Medical Coding and Billing

Training protocol

Medical Billing & Coding

The process of submitting and following up on claims with health insurance companies or patients in order to receive payment for services provide by a healthcare provider to the patient.

Types of Medical Billing services

There are two types of billing services

- In house Billing
- Out Source Billing

Health care providers/ Physician

A health professional, health practitioner or healthcare provider (sometimes simply "provider") is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities.

Referring and attending physician

A **referring physician** is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program. **Attending or ordering physicians** is defined as a **physician** who orders services for the patient.

Note: Referring physician is must when patient have Medicare Insurance.

Demographic Form

Patient Demographics sheet contains all the basic demographic information about an individual or patient. A good patient demographic form is the key to obtaining accurate information which is required for claim submission. Providing as much information as possible will reduce the insurance company's need to contact billing office.

Following are the mandatory information in a demographic form.

- Patient Name
- Gender
- Date of birth (DOB)

- Address
- Phone Number
- Zip code

What is Claim

The statement or list of services (ICD & CPT) (international classification of diseases) & (current procedural terminology) and their costs from a healthcare provider or facility submitted to insurance in order to get payment. There are two types of claim.

1. Professional Claim
2. Institutional Claim

Professional Claim

Professional claim is generated for work performed by physicians, suppliers and other non-institutional providers for both outpatient and inpatient services. Professional charges are billed on a CMS-1500 form.

Institutional Claim

Institutional claim is generated for work performed by hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services including the use of equipment and supplies, laboratory services, radiology services, and other charges. Institutional charges are billed on a UB-04.

Insurances or Payers

That pays for medical and surgical expenses that are incurred by the insured (patient). Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly.

Following are the types of medical insurances

- Government insurances
- Commercial insurances
- Worker compensation
- MVA

Government insurances

- Medicare (more than 65 years old or disability under age 65)
- Medicaid (For poor people)
- Tricare

Commercial insurances

All other insurance except Medicaid and Medicare are commercial insurance. Most common insurances are:

- Aetna
- Cigna
- BCBS (Blue Cross blue Shield)
- Humana
- United Health Care (UHC)

Worker compensation: Workers' compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment.

MVA: it provides compensation to people injured in automobile accidents.

Self-pay: Self-pay patient is someone who choose to pay for their treatment directly rather than using private health insurance.

Medical Screening Exam/Medical Screening Only: The Emergency Medical Treatment and Active Labor Act (EMTALA), requires a **medical screening exam** and stabilizing treatment for all patients presenting to an emergency department in the United States. We are not billing MSE/MSO patient.

Subscriber or Guarantor

Subscriber is the person, who represents the family unit in relation to the prepayment plan.

Guarantor the person held accountable for the patient's bill. The guarantor is always the patient, unless the patient is a minor or an incapacitated adult. The guarantor is not the insurance subscriber.

Clearing House

Clearing house is a bridge between billing companies and insurance companies and is used to submit errorless claims to insurance companies after filtration. It's also updates the claim as it is processed. We are using **Ability** as clearing houses.

Copay, Coinsurance, Deductible, Premium

Copay: A Copayment or copay is a fixed payment for a covered service, paid when an individual receives service.

Co-Insurance: A co-sharing agreement between the insured and the insurer under a health insurance policy which provides that the insured will cover a set percentage of the covered costs after the deductible has been paid.

Deductible: The deductible is the amount of expenses that must be paid out of pocket before an insurer will pay any expenses.

