Patient	Why did the patient come to see the provider?
Why = Diagnosis 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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Lauren Gardner



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