



MEDICAL BILLING AND CODING CERTIFICATION
DOWNLOADABLE EBOOK

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INTRODUCTION

This ebook will brief you on every aspect of the medical billing and coding field: from a breakdown of each code set to starting your own practice.

DOWNLOADABLE MATERIAL

Along with our online video courses, we provide free downloadable resources like Powerpoint presentations, vocabulary lists, sample problems, and review quizzes to help you in your studies.

The course is divided into six sections. In section one, we introduce you to the general topic of medical billing and coding.

In section two, we talk about the practice and the basics of the medical coding process.

In section three, you learn about the medical billing claims process and how it pertains to health insurance payers, Medicare and Medicaid, and the rest of the healthcare industry.

In section four, we apply the knowledge you've learned and work with some real-world problems in coding and billing. This section gives you a detailed look into what it's like to work as a medical coder or biller.

In section five, we help you prepare for the American Association of Professional Coder's Certified Professional Coder exam.

And finally, in section six we show you some of the next steps to take in the field, including where to go to school, where to get certified, and how to avoid online scams.

DISCLAIMER

Bear in mind that this ebook, and all our provided content on our website alone will not prepare you to take the exams to become a certified medical biller or coder. In order to learn the specifics of these fields and prepare yourself for their exams, you'll want to take classes at one of the many schools and training programs around the country. You can count on us for that, too: our website can help you pick out the school or training program that's right for you.

Let's get started!

WHAT IS MEDICAL BILLING AND CODING?

Medical billing and coding are two closely related aspects of the modern health care industry. Both practices are involved in the immensely important reimbursement cycle, which ensures that health care providers are paid for the services they perform.

MEDICAL CODING

Medical coding, at its most basic, is a little like translation. It's the coder's job to take something that's written one way (a doctor's diagnosis, for example, or a prescription for a certain medication) and translate it as accurately as possible into a numeric or alphanumeric code. For every injury, diagnosis, and medical procedure, there is a corresponding code.

There are thousands and thousands of codes for medical procedures, outpatient procedures, and diagnoses. We'll cover which codes represent which injury or sickness, and which codes correspond to each procedure, in greater depth in Section 2.

For now, let's start with a quick example of medical coding in action.

MEDICAL CODING EXAMPLE

A patient walks into a doctor's office with a hacking cough, high production of mucus or sputum, and a fever. A nurse asks the patient their symptoms and performs some initial tests, and then the doctor examines the patient and diagnoses bronchitis. The doctor then prescribes medication to the patient.

Every part of this visit is recorded by the doctor or someone in the healthcare provider's office. It's the medical coder's job to translate every bit of relevant information in that patient's visit into numeric and alphanumeric codes, which can then be used in the billing process.

There are a number of sets and subsets of code that a medical coder must be familiar with, but for this example we'll focus on two: the International Classification of Diseases, or ICD, codes, which correspond to a patient's injury or sickness, and Current Procedure Terminology, or CPT, codes, which relate to what functions and services the healthcare provider performed on or for the patient. These codes act as the universal language between doctors, hospitals, insurance companies, insurance clearinghouses, government agencies, and other health-specific organizations.

The coder reads the healthcare provider's report of the patient's visit and then translates each bit of information into a code. There's a specific code for what kind of visit this is, the symptoms that patient is showing, what tests the doctor does, and what the doctor diagnoses the patient with.

Every code set has its own set of guidelines and rules. Certain codes, like ones that signify a pre-existing condition, need to be placed in a very particular order. Coding accurately and within the specific guidelines for each code will affect the status of a claim.

The codes for the procedures performed must also correspond to the diagnoses made by the physician. Having the correct procedure codes match up with the diagnosis codes ensures that healthcare providers and patients will be properly reimbursed by insurance companies.

The coding process ends when the medical coder enters the appropriate codes into a form or software program. Once the report is coded, it's passed on to the medical biller.

