QuickStudy MEDICAL

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 **I**nternational **C**lassification of **D**iseases, **10th** Revision, **C**linical **M**odification
- **ICD-10-CM** used to code diagnoses
- **ICD-10-PCS** contains codes used to bill for inpatient (hospital) procedures
- **CPT** stands for **C**urrent **P**rocedural **T**erminology; and is used to code procedures
- **HCPCS** stands for **H**ealth care **C**ommon **P**rocedural **C**oding **S**ystem
- **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
  - **A**dvanced **L**ife **S**upport (ALS) is a level of service provided by ambulance personnel
  - **DMEPOS**: **D**urable **M**edical **E**quipment, **P**rosthetic, and **O**rthotic **S**upplies
- **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
- **Outpatient**: an individual provided health care services without an overnight stay in the facility
- **Inpatient**: an individual staying overnight in an acute-care or other health care facility

Legal Guidelines

- **HIPAA**: **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct, 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 changed 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 this 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 (bundle) 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
1. Read through the Superbill and the physician's notes
2. Abstract physician's notes
3. Query the health care provider if details are missing or unclear
4. Code the diagnosis(es)
5. Code the procedure(s)
6. 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)
INH	Inhaled solutions (breathed in by the patient)
IO	Intraosseus (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)
VAR	Various—includes administration into joints, cavities, tissues, or topical applications

- **CLIA**: **C**linical **L**aboratory **I**mprovement **A**mendments; federal legislation created for the monitoring and regulation of clinical procedures
- **EPSDT**: **E**arly and **P**eriodic **S**creening, **D**iagnostic, and **T**reatment services; a Medicaid preventive health program for children (under 21 years of age)
- **HPSA**: **H**ealth **P**rofessional **S**hortage **A**rea
- **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

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CODING TIPS

ABC123	Never code out of the Alphabetical Indexes!
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	**C**hief **C**omplaint: 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
Who = The Patient Why = Diagnosis Code(s) What = Procedure Code(s) How = External Cause Codes	· 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?

Guide To Medical Billing And Coding

Rachel S Tattersall

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Table of Contents Guide To Medical Billing And Coding

1. Understanding the eBook Guide To Medical Billing And Coding
    - The Rise of Digital Reading Guide To Medical Billing And Coding
    - Advantages of eBooks Over Traditional Books
2. Identifying Guide To Medical Billing And Coding
    - Exploring Different Genres
    - Considering Fiction vs. Non-Fiction
    - Determining Your Reading Goals
3. Choosing the Right eBook Platform
    - Popular eBook Platforms
    - Features to Look for in an Guide To Medical Billing And Coding
    - User-Friendly Interface
4. Exploring eBook Recommendations from Guide To Medical Billing And Coding
    - Personalized Recommendations
    - Guide To Medical Billing And Coding User Reviews and Ratings
    - Guide To Medical Billing And Coding and Bestseller Lists
5. Accessing Guide To Medical Billing And Coding Free and Paid eBooks
    - Guide To Medical Billing And Coding Public Domain eBooks
    - Guide To Medical Billing And Coding eBook Subscription Services
    - Guide To Medical Billing And Coding Budget-Friendly Options

6. Navigating Guide To Medical Billing And Coding eBook Formats
    - ePub, PDF, MOBI, and More
    - Guide To Medical Billing And Coding Compatibility with Devices
    - Guide To Medical Billing And Coding Enhanced eBook Features
7. Enhancing Your Reading Experience
    - Adjustable Fonts and Text Sizes of Guide To Medical Billing And Coding
    - Highlighting and Note-Taking Guide To Medical Billing And Coding
    - Interactive Elements Guide To Medical Billing And Coding
8. Staying Engaged with Guide To Medical Billing And Coding
    - Joining Online Reading Communities
    - Participating in Virtual Book Clubs
    - Following Authors and Publishers Guide To Medical Billing And Coding
9. Balancing eBooks and Physical Books Guide To Medical Billing And Coding
    - Benefits of a Digital Library
    - Creating a Diverse Reading Collection Guide To Medical Billing And Coding
10. Overcoming Reading Challenges
    - Dealing with Digital Eye Strain
    - Minimizing Distractions
    - Managing Screen Time
11. Cultivating a Reading Routine Guide To Medical Billing And Coding
    - Setting Reading Goals Guide To Medical Billing And Coding
    - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Guide To Medical Billing And Coding
    - Fact-Checking eBook Content of Guide To Medical Billing And Coding
    - Distinguishing Credible Sources
13. Promoting Lifelong Learning
    - Utilizing eBooks for Skill Development
    - Exploring Educational eBooks
14. Embracing eBook Trends
    - Integration of Multimedia Elements

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