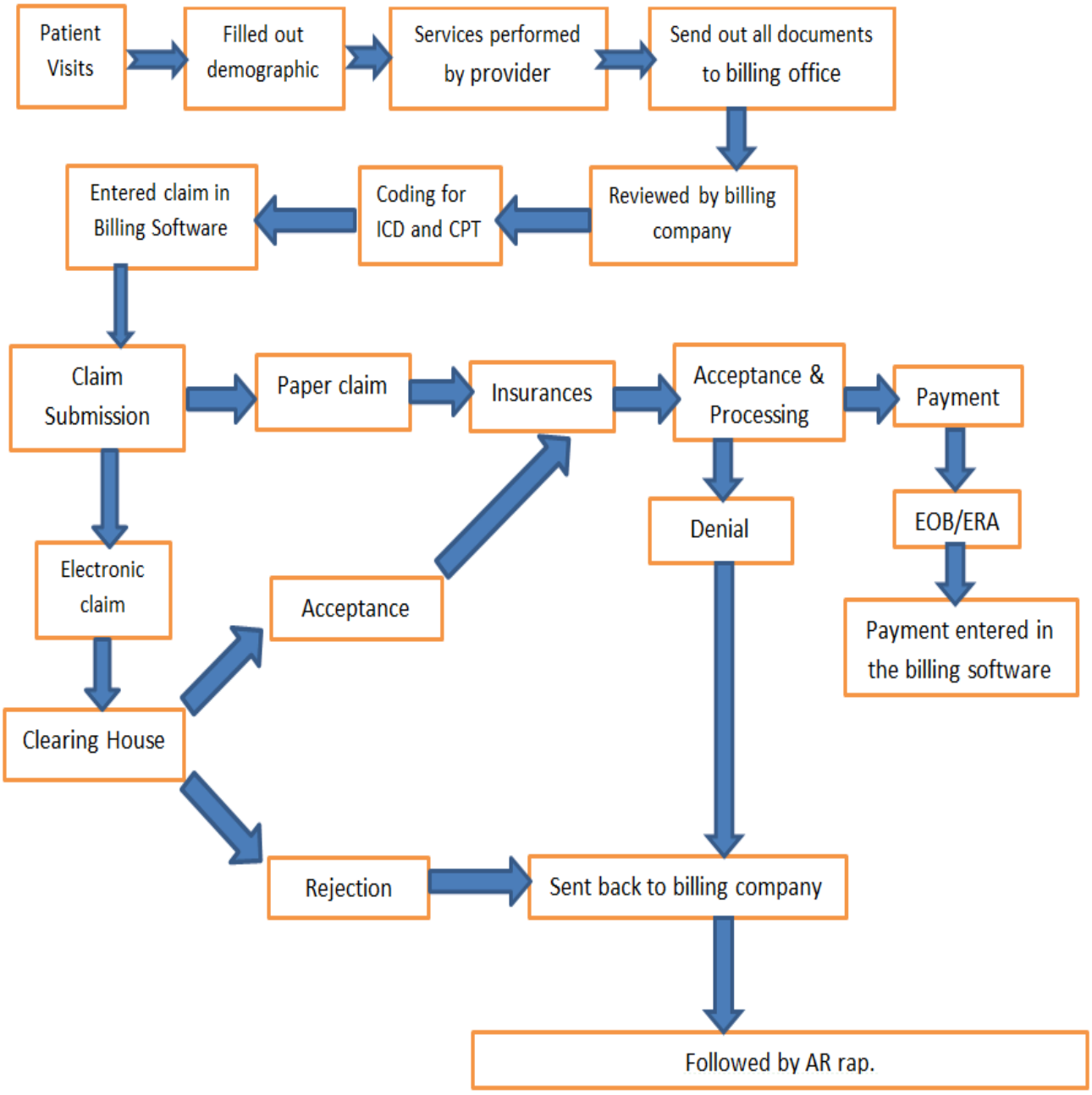
Premium: A Premium is the amount of money you have to pay for insurance. Premiums are usually paid in monthly or quarterly installments. Choosing a medical plan that fits your needs and budget is based mostly on balance.

EOB and ERA

EOB is abbreviated as explanation of benefit and it is in paper format while

ERA is abbreviated as electronic remittance advice and it is in electronic format.

Flow Chart of Medical Billing



Medical Coding

It is the process of transforming descriptions of medical diagnoses and procedures into universal medical code numbers.

SOURCE: The diagnoses and procedures are usually taken from a variety of sources within the health care record, such as the transcription of the physician's notes, laboratory results, radiologic results, and other sources.

Uniform system for documentation & tracking of services delivered

Why is coding important? It's how we get paid!!

In the current US health care system, payment for services depends on accurate and complete coding. In fee for service settings, the reimbursement (to the patient or provider) depends directly on what was coded.

Documentation

- ✔ **If it isn't documented , you didn't do it**
- ✔ **Must be legible**
- ✔ **Must be documented in a legal document**

Coding and documentation are integrally connected. Documentation in the medical record must confirm that sufficient services were delivered to justify the codes used. A common dictum is "If it isn't documented, it wasn't done."

Legibility is important. The CMS definition of legibility is that anyone unfamiliar with the handwriting can read it. If documentation is not legible, the content is essentially not documented

The medical record is a legal document, and may be used in court. All patient record must be presented in a legal document like prescription, encounter, progress note etc. HIPAA clarified that every patient has a right to see their medical record, and to append corrections. Keep this in mind.

Types of Codes:

The multiple types of codes fall into 2 general categories;

1. Diagnosis codes (ICD code) – In the United States, the system typically used for this is the **International Classification of Diseases**, 10th revision (ICD-10). The code set is updated at least annually based on the input of providers, payers and others.