MEDICAL BILLING

On one level, medical billing is as simple as it sounds: medical billers take the information from the medical coder and make a bill for the insurance company. This bill is called a claim, and will be discussed more in depth in Section 3. The biller also receives evaluated or 'adjudicated' claims, analyzes them, and then creates bills for patients.

Of course, as with everything related to the health care system, this process isn't as simple as it seems.

MEDICAL BILLING EXAMPLE

To get a better look at medical billing, let's rewind the example we used earlier. Our same patient has a cough, a fever, and is producing lots of mucus. This patient calls the doctor and schedules an appointment. It's here that the medical billing process begins.

The medical biller takes the codes, which show what kind of visit this is, what symptoms the patient shows, what the doctor's diagnosis is, and what the doctor prescribes, and creates a claim out of these using a form or a type of software. The biller then sends this claim to the insurance company, which evaluates and returns it. The biller then evaluates this returned claim and figures out how much of the bill the patient owes, after the insurance is taken out.

If our bronchitis-afflicted patient has an insurance plan that covers this type of visit and the treatment for this condition, their bill will be relatively low. The patient may have a co-pay, or have some other form of arrangement with their insurance company. The biller takes all of this into account and creates an accurate bill, which is then passed on to the patient.

In the case of a patient being delinquent or unwilling to pay the bill, the medical biller may have to hire a collections agency in order to ensure that the healthcare provider is properly compensated.

The medical biller, acts as a sort of waypoint between patients, healthcare providers, and insurance companies. Think of the biller, like the coder, as a sort of translator—where the coder translates medical procedures into code, the biller translates codes into a financial report. The biller has a number of other responsibilities, which we'll discuss further in Section 3, but for now you should simply know that the biller is in charge of making sure the healthcare provider is properly reimbursed for their services.

WORKING IN MEDICAL BILLING AND CODING

Now is a very good time to look at a career in medical billing and coding. The American health care system is modernizing just as a large portion of the populace enters retirement, and the demand for healthcare professionals who can process crucial data is growing daily.

According to the Bureau of Labor and Statistics, the medical billing and coding field is expected to grow by 21% between now and 2020. That's almost 40,000 job openings in the next six to seven years.

Not only are there a large number of job openings in coding and billing, many of these jobs are fairly lucrative. Entry-level coders and billers made an average of 34,000 dollars in 2012—that's \$16.42 an hour when you're starting out. The top ten percent of coders across the United States make \$27 an hour, and coders in some states make even more than that.

The field of medical billing and coding is growing as a result of a number of factors, chief among them being an aging population, an increasing focus on health data and informatics, and the digitization of health records. As the health care system turns increasingly to electronic health records, billing and coding specialists who are computer-savvy will have a leg up on the rest of field.

Let's now take a look at some of the day-to-day tasks performed by professional medical coders and billers. As with the previous course (*What is Medical Billing and Coding?*), we'll divide this course into two sections to look at the daily activities of a medical biller and a medical coder. Bear in mind that, occasionally, one person performs the duties of both positions.

MEDICAL CODING

Professional coders start the day by reviewing the reports they have to code. Their job is relatively straightforward: a coder examines a doctor's report from a procedure or checkup, and then the coder determines the best way to translate this into code.

MEDICAL CODING EXAMPLE

For example, a note may read that a patient visited the doctor with a sore throat. Upon examination of the throat, the doctor suspected streptococcus, a common infection of the throat. The doctor performed a rapid strep test. With a positive diagnosis of strep throat, the doctor prescribed a week's worth of amoxicillin, an antibiotic drug.

The coder would read this note and, using the ICD-9-CM and CPT manuals, determine the best way to code this diagnosis and procedure. In this instance, the coder would use a CPT code of 87880 for the rapid strep test, a CPT code of 00781-6041 for the prescription of orally administered amoxicillin, and an ICD-9-CM code of 680.0, for streptococcal sore throat.

