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
  - **Advanced Life Support (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 diagnoses(s)
5. Code the procedure(s)
6. Link every procedure code to at least one diagnosis code to document medical necessity

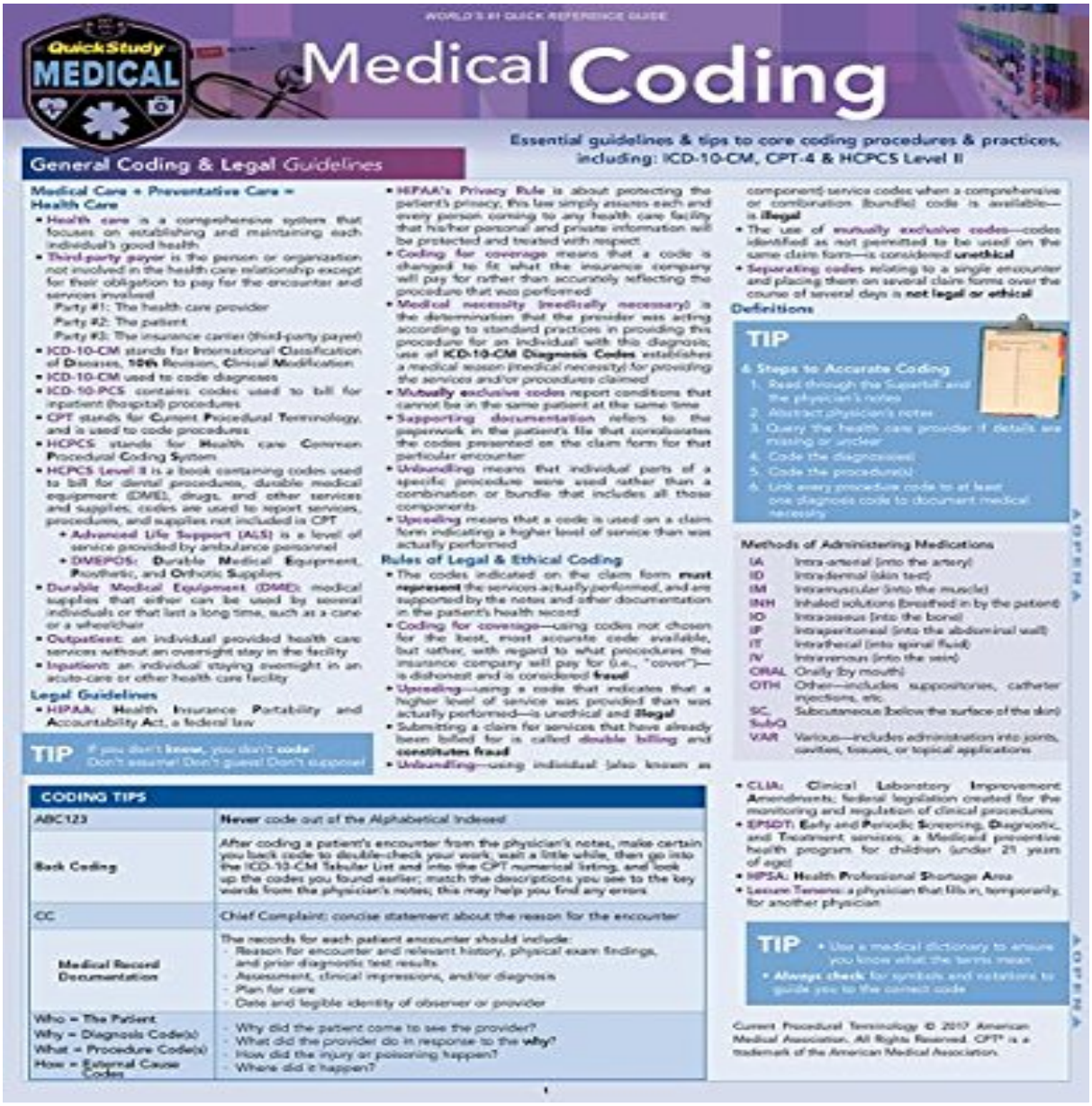
Methods of Administering Medications

IA	Intra-arterial (into the artery)
ID	Intra-dermal (skin test)
IM	Intramuscular (into the muscle)
INH	Inhaled solutions (breathed in by the patient)
IO	Intraosseous (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

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	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
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?



Medical Coding: A Quickstudy Laminated Reference Guide