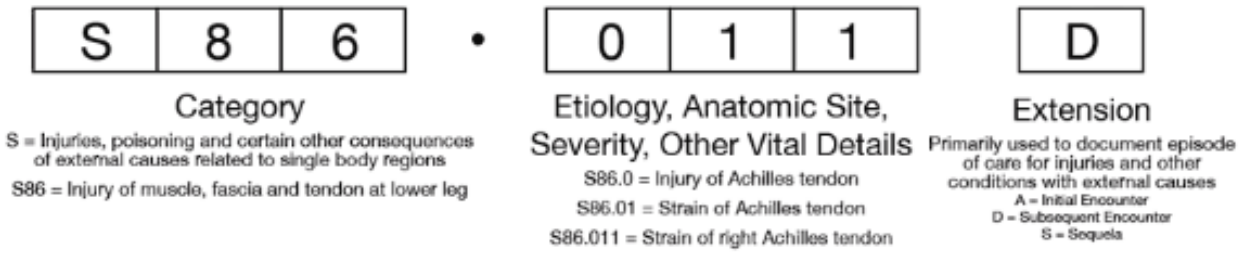
2. Codes for services rendered (CPT Codes) – These are of several types, broadly classified as Current Procedural Terminology CPT. The **Current Procedural Terminology** (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel The CPT code describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, organizations, and payers for administrative, financial, and analytical purposes.

ICD-10-CODES

- ✔ **2-7Alpha-numeric**
- ✔ **Always be as specific as possible**

ICD-10-CM codes are used to record the **diagnoses** for which a patient was seen/treated. The diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all United States (U.S.) health care treatment settings. Diagnosis coding under this system uses 2–7 alpha and numeric digits and the first character must always be an alpha character.

Codes in the ICD-10-CM code set can have three, four, five, six, or seven characters. Many three-character codes are used as headings for categories of codes; these three-character codes can further expand to four, five, or six characters tol add more specific details regarding the diagnosis.



The first three characters of an ICD-10 code designate the **category** of the diagnosis.

- In this instance, the letter "S" designates that the diagnosis relates to "Injuries, poisoning and certain other consequences of external causes related to single body regions." "S," used in conjunction with the numerals "8" and "6," indicates that the diagnosis falls into the category of "Injury of muscle, fascia and tendon at lower leg."

A three-character category that has no further subdivision (i.e., no greater specificity) can stand alone as a code. The next three characters (characters three through six) correspond to the related etiology (i.e., the cause, set of causes, or manner of causation of a disease or condition), anatomic site, severity, or other vital clinical details.

- So, in this case, the numbers "0," "1," and "1" indicate a diagnosis of "Strain of the right Achilles tendon."

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character extension, if applicable.

> **For example:** R51 for headache is a complete code but R10 for abdominal pain is not a complete code for abdominal pain.

The 7th character

The episode-of-care seventh characters are used primarily for injuries, poisonings and other consequences of external causes; there are three seventh-character extensions for most of these conditions, with the exception of fractures. These include:

Initial encounter ("A"): initial encounter is defined as the period when a patient is receiving active treatment for an injury, poisoning or other consequences of an external cause. An "A" may be assigned on more than one claim. For example, consider a patient seen in the emergency department (ED) for a

head injury that first is evaluated by an ED physician. If the ED physician requests a CT scan that subsequently is read by a radiologist and a neurologist, the seventh character “A” is used by all three physicians and also reported on the ED claim. If the patient required admission to an acute-care hospital, the seventh character would be reported for the entire acute-care hospital stay because “A” is used for the entire period when the patient receives active treatment.

Subsequent encounter (“D”): this is an encounter occurring after the active phase of treatment, when a patient is receiving routine care during a period of healing or recovery. For example, a patient with an ankle sprain may return to the office to have joint stability re-evaluated to ensure that the injury is healing properly. In this case, the seventh character “D” would be assigned.

Sequela (“S”): the seventh-character extension “S” is assigned for complications or conditions arising as a direct result of an injury. An example of a sequela is a scar resulting from a burn.

Place Holder

Keep in mind not every ICD-10 will have a character for every place in the code, but may require a **seventh character**. Codes may not have a fourth, fifth or perhaps even a sixth place, yet a seventh character may still apply. This frequently occurs with poisonings and injuries.

The letter "x” serves as a placeholder when a code contains fewer than six characters and a seventh character applies. The "x” also allows for future expansion of the codes.

For example, a patient presents with an **accidental poisoning by an anti-allergic drug**. For the initial encounter, coders should report ICD-10-CM code **T45.0x1A**. In this case, the x in the fifth position serves as a placeholder so that the sixth and seventh characters are in the correct position. If a coder inadvertently omits the placeholder, the resulting code would be T45.01A, which is invalid.

Coders should also note that an ICD-10-CM code can start with an X (i.e., codes X00-X99). The X series of codes is part of Chapter 20: External Causes of Morbidity.