The coder will then enter the correct codes into a form or, more often, a computer program, and then move on to the next report. This process of reading reports, translating them into the correct code and entering them will continue

for the rest of the day. Most coding is relatively straightforward, and most coders become familiar with the codes for the more common procedures completed in their respective office. A coder for a general practitioner, for example, will become very familiar with the codes for a general office visit (99214) and flu shots (90658). Coders must adhere to the guidelines for each code. Certain conditions, for example, need to be coded in a particular order. To learn more about coding guidelines, please refer to Section 2, specifically the courses *ICD-9 & ICD-9-CM* through *CPT Modifiers*.

Still, there may be instances where there is significant confusion or a gray area in the code. Coding guidelines may also get incredibly intricate and specific as the symptoms, conditions, or procedures performed get more complicated. In cases where referring to the appropriate manuals and their guidelines is not sufficient, most coders will reach out to the larger coding community for advice and guidance.

Above all else, the coder must make sure that the procedure code used corresponds to the diagnosis code. If the procedure listed does not make sense with the diagnosis provided, this may result in a rejected claim, which can muddy the reimbursement process considerably.

One last point: Each medical office has a specific lag time for coding reports. This lag time is typically two to five business days. That means that coders must complete their coding within five days of the procedure or doctor's visit. Hitting these deadlines ensures that the billing and reimbursement process can move along smoothly. It's the coder's responsibility to manage these deadlines and work in a timely, efficient manner.

MEDICAL BILLING

The job of the medical biller begins as the medical coder's job ends. As we learned in the previous course, it's the medical biller's responsibility to create accurate, legal bills for the healthcare provider's office and to send them in a timely fashion to an insurance company, or payer. It's also the biller's job to send out and collect payments from patients. What follows is an abbreviated description of the medical billing process. For a more in-depth look at the biller process, please refer to *More About Insurance and the Insurance Claims Process* in Section 3.

The medical biller's day involves a number of different processes. The medical biller is responsible for creating accurate, formally correct claims, checking for accuracy in transaction reports, and creating bills for patients.

First, the medical biller takes the codes from the medical coder, whether in a form or via a computer program, and creates a medical claim. As we covered in the last course, a claim is an itemized list of procedures, services, and costs that is sent from a healthcare provider to a payer in order to collect reimbursement for the provider.

This process, while simple in theory, can be very complicated. First, the biller must confirm that all of the codes correspond to one another. Consider this a quality check after the medical coder completes their report. This requires the

medical biller to be familiar not only with medical terminology, but also with the current forms of CPT, ICD and HCPCS codes.

Medical billers must also become familiar with the patient's insurance policy in order to determine if the procedures and services performed by the healthcare provider are covered by that patient's plan. Essentially, the medical biller needs to make sure that each code, and thus each procedure, listed on the claim is actually billable. This generally depends on the payer and the contract the healthcare provider or patient has with that payer. Each insurance payer has a set of rules or guidelines that determine what can and cannot be billed for under the policyholders contract.

Medical facilities each have different rates for particular procedures as well, so a medical biller must create a claim that corresponds to the provider's established rates.

The medical biller takes all of these considerations in mind and creates an accurate medical claim, and then sends it off to the payer. Depending on what payer the medical biller is sending the claim to, the claim may first go through a clearinghouse or straight to the payer.

We'll cover what a clearinghouse is in *Medical Billing Vocabulary and Key Concepts* in Section 3. For now, just know that certain payers and clearinghouses require specific forms or software. If you are sending a claim to Medicaid, for example, you must the claim as a CMS-1500 form. We'll cover this process in more depth in Section 3.

Once a claim is sent out, the payer performs an evaluation known as payer adjudication. This is a process we'll cover in more depth in Section 3, as well. Essentially, the payer decides how much of the bill it will reimburse the provider for and sends it back to the provider in the form of a transaction report.

