



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 **International Classification of Diseases, 10th Revision, Clinical Modification**.
- **ICD-10-CM** used to code diagnoses.
- **ICD-10-PCS** contains codes used to bill for inpatient (hospital) procedures.
- **CPT** stands for **Current Procedural Terminology**, and is used to code procedures.
- **HCPCS** stands for **Health Care 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 service 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.
- **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:** Health Insurance Portability and Accountability Act, 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**.

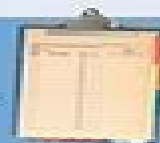
- The use of **mutually exclusive codes**—codes identified as not permitted to be used on the same claim form—is considered **unethical**.
- **Separating** codes relating to a single encounter and placing them on several claim forms over the course of several days is **not legal or ethical**.

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** 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** Subcutaneous (below the surface of the skin)
- SubQ** Various—includes administration into joints, cavities, tissues, or topical applications
- VAR**

- **CLIA:** Clinical Laboratory Improvement Amendments; federal legislation created for the monitoring and regulation of clinical procedures.
- **EPSDT:** Early and Periodic Screening, Diagnostic, and Treatment services; a Medicaid preventive health program for children (under 21 years of age).
- **HPSA:** Health Professional Shortage Area.
- **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 Index!
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 did the patient come to see the provider?
Why = Diagnosis Code(s)	What did the provider do in response to the why?
What = Procedure Code(s)	How did the injury or poisoning happen?
How = External Cause Codes	Where did it happen?

Medical Coding Basics

VIRUTI SHIVAN



Medical Coding Basics:

Medical Coder - The Comprehensive Guide DEAN STRATTON, Medical Coder The Comprehensive Guide Mastering the Art of Healthcare Coding and Billing Step confidently into the field of medical coding with this all in one guidebook Designed for both beginners and professionals this book equips you with the essential skills to thrive in a rapidly evolving healthcare industry What You ll Learn The fundamentals of medical terminology and coding principles Step by step instruction in ICD 10 and CPT coding systems How medical coding connects to healthcare billing and compliance Tips for accuracy efficiency and avoiding common mistakes Guidance on certification requirements and career advancement Real world coding examples and scenarios Why Choose This Guide Covers both beginner foundations and advanced practices Focused exclusively on text based learning no filler images Provides practical insights for real healthcare settings Helps you prepare for a successful coding career Perfect For Students training for coding certification Healthcare professionals expanding skills Anyone pursuing a medical coding career This comprehensive textbook ensures you re ready to excel as a medical coder mastering both the technical and professional aspects of the field *Medical Coding Essentials: A Guide to Master ICD-10-CM Diagnostics* Dr. Sowjanya Gurugubelli, Mrs. Vinny Therissa Mangam, Mr. Prakash Nathaniel Kumar Sarella, Mr. Gourab Saha, Dr. Syed Afzal Uddin Biyabani, 2025-01-08 Medical Coding Essentials A Guide to Master ICD 10 CM Diagnostics is designed to provide aspiring medical coders with a structured approach to mastering ICD 10 CM coding and preparing for the CPC certification exam This book combines theoretical knowledge with practical applications featuring numerous examples case studies and practice questions that mirror the actual certification exam The content is organized to build your knowledge progressively from fundamental concepts to complex coding scenarios Each chapter includes learning objectives key terms coding guidelines and practice exercises to reinforce your understanding The book also features tips and strategies specific to the CPC exam making it an invaluable resource for certification preparation *Medical Coding and Billing - The Comprehensive Guide* VIRUTI SHIVAN, Dive into the world of medical coding and billing with Medical Coding and Billing The Comprehensive Guide This essential resource provides a thorough understanding of the crucial role these fields play in healthcare administration Whether you re a student a healthcare professional or simply interested in the administrative side of healthcare this guide offers comprehensive coverage of the latest coding systems billing procedures and regulatory requirements Written by experts in the field the book navigates through complex coding systems including ICD 10 CPT and HCPCS ensuring you re up to date with current practices Beyond the codes it delves into the practical aspects of billing claims processing and the nuances of insurance Essential topics like compliance ethics and the impact of coding on revenue cycle management are covered in depth This guide also addresses the ever evolving landscape of healthcare legislation providing insights into how these changes affect medical coding and billing Furthermore to ensure a clear focus on content this book does not include images or illustrations for copyright purposes Whether you re aiming for

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ll learn to pull the right information from medical documents select the right codes determine the correct sequencing of those codes and properly audit cases Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records allowing you to practice coding with advanced material UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service More than 150 full color illustrations depict and clarify advanced coding concepts Coverage of CPT E M guidelines changes for office and other outpatient codes From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice NEW Coding updates include the latest information available including 2024 code updates when released Buck's The Next Step: Advanced Medical Coding and Auditing, 2025/2026 Edition - E-BOOK Elsevier Inc,Jackie Koesterman,2024-12-26 Master advanced coding skills Buck s The Next Step Advanced Medical Coding and Auditing shows how to code for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Real world cases cleared of any patient identifiers takes your coding proficiency a step further by providing hands on practice with physician documentation With this guide you ll learn to pull the right information from medical documents select the right codes determine the correct sequencing of those codes and properly audit cases NEW Coding updates include the latest information available including 2026 code updates when released Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records allowing you to practice coding with advanced material UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service More than 150 full color illustrations depict and clarify advanced coding concepts Coverage of CPT E M guidelines changes for office and other outpatient codes From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice **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

The Enigmatic Realm of **Medical Coding Basics**: Unleashing the Language is Inner Magic

In a fast-paced digital era where connections and knowledge intertwine, the enigmatic realm of language reveals its inherent magic. Its capacity to stir emotions, ignite contemplation, and catalyze profound transformations is nothing short of extraordinary. Within the captivating pages of **Medical Coding Basics** a literary masterpiece penned with a renowned author, readers embark on a transformative journey, unlocking the secrets and untapped potential embedded within each word. In this evaluation, we shall explore the book's core themes, assess its distinct writing style, and delve into its lasting impact on the hearts and minds of those who partake in its reading experience.

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