Note that the location of the X within a code matters. When x is in the fourth, fifth, and/or sixth character, it appears lowercase and is a placeholder. When X is at the beginning of the code, it is uppercase and indicates the chapter.

Codes from A00.0 through T88.9

The appropriate codes from A00.0 through T88.9 must be used to identify diagnosis, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

Codes from V00-Y99 - External causes of morbidity

This chapter permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects. Where a code from this section is applicable, it is intended that it shall be

used secondary to a code from another chapter of the Classification indicating the nature of the condition.

Codes from Z00-Z99 - Factors influencing health status and contact with health services

Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Category Z00-Z99 is provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as 'diagnoses' or 'problems'. This can arise in two main ways:

- When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.
- When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Coding Sign and Symptoms If you are not certain about the diagnosis

General coding guidelines in ICD-10-CM instruct that codes describing symptoms and signs are acceptable for reporting when the provider has not established a related, definitive (confirmed) diagnosis. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0–R99) contains many (but not all) codes for symptoms.

Chapter 18 also includes codes for Symptoms, Signs and Abnormal Clinical and Laboratory Findings Not Elsewhere Classifiable, for ill-defined conditions where no diagnosis classifiable elsewhere is recorded. These conditions are represented through the range of R00-R59. They consist of categories for:

- Cases when no more specific diagnosis code can be made
- Signs or symptoms existing at the time of initial encounter that were transient or not determined
- Provisional diagnosis when patient failed to return for further investigation or care

List all codes for which you provided the services

For patients with multiple chronic problems, code all documented conditions that affect the care delivered. Do not code stable problems that are not addressed.

For example, a 56 year old is seen with URI symptoms and facial pain of 3 days duration. She is a type 1 diabetic in good control who also suffers from chronic pain due to arthritis. Her exam is consistent with

acute maxillary sinusitis. Because of her diabetes, antibiotics are prescribed (whereas a trial of conservative measures might have been chosen for a non-diabetic). The diagnoses to be coded are:

- ✔ J01.00 Acute maxillary sinusitis, unspecified
- ✔ E10.9 Diabetes, type 1 (uncomplicated, in control)+

Order of Diagnosis Code

Diagnoses should be listed in order of priority, with the primary reason for the visit being first.

For example, a 45 year old woman is seen for a sprained right ankle. While she is in the office, she asks the provider to refill her blood pressure medicine. She'd also like to check her cholesterol; her last level was good, but it was over 5 years ago. She has earlier been diagnosed with arthritis also. The diagnoses to be coded are:

- ✔ S93.401A - Sprain of unspecified ligament of right ankle, initial encounter
- ✔ I10- Hypertension
- ✔ Z13.220 Encounter for screening for lipoid disorders

The arthritis should not be coded unless the patient also complained of symptoms relative to that problem.

Selection of Principal Diagnosis

A medical coder should use a patient's entire medical record to determine selection of a principal diagnosis and not rely solely on the discharge summary or face sheet. The Uniform Hospital Discharge Data Set (UHDDS) defines principal diagnosis as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". This definition should be "ingrained" in coders' minds and applied as they go through the record.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

Keep these in mind while selecting principal diagnosis:

- When a patient presents for an out-patient surgery, code the reason for the surgery as a Principal Diagnosis, even if the surgery is not performed due to contraindication.
- When a patient is admitted for observation for a medical condition, assign a code for that medical condition as principal diagnosis.
- When a patient presents for an outpatient procedure and develops complications requiring admission to observation, code the reason for the procedure as the principal diagnosis, followed by codes for the complication as secondary diagnosis.
- Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.
- If the same condition is described as both acute (sub-acute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (sub-acute) code first.
- When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first.
- When multiple injuries exist, the code for the most severe injury as determined by the attending physician is sequenced first.
- When the visit is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication may be assigned.

Uncertain Diagnosis

Do not code diagnosis documented as “probable”, “suspected’, “questionable”, “rule out”, or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the conditions to the highest degree certainty for that visit such as symptoms, signs, abnormal test results, or other reason for the visit.

- If a patient admitted to the hospital for a “rule out MI” who rules out should NOT be coded as Myocardial Infarction.
  R50.9 chest pain, unspecified is appropriate.
- An outpatient seen with epigastric pain suspected to be peptic ulcer disease should NOT be coded with PUD unless the diagnosis is confirmed radiographically or endoscopically.
  R10.13- Abdominal pain, epigastricis appropriate

CPT CODES

Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes are used in conjunction with ICD-10-CM diagnostic coding during the medical billing process. This expansive, important code set is published and maintained by the American Medical Association (AMA) and updated yearly by the AMA and the CPT Editorial Board.