The biller then reviews this transaction report and checks it for accuracy. The biller makes sure the charges and reimbursements correspond to the provider's agreement with the payer. If the transaction report is accurate, the biller then processes a bill for the patient, with an explanation of which services and procedures are covered, and for how much, and which procedures the patient is responsible for paying for.

The final phase of the medical biller's day is that of collections. Should a patient be unable or unwilling to pay for the medical services rendered, a medical biller is in charge of sending them reminders and, as a last resort, sending their bill on to a collections service. The collections process varies, and depends on the healthcare provider's policy.

Now that you've learned a little bit about the day-to-day activities of both medical billers and medical coders, it's time to learn about the certification process in both of these fields.

MEDICAL CODING CERTIFICATION

If you're going to pursue a career as a medical coder, you'll want to consider getting certified. The field of health informatics and information management values accuracy and diligence, and a certification designates you as a qualified expert in your field.

While it's not required that you become a certified medical coder, it is very strongly recommended. Certification ensures your employers that your work is accurate, and it makes you a significantly more attractive candidate. A medical coding certification from one of the top professional organizations will increase your base salary and significantly improve your chances for career advancement.

You can earn a certification from a professional coding organization. Let's take a look at the two largest professional such organizations.

AAPC

By far the largest organization of coders is the American Association of Professional Coders (AAPC). The AAPC offers general and specialized certifications in coding and billing.

A general certification is the best place to start as a new medical coder. The AAPC's Certified Professional Coder (CPC) exam remains the most popular certification in the field. This nearly six-hour exam will be discussed at length in Section 5.

The AAPC recommends that all persons interested in the CPC exam have an associate's degree.

SPECIALIZED CERTIFICATIONS

This general certification covers 24 different aspects of the coding profession, including diagnostic codes, procedure codes for over a dozen specific fields, coding guidelines, medical terminology and more. The AAPC also offers two more specialized general certifications: the CPC-H™, which is designed to test the faculty of coders working in hospital outpatient facilities, and the CPC-P™, which certifies coders who are working for insurance payers. For the sake of simplicity, Section 5 focuses only on the general CPC™.

Once you've been certified as a professional coder and worked for a few years in the field, you may want to earn qualifications in a particular area of coding. Since medical coding is intricate and detail-oriented, many coders find it easier, and more lucrative, to code in one specific field. The AAPC offers certifications in Ambulatory Surgery Center coding (the CASCC™), Cardiology (the CCC™), Family Practice (CFPC™) and several other subjects.

In general, only those coders who have extensive experience coding in a particular field should look to earn a specialized certification.

CONTINUING EDUCATION

In addition to completing one of the AAPC's examinations, certified individuals must complete 36 hours of continuing education every two years. This ensures that your certification is not a one-time event, and that you will keep up-to-date on your skills. Some examples of continuing education include seminars, workshops, web-based training courses, chapter meetings, and other hands-on learning experiences.

CPC-A

You should also note that completing an AAPC CPC exam, without any prior experience in coding, will not make you a fully certified coder. Individuals who pass the CPC exam without any experience in the field will have to work as an apprentice, which is designated by a "-A" on their certification. For example, an apprentice CPC would be designated a CPC-A until he or she completed the work experience or continuing education needed.

Individuals can move from apprentice coders to full-time coders by receiving two letters of recommendation signifying two years of experience working with CPT, ICD and HCPCS codes, or provide proof of completion of at least 80 contact hours of education in coding. To learn more about the apprentice program, see *The CPC Apprentice Program* in Section 5.

AHIMA

The American Health Information Management Association, or AHIMA, is another large professional organization for coders. Like the AAPC, AHIMA offers a number of certifications for professional coders, including the Certified Coding Assistant (CCA), Certified Coding Specialist (CCS), and Certified Coding Specialist - Physician-based (CCS-P).

AHIMA REQUIREMENTS

Like AAPC, AHIMA requires an annual membership fee and the completion of a number of continuing education credits every two years if you are to remain certified. AHIMA requires certified members to complete and report 20 continuing education units every two years in order to hold their certification.

