Medical Coding and Billing

Objectives

• Provide a basic understanding of the **coding** process
• Understand the importance of complete, accurate **documentation** to the coding process
• Learn the **benefits of coding**
• Clarify the connection between **data quality** and coding

Coding Process

• The delivery of quality healthcare depends on the accurate and timely capture of medical data
• Healthcare professionals are key players in ensuring the collection of medical information
• What is coding?
  ▫ Numerical representation of diseases and treatment
  ▫ Assignment of codes based on care and services received
  ▫ Collection, storage and sharing of data and statistics
• Originally performed to classify mortality (cause of death) data on death certificates, and morbidity and procedural data

What is ICD-9-CM coding?

• ICD-9 is an international disease classification system that groups related disease entities and conditions for the purpose of reporting statistical information
  ▫ Volume 1 tabular list of diagnosis codes
  ▫ Volume 2 alphabetical index
  ▫ Volume 3 contains procedure codes, which are used for billing inpatient hospital stays

What is CPT-4?

• The Current Procedural Terminology coding system describes medical and surgical procedures and services performed by physicians and other healthcare providers
  ▫ Serves a number of purposes
  ▫ Essential to billing for patient care services
  ▫ System used to develop the Resource Based Relative Value System (RBRVS) to assist in determining the amounts paid to doctors and other medical providers for services
  ▫ Uniform codes that translate the same for doctors, hospitals, patients, insurance companies, and other parties

What is HCPCS?

• HCPCS
  ▫ Healthcare Common Procedure Coding System
  ▫ Standardized coding system using alpha numeric codes that are used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office
Levels of HCPCs

- **Questions on the Use of Level I HCPCS**
  - Level I of the HCPCS is comprised of Current Procedural Terminology (CPT-4), a numeric coding system maintained by the American Medical Association (AMA). The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures for which they bill public or private health insurance programs. Level I of the HCPCS covers all medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Level I of the HCPCS, the CPT-4 codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

- **Questions on the Use of Level II HCPCS**
  - Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the level II HCPCS codes were established for submitting claims for these items.

Diagnosis

- **Principal diagnosis:**
  - “the diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care in hospital (or attendance at the health care facility)”

- **Secondary Diagnosis:**
  - “a condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility”

Documentation and Coding

- **Documentation and Coding**
  - The medical record is the source document for coding
  - Coders rely on the documentation in the record to determine what codes to assign for services provided
  - Responsibility for capturing accurate diagnosis and procedures, in particular, principal diagnosis, lies with the provider, not the coder
  - A joint effort between providers and coders is essential to achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures

Coded Data

- **Coded data is:**
  - compiled and analyzed to reveal public health patterns and identify ways to better use resources and cut healthcare costs
  - Used on hospital and physician reimbursement claims to describe diagnoses, services, and procedures provided
  - Coded data serves several important functions within healthcare to include:
    - Hospital payments and physician reimbursement
    - Quality review
    - Benchmarking measurements
    - Collection of general medical statistical data
    - Clinical
Coded Data

- Functions of coded data within healthcare
  - Epidemiology
  - Population health
  - Business
  - Research
  - Used for statistical analysis

- Coded data is used internally by institutions for:
  - Quality management
  - Case-mix management
  - Planning
  - Marketing
  - Other administrative and research activities

Documentation Errors

- Common provider documentation errors:
  - Inconsistent documentation
  - Incomplete progress notes
  - Undocumented care
  - Missing test results
  - Historical diagnosis documented as current
  - Chronic conditions not documented
  - Post-op complications not listed
  - Illegibility
  - Documentation not completed on time

Benefits of Coding

- Coding:
  - Permits the easy retrieval of information according to diagnoses and procedures
  - Provides a consistent method for the collection and retrieval of data
  - Allows healthcare entities to assign codes for the condition treated, and for any procedures rendered by the provider
  - Standardizes diagnoses and procedures into accepted data sets
  - Is used to capture inpatient and outpatient procedures
  - Is the HIPAA-mandated system used for billing all medical services and procedures related to:
    - ICD-9 – diagnoses and procedures
    - CPT-4 – services and procedures
    - HCPCS – drugs, supplies, and services

Benefits of Coding

- Correct code assignment is important and plays a significant role in:
  - Resource utilization
  - APC assignment
  - DRG assignment
  - Reimbursement

- Correct code assignment permits access to medical records by diagnoses and procedures for use in:
  - Clinical care
  - Research
  - Education

- Correct code assignment is beneficial to health policy development and planning

Data Quality and Compliance

- Documentation in the medical record must be of highest quality

- Incomplete or missing data could:
  - Compromise patient care
  - Contribute to incorrect assumptions made by policy makers
  - Result in inaccurate research findings

Data Quality

- Data accuracy
  - Shared responsibility between the coder and the provider
  - Collaborative effort between the two

- Data accessibility
  - Complete, accurate, legible, and timely documentation
Audits

• Purpose of audits
  ▫ Allows for examination of the documentation within the medical record to ensure the accuracy of the codes assigned and that no codes have been missed
  ▫ Ensures the appropriate reimbursement for care provided to patients
  ▫ Assesses the quality of coding by individuals (i.e., coders, providers, and other healthcare professionals), and highlight areas needing further education

Compliance

• Medical necessity
  ▫ The need for an item or service to be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member
  ▫ Treatment and services should be linked to an appropriate diagnosis, symptom or complaint
  ▫ Up to four ICD-9 codes can be linked to a CPT code

Compliance

• Fraud and abuse prevention
  ▫ Overcoding/upcoding – Assigning a code specifically for the purpose of obtaining a higher level of payment
  ▫ Undercoding – Failure to assign codes based on the care that was provided
  ▫ Example:
    ▪ Difference between two codes - 99212 for $29 and 99213 for $55
    ▪ However, $55 - $29 = $26
      $26 twice a week
      X 48 weeks
      X 3 doctors in a physician practice
      = $7,488

Summary

• Coding
  ▫ Coding allows healthcare providers to collect, store, and share important medical data and statistical information regarding the care provided to an individual using a common language
  ▫ While it is important for hospitals, providers, and other healthcare entities who provide care to be reimbursed for the resources they expend, coding is important for more than reimbursement
    ▪ Research
    ▪ Population health
    ▪ Benchmarking
    ▪ Quality review

Summary

• Documentation
  ▫ The medical record is the major source document for coding and reporting of diagnoses and procedures
  ▫ Coding and documentation should be integrated into the process of providing care
  ▫ Seek clarification from providers for questions regarding documentation
  ▫ Responsibility for the capture of accurate diagnoses and procedures lies with the provider, not the coder
  ▫ Teamwork is essential between providers and coders
  ▫ Quality care is a principal measure
  ▫ Process must work for providers
  ▫ Remember “Not documented, Not coded”
Summary

• Data Quality and Compliance
  - Documentation must be complete and accurate
  - Incomplete data can:
    - Compromise patient care
    - Contribute to incorrect assumptions by policymakers
    - Lead to inaccurate research findings
  - Data accuracy is a shared responsibility between coder and the provider
  - Ensure codes assigned meet requirements for medical necessity
  - Treatment and services should be linked to an appropriate diagnosis, symptom, or complaint
  - Address issues of overcoding, undercoding, and unbundling

Works Cited