CPT codes are an integral part of the billing process. CPT codes tell the insurance payer what procedures the healthcare provider would like to be reimbursed for. As such, CPT codes work in tandem with ICD codes to create a full picture of the medical process for the payer.

- ✔ "This patient arrived with these symptoms (as represented by the ICD code) and we performed these procedures (represented by the CPT code)."

CPT code format

Each CPT code is five characters long, and may be numeric or alphanumeric, depending on which **category** the CPT code is in. CPT codes are divided into three Categories.

- o Category I is the most common and widely used set of codes within CPT. It describes most of the procedures performed by healthcare providers in inpatient and outpatient offices and hospitals.
- o Category II codes are supplemental tracking codes used primarily for performance management.
- o Category III codes are temporary codes that describe emerging and experimental technologies, services, and procedures.

CPT is designed for flexibility and revision, and so there is often a lot of "space" between codes. Unlike ICD, each number in the CPT code does not correspond to a particular procedure or technology.

Category I

Medical coders will spend the vast majority of their time working with Category I CPT codes. Category I CPT codes are divided into six large sections based on which field of health care they directly pertain to. There are six sections of the category I codes in CPT codebook and each section is arranged by their numerical range.

- o Evaluation and Management: 99201 – 99499
- o Anesthesiology: 00100 – 01999; 99100 – 99140

- Surgery: 10021 – 69990
- Radiology: 70010 – 79999
- Pathology and Laboratory: 80047 – 89398
- Medicine: 90281 – 99199; 99500 – 99607

Within each of these code fields, there are subfields that correspond to how that topic—say, Anesthesia—applies to a particular field of healthcare. For instance, the Surgery section, which is by far the largest, is organized by what part of the human body the surgery would be performed on.

Each of these fields has its own particular guidelines when it comes to use. For example, the Surgery section has a guideline for how to report extra materials used (such as sterile trays or drugs) and how to report follow-up care in the case of surgical procedures.

Certain codes have related procedures indented below them. These indented codes are important variations on the code above them, and denote different methods, outcomes, or approaches to the same procedure.

- ✔ **For example**, the code for the elevation of a simple, extradural depressed skull fracture is 62000. The code for the elevation of a compound or comminuted, extradural depressed skull fracture is 62005.

Category II

These codes are five character-long, alphanumeric codes that provide additional information to the Category I codes. These codes are formatted to have four digits, followed by the character F. These codes are optional, but can provide important information that can be used in performance management and future patient care.

- ✔ **For example**, if a doctor records a patient's Body Mass Index (BMI) during a routine checkup, we could use Category II code 3008F, "Body Mass Index (BMI), documented."

These codes never replace Category I or Category III codes, and instead simply provide extra information. They are divided into numerical fields, each of which corresponds with a certain element of patient care. These fields are, in order:

1. Composite Codes – These codes combine a number of procedures that typically occur in conjunction with one main procedure.

- ✔ For example: 0001F: heart failure assessed (includes all of the following):
  - ❖ Blood pressure measured
  - ❖ Level of activity assessed
  - ❖ Clinical symptoms of volume overload assessed
  - ❖ Weight recorded

- ❖ Clinical signs of volume overload assessed

2. Patient Management – Includes patient care provided for specific clinical purposes like pre- and postnatal care.

For example: 0503F: Postpartum care visit

3. Patient History –Describes measures for select elements of patient history or symptom review.

For example: 1030F: Pneumococcus immunization status assessed

4. Physical Examination

For example**:** 2014F: Mental status assessed

5. Diagnostic/Screening Processes or Results –Includes results of tests ordered, including clinical lab tests and radiological procedures.

For example: 3006F: Chest X-ray documented and reviewed

6. Therapeutic, Preventive, or Other Interventions –Describes pharmacologic, procedural or behavioral therapies

For example: 4037F: influenza immunization ordered or administered

7. Follow-up or Other Outcomes –These codes describe the review and communication of test results to a patient, patient satisfaction, patient functional status, and patient morbidity or mortality

For example: 5005F: patient counseled on self-examination for new or changing moles

8. Patient Safety– Includes codes that describe patient safety precautions

For example: 6015F: Patient receiving or eligible to receive foods, fluids, or medication by mouth

9. Structural Measures–This short section includes codes that describe the setting of the delivered care, and also covers the capabilities of the healthcare provider

For example: 7025F: patient information entered into a reminder system with a target due date for the next mammogram

There are not nearly as many Category II CPT Codes as there are in Category I, and in general Category II codes are not used as much. Still, it is an important element of the CPT code set, and you should be familiar with the basics of Category II codes as you prepare for a career in the field.