Continuing education can come in the form of seminars, AHIMA meetings, formal education programs, training courses, and more. If you receive any of the above coding certifications (CCS, CCA, CCS-P), you are required to complete not only 20 units of continuing education, but a self-assessment as well.

AHIMA also offers certifications for administrative and more informatics-driven positions. To learn more about the AHIMA certification process, visit their website: www.ahima.org/certification

MEDICAL BILLING CERTIFICATION

Since the job in medical billing requires handling important forms and private information in a timely, discrete manner, many employers prefer hiring certified individuals to work in their offices. Certification is not a requirement, but professional medical billers will find that certification leads to more job opportunities, better pay, and more chances for significant career advancement.

Since the certification can mean the difference between a high-paying, stable job and a lower-paying, temporary position, it's an important thing to learn about before you start your career in medical billing. Let's look at two such certifications now.

We'll break down the different medical certifications by the organization that grants them. For the sake of brevity, we'll cover the two largest certifying organizations in medical billing, the American Medical Billing Association (AMBA) and the American Association of Professional Coders (AAPC).

AMBA

The AMBA is a professional organization dedicated entirely to the medical billing field. The AMBA has been certifying medical billing professionals through their Certified Medical Reimbursement Specialist (CMRS) exam for over a decade.

This exam, much like the CPC exam, is a large, comprehensive exam that tests individuals on all phases of the medical billing process. Students must be a member of AMBA to take the exam. Membership in AMBA costs \$99 annually.

The exam is comprised of 16 sections, covering:

Medical Terminology	Insurance
Anatomy and Physiology	Insurance Carriers
Information Technology	Acronyms
Web and Information Technology	Compliance
ICD-9-CM Coding	Fraud and Abuse
CPT-4 Coding	Managed Care
Clearinghouses	General
CMS 1500	Case Studies

There are over 800 questions in this exam, and students must earn an 85% or higher to pass. Students take this exam online and have 45 days from sign-up to complete the exam. The CMRS exam is divided into sections. Upon completion of one section, the student's grade will be available immediately. Comprehensive scores are also available immediately upon completion.

Should you fail to score 85% or higher on the test, you are allowed two free retakes, with at least 30 (but no more than 60) days between retakes.

In order to prepare for the exam, you can purchase the CMRS study guide for \$199 in the AMBA store: www.ambastore.net

The CMRS recommends at least some experience in billing, or a very strong foundation in the practice, before you take the exam. You are also required to have a high school diploma or equivalent in order to take the class.

You are allowed—and encouraged—to use the current publications for medical coding during the exam, including the CPT, ICD-9-CM, and HCPCS Level II coding manuals.

Once you’ve passed your exam, you’ll need to maintain your certification. In order to do this, the AMBA requires you to complete 15 credits of continuing education each year, in addition to maintaining your annual membership.

Continuing education credits includes classes available through AMBA, AMA, Cengage, and a number of other organizations. Continuing education credits through the AAPC, American Health Information Management Association (AHIMA), Practice Management Institute (PMI), and Medical Group Management Association (MGMA) are available for half-credit toward your continuing education credits. The full list of approved continuing education courses is available at www.ambanet.net/ceu.pdf

AAPC

As the largest organization of health information professionals, the American Association of Professional Coders focuses mainly on medical coding, but they do offer a medical billing certification.

This certification, which is earned upon the completion of the Certified Professional Biller (CPB™) exam, tests the medical biller on every facet of the billing profession. Like the CPC™ discussed in the previous course *Medical Coding Certification*, this certification is a rigorous but well-respected benchmark for professionals in the health information field.

