

Medical Coding



General Coding & Legal Guidelines

Essential guidelines & tips to core coding procedures & practices, including: ICD-10-CM, CPT-4 & HCPCS Level II

Medical Care * Preventative Care * Marabb 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

Party #1: The health care provider Party #2: The patient

- Party #3: The insurance carries (third-party payer):
- ICO-10-CM stands for international Classification. of Diseases, 10th Revision, Clinical Modification
- ICO-16-CM used to code disconoses
- . ICO-50-PCS contains codes used to bill for inputient (hospital) procedures
- CPT stands for Current Procedural Terminology. and is used to code procedures.
- * HICPCS stands for Health care Common Procedural Coding System
- · HCPCS Level II is a book containing codes used to bill for dontal 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 porsonnel.
 - · 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.
- · Outputient: an individual provided health care services without an evernight stay in the facility
- · Inputient an individual staying overright in an acute-care or other health care facility:

Legal Guidelines

· HIPAA: Health Insurance Portability and Accountability Act, a federal law

TIP System don't beam, you don't sender!

- . HIPAA's Privacy Bule is about protecting the patient's privacy; this law simply assures each and every person coming to any health care facility that his/hor personal and private information will be protected and treated with respect
- . Coding for coverage means that a code is shanged to fit what the insurance company self pay for rather than accurately reflecting the propedure that was performed
- · Medical mesessity (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 established a medical reason breedical recessity! 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 poponeok in the patient's file that corroborates. the codes presented on the slaim form for that marticular emonument
- · Unbundling means that individual parts of a specific procedure were used rather than a combination or bundle that includes all those
- Upcoding means that a code is used on a claim. form indicating a higher level of service then was solution professional

Rules of Legal & Ethical Coding.

- . The codes indicated on the claim from must represent the services actually performed, and are supported by the notes and other documentation. in the petient's health recent
- Coding for coverage—using codes not chosen. for the best, most accurate code available, but rather, with regard to what procedures the murance company will pay for b.e., "cover">-is dishonest and is associationed fraud-
- · Uponding-using a code that indicates that a higher level of service was provided than was actually performed—is unothical and illegal
- Submitting a claim for services that have already. been billed for is called double billing and especialisates fraud
- Unbundling—using individual bits known as

- component) service codes when a comprehensive or combination (bundle) code is evaluablein illegal.
- . The use of mutually enclusive codes-codes identified as not permitted to be used on the some claim form—is considered unathiral
- 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

Owlink General

TIP

Stage to Accorde Coding

- I Food Brough the Superior
- Administration of policies in the second
- Guery the health care a money to arrise.

 Code the diagrammas.
- h Cook the property
- 6. Link every procedure sinds to at least one diagnosis state to document medical

Methods of Administering Medications

100	State waterone brook gain waterds.
100	Intradermal (skin text)
	Intramuscular Sinto the muscled
10000	Inhaled solutions foresthed in by the petier
30	Intransaus (eta the bone)
98	Introperitorical (into the abdominal wall).
10000	The second secon

Introdhecal brito spinst Buidt Introversions finds the select ORAL. Chally by mouth? OTH Other-includes appropriates, carbone

sections, etc. SEL Substitutioness theless the surface of the skint. Section 2

VAR Various-includes administration into joints. cavities, tissues, or topical applications

- · CLIA: Clinical Laboratory Improvement Amendments; federal legislation prested for the manitoring and regulation of clinical procedures.
- EPSOT: Early and Periodic Screening, Diagnostic. and Treatment services; a Medicard prehealth program for shildren lander 21 years
- * HPSA: Health Professional Shortage Area
- Locum Tenenc a physician that fills in, temperantly. for another physician

TIP

- Non-a medical photocomy to encure
you below what the terms from:

- Always about he symbols and nations to
good you to the second cole

Current Procedural Terminology & 2017 American Medical Association, All Bights Reserved. CPT^a is a trademark of the American Medical Association.

CODING TIPS		
A8C123	Never code out of the Alphabetical Indexest	
Back Coding	After coding a perient'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-16-CM Tabular List and a too the CPT numerical listing, and look up the codes you found asfile; match the decorpitions got see to the key words from the physician's notes; this may help you find any errors.	
oc	Oxef Complaint, concise statement about the reason for the encounter	
Medical Record Documentation	The records for each patient encounter should include: - Research for encounter and relevant history, physical exam findings, and prior diagnostic test nesults - 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) Hore = Entertal Cause	Why did the petient come to see the provider? What did the provider do in response to the why? How did the injury or poleoning happen? Where did it happen?	

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D Keegan

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