Category III

The third category of CPT codes is made up of temporary codes that represent emergent or experimental services, technology, and procedures. Like Category II, these codes are five characters long, and are comprised of four digits and a terminal letter. In this case, the last letter of Category III codes is T.

For example, the code for the fistulization of sclera for glaucoma, through ciliary body is 0123T.

Category III codes allow for more specificity in coding, and they also help health facilities and government agencies track the efficacy of new, emergent medical techniques. Think of Category III as codes that may become Category I codes or that just don't fit in with Category I.

Category I codes must be approved by the CPT Editorial Panel. This Panel mandates that procedures or services must be performed by a number of different facilities in different locations, and that the procedure is approved by the FDA. Due to the nature of emerging medical technology and procedures, it's not always possible for an experimental procedure to meet these criteria, and thus become a Category I code.

Whether a Category III code becomes a Category I code or not, all Category III codes are archived in the CPT manual for five years.

CPTs & ICDs Linkage

Every CPT code must be supported by a corresponding ICD-10 diagnosis code that supports medical necessity for the procedure that was performed. One diagnosis may support several procedure codes.

A patient who presents with ankle instability may require as many as three billable procedures to stabilize the joint, and all three of these procedures will be paid. All of this information is part of the medical record

Technical and professional component

Technical Component: In health care informatics, that portion of a procedure undertaken by a technician, rather than by a physician. We will use modifier TC for technical component.

Professional Component: In health care informatics, the service or therapy provided by a physician in interpreting the test by supervision. Modifier 26 is used for it.

Evaluation and Management codes (E/M)

Evaluation and Management Coding (commonly known as E/M Coding) is a medical billing process that practicing health care providers in the United States must use to be reimbursed by insurance for patient encounters.

Billing an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- **Patient type;**
- **Setting of service; and**
- **Level of E/M service performed**

Patient Type

For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.

- A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.
- An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

Setting of Service

E/M services are categorized into different settings depending on where the service is furnished. Examples of settings include:

- Office or other outpatient setting
- Hospital inpatient
- Emergency department (ED)
- Nursing facility

Level of E/M service performed

The code sets used to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code the physician or NPP may bill within the appropriate category. In order to bill any code, the services furnished must meet the definition of the code. It is the physician's or NPP's responsibility to ensure that the codes selected reflect the services furnished. There are three key components when selecting the appropriate level of E/M service provided:

- **History**
- **Examination**
- **Medical decision making**

Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

Below mentioned are the CPT codes of E&M used in different outpatient and inpatient services

Outpatient/Office E/M codes

Office E / Outpatient /M code (New Patients)	
99201	10 Minutes
99202	20 Minutes
99203	30 Minutes
99204	45 Minutes
99205	60 Minutes

Office E / Outpatient /M code (Established Patients)	
99211	5 Minutes
99212	10 Minutes
99213	15 Minutes
99214	25 Minutes
99215	40 Minutes

Hospital Inpatient E/M codes

Hospital inpatient E/M Admission	
99221	30 Minutes
99222	50 Minutes
99223	70 Minutes

Hospital inpatient E&M Follow-up/Subsequent	
99231	15 Minutes
99232	25 Minutes
99233	35 Minutes

Hospital inpatient E&M Discharge	
99238	30 Minutes
99239	>30 Minutes

Emergency Department E/M Codes

Emergency Department E/M Codes	
99281	Limited / Minor Problem
99282	Low Moderate Severity
99283	Moderate Severity
99284	High/ Urgent Severity
99285	High Severity & Life threatening disease

In emergency room billing we are creating both **professional** and **institutional** claim. For professional claim we will choose level of visit as per above mentioned description while for institutional claims we will choose level depends upon the resource used.

Other CPT codes except E&M

Laboratory test Services

Laboratory services are ordered by your doctor or practitioner. Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests. Code ranges for laboratory services are:

- 80047 – 89398

Radiological Services

Radiologists use a variety of imaging techniques such as X-ray radiography, ultrasound, computed tomography (CT), nuclear medicine, positron emission tomography (PET) and magnetic resonance imaging (MRI) to diagnose or treat diseases. These are called radiological services.

X-rays

X-rays are a type of electromagnetic radiation, just like visible light. An x-ray machine sends individual x-ray particles through the body. The images are recorded on a computer or film. Structures that are dense (such as bone) will block most of the x-ray particles, and will appear white.

We can select CPT code for x-ray as per views taken by the physician. Some examples are mentioned below.

Wrist X-Ray	73100 (2 views)	73110 (3 views or more)
Chest X-ray	71010 (1 View)	71020 (2 views)

CT Scans

A computerized tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are also sometimes known as CAT scans, which stands for computerized axial tomography

We can select CPT code for CT scan as per contrast or without contrast. For example:

CT scan of Head without contrast	70450
CT scan of Head without contrast	70460
CT scan of Head with and without contrast	70470

Revenue Codes

Revenue codes are 4-digit numbers that are used on hospital bills to tell the insurance companies either where the patient was when they received treatment, or what type of item a patient might have received as a patient. A medical claim will not be paid if this is missing from a bill. For example:

Emergency Department	0450
Pharmacy	0250
X-ray	0320

MODIFIER

Modifier is a two character code that indicates a service or a procedure has been altered by some specific circumstance but has not changed in its definition or code.

When a simple CPT code isn't enough, we turn to modifiers. These important additions to CPT codes give extra information about **how**, **where** and **why** a procedure was performed. Since medical procedures and services are often complex, we sometimes need to supply additional information when we're coding.

- A modifier may describe whether multiple procedures were performed
  - **Why** that procedure was necessary
  - **Where** the procedure was performed on the body
  - **How** many surgeons worked on the patient

Advantages of Modifiers

- To indicate a procedure performed has both Professional and Technical Component.
- To indicate a procedure performed more than one physician or more than in one location.
- A service has been increased or reduced or only a part of the procedure was performed.
- A bilateral procedure was performed.
- A service or procedure was providing more than once.
- Unusual events occurred.
- Modifiers may increase or decrease the reimbursement of a procedure or service.
- Modifiers indicate additional information on a service performed.

Types of Modifiers

- CPT Modifiers
- Physical Status Modifiers
- HCPCS Modifiers

CPT Modifiers

CPT modifiers are added to the end of a CPT code with a hyphen. In the case of more than one modifier, you code the "**functional**" modifier first, and the "**informational**" modifier second. The distinction between the two is simple: you always want to list the modifiers that most directly affect the reimbursement process first.
The following is the list of some of commonly used CPT modifiers, and a brief description of what they mean when it is not already clear.

Modifier 24 - Unrelated Evaluation & Management Service by the same Physician during a Postoperative Period

Modifier 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Modifier 50 - Bilateral Procedure

Modifier 51 - Multiple Procedures

When multiple procedures performed on the same day or at the same session by the same provider

Modifier 52 - Reduced Services

A service or procedure may be partially reduced or eliminated at the MD's discretion. If a procedure is not completed in its entirety, the procedure is to be billed with modifier 52

Modifier 58 - Related procedure or service by the same physician during the post-operative period.

Modifier 59 - Distinct Procedural Service

Modifier 59 is used to clearly designate when distinct, independent and separate multiple procedures are provided. The procedure must not be a component of another procedure.

Modifier 73 - Discontinued outpatient procedure prior to anesthesia administration

Modifier 74 - Discontinued outpatient procedure after anesthesia administration

Modifier 76 - Repeat Procedure on the same day by the same physician

Modifier 77 - Repeat Procedure on the same day by the different physician

Modifier 78 -Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the post-operative period

Modifier 79 - Unrelated procedures or service by the same physician during the postoperative period

Physical Status Modifiers

Anesthesia procedures have their own special set of modifiers, which are simple and correspond to the condition of the patient as the anesthesia is administered. These codes are:

P1 – a normal, healthy patient
P2 – a patient with mild systemic disease
P3 – a patient with severe systemic disease
P4 – a patient with severe systemic disease that is a constant threat to life
P5 – a moribund patient who is not expected to survive without the operation
P6 – a declared brain-dead patient whose organs are being removed for donor purposes

HCPCS Modifiers

These modifiers describe things like which side of the body or which body part the procedure is performed on.

E1: upper left eyelid
E2: lower left eyelid
E3: upper right eyelid
E4: lower right eyelid
FA: left hand, thumb
F1: left hand, second digit
F2: left hand, third digit
F3: left hand, fourth digit
F4: left hand, fifth digit
F5: right hand, thumb
F6: right hand, second digit
F7: right hand, third digit
F8: right hand, fourth digit
F9: right hand, fifth digit
LT: left side (used to identify procedures performed on the left side of the body)
RT: right side (used to identify procedures performed on the right side of the body)

HCPCS

HCPCS stands for **Healthcare Common Procedure Coding System**, commonly pronounced as "hicks-picks". HCPCS was developed by the Centers for Medicare and Medicaid (CMS) for the same reasons that the AMA developed CPT: for reporting medical procedures and services. Up until 1996, using HCPCS was optional. In that year, however, the government passed the Health Information Portability and Accountability Act, or HIPAA which made the use of HCPCS mandatory in certain cases.

The code set is divided into three levels:

- Level IHCPCS codes are identical to CPT codes
- Level II HCPCS codes are designed to represent non-physician services like ambulance rides, wheelchairs, walkers, other durable medical equipment, and other medical services that don't fit readily into Level I.

Level II HCPCS codes are alphanumeric medical procedure codes. Here's the full breakdown of HCPCS Level II codes by their alphabetic grouping:

- A-codes: Transportation, Medical and Surgical Supplies, Miscellaneous and Experimental
- B-codes: Enteral and Parenteral Therapy
- C-codes: Temporary Hospital Outpatient Prospective Payment System
- D-codes: Dental codes
- E-codes: Durable Medical Equipment
- G-codes: Temporary Procedures and Professional Services
- H-codes: Rehabilitative Services
- J-codes: Drugs administered other than oral method, chemotherapy drugs
- K-codes: Temporary codes for durable medical equipment regional carriers
- L-codes: Orthotic/prosthetic services
- M-codes: Medical services
- P-codes: Pathology and Laboratory
- Q-codes: Temporary codes
- R-codes: Diagnostic radiology services
- S-codes: Private payer codes
- T-codes: State Medicaid agency codes
- V-codes: Vision/hearing services

Coders use HCPCS codes much like they would ICD or CPT codes. Upon receiving a medical report, you'd take notes on which procedure was performed, which products were prescribed, injected, or otherwise delivered to the patient, and then you'd use your HCPCS code set to find the appropriate code.

ELECTRONIC VS PAPER CODING

In the past, coders entered their codes into paper forms, which they then passed on to the medical billing individual or organization. Today, in order to speed up the coding process and ensure more accuracy, the medical coding profession uses different medical coding software.

The software programs may come with look-up tools that help coders find the correct code, but coders should always use their coding manuals to get the last word on which codes to use.

The benefits of working with coding software are numerous. Coders (and billers) can track claims and easily call up old reports to check for efficiency and errors. Coding software is also excellent for tracking data over long periods of time and for performance management evaluations.

HIPAA

HIPAA is **Health Insurance Portability and Accountability Act** of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.

Common Abbreviations

- DOS: Date of Service (the date when patient receives services from provider)
- DOB: Date of Birth
- DOA: Date of Accident
- CLIA: Clinical laboratory improvement Amendments
- SSN: Social Security Number
- POS: Place of Service
- HIPAA: Health Insurance Portability and Accountability Act
- EOB: Explanation of Benefit.
- CMS: Center for Medicare and Medicaid Services
- COB: Coordination of Benefit.
- EMR: Electronic Medical Record.
- NPI: National Provider Identifier

Billing Process

1. Patient demographic
2. Insurance
3. Claim
4. Payment
   -

Training Protocol Check Sheet

Medical Billing and Coding _____

- Types of Medical Billing services _____
- Heath Care Providers _____
- Claim _____
- Insurances _____
- Subscriber _____
- Clearing House _____

Flow Chart of Medical Billing _____

Medical Coding _____

ICD-10-CM Codes _____

- ICD-10-CM code Structure _____
- The 7th character _____
- Place Holder _____
- Codes list _____

Coding Guidelines _____

- Coding signs and Symptoms _____
- Order of diagnosis code _____
- Selection of Principal Diagnosis _____
- Uncertain Diagnosis _____

CPT codes _____

- CPT code format _____
- Category I _____
- Category II _____
- Category III _____

CPTs &ICDs Linkage _____

Technical and Professional components _____

Evaluation and Management _____

- Patient Type _____
- Setting of service _____
- Level of E/M service performed _____
- E/M codes list _____

Other CPT codes except E/M _____

- Laboratory test services _____
- Radiology services _____

Revenue codes _____

Modifiers _____

- Advantages of modifiers _____
- CPT Modifiers _____
- Physical Status Modifier _____
- HCPCS Modifier _____

HCPCS _____

Electronic VS Paper Coding _____

HIPPA _____

Common Abbreviations _____

Disclaimer

I _____ hereby acknowledge that I have undergone _____ weeks training program at Max Remind i.e. from _____ to _____ and understood the above marked concepts during my training.

Signature

_____

How to calculate different amounts on EOB and ERA

Billed Amount (100) = Allowed amount (50) + Adjustment amount (50)

Adjusted amount (50) = Billed amount (100) - Allowed amount (50)

Allowed Amount (50) = paid amount (30) + Patient responsibility (20)

Paid Amount (30) = Allowed amount (50) - Patient responsibility (20)

Patient responsibility (20) = Allowed amount (50) - Paid amount (30)

Rejected amount (20) = Allowed amount (50) - Paid amount (30)

THANK YOU

Allowed amount= Paid Amount + Patient responsibility (Deductible + Co-pay + Coinsurance) + Second adjustment

71.60 = 50 + 20 + 1.60

Billed amount= Allowed amount + adjustment amount

105 90 15