The CPB™ exam takes five hours and 40 minutes to complete, and consists of 200 questions focused on:

Types of insurance	Billing
Billing regulations	Coding
HIPAA and compliance	Case Studies
Reimbursement and collections	

Unlike the CMRS exam, individuals taking the CPB™ exam must complete the test in one sitting. Students should bring their code books, which list ICD-9-CM, CPT and HCPCS codes. Students must earn a 65% or higher in order to pass the exam.

Like the CMRS certification, individuals must pay for a membership in the sponsoring organization (in this case, the AAPC) and must demonstrate completion of a certain amount of continuing education courses in order to maintain their certification. For the CPB™, individuals must complete 36 units of continuing education every two years.

Continuing education may take the form of seminars, online classes, meetings, training courses, and other forms of instruction. In order to get a full picture of what continuing education units are available, visit the AAPC's Continuing Education Unit (CEU) page here: www.aapc.com/medical-coding-education/help/index.aspx

REVIEW QUIZ

You can find the Section 1 Review Quiz on our website at: www.medicalbillingandcodingcertification.com

Feel free to rewatch any course videos and look at our downloadable materials for extra information.

LEARN MORE ABOUT MEDICAL CODING

Medical coding is a little bit like translation. Coders take medical reports from doctors, which may include a patient's condition, the doctor's diagnosis, a prescription, and whatever procedures the doctor or healthcare provider performed on the patient, and turn that into a set of codes, which make up a crucial part of the medical claim.

WHY WE CODE

Let's start with a simple question about medical coding: Why do we code medical reports? Wouldn't it be enough to list the symptoms, diagnoses, and procedures, send them to an insurance company, and wait to hear which services will be reimbursed?

MEDICAL CODING EXAMPLE

To answer that, we have to look at the massive amount of data that every patient visit entails. If you go into the doctor with a sore throat, (as a patient did in the example in *Working in Medical Billing and Coding* in Section 1,) and present the doctor with symptoms like a fever, sore throat, and enlarged lymph nodes, these will be recorded, along with the procedures the doctor performs and the medicine the doctor prescribes.

In a straightforward case like this, the doctor will only officially report his diagnosis, but that still means the portion of that report that will be coded contains a diagnosis, a procedure, and a prescription.

Take a step back, and this is suddenly a lot of very specific information. And that's just for a relatively simple doctor's visit. What happens when a patient comes into the doctor with a complicated injury or sickness, like an ocular impairment related to their Type-2 diabetes? As injuries, conditions, and illnesses get more complex, the amount of data that needs to be conveyed to insurance companies increases significantly.

Simply put, the volume of information is too great. According to the Centers for Disease Control (CDC), there were over 1.2 billion patient visits in the past year. That's a stat that includes visits to physician offices, hospital outpatient facilities and emergency rooms. If there were just five pieces of coded information per visit, which is an almost unrealistically low estimate, that'd be 6 billion individual piece of information that needs to be transferred every year. In a system loaded with data, medical coding allows for the efficient transfer of huge amounts of information.

Coding also allows for uniform documentation between medical facilities. The code for streptococcal sore throat is the same in Arkansas as it is in Hawaii. Having uniform data allows for efficient research and analysis, which government and health agencies use to track health trends much more efficiently. If the CDC, for example, wants to analyze the prevalence of viral pneumonia, they can search for the number of recent pneumonia diagnoses by looking for the ICD-9-CM code 480.

Finally, coding allows administrations to look at the prevalence and effectiveness of treatment in their facility. This is especially important to large medical facilities like hospitals. Like government agencies tracking, say, the incidence of a certain disease, medical facilities can track the efficiency of their practice by analyzing

As you can see, medical coding simplifies the business of health considerably. Now that we understand the importance of this practice, let's take a look at the three types of code that you'll have to become familiar with as a medical coder.

THREE TYPES OF CODES YOU'LL HAVE TO KNOW ICD

There are three sets of code you'll use on a daily basis as a medical coder.

The first of these is the International Classification of Diseases, or ICD codes. We'll cover ICD codes and how to use them in a little more depth in the courses *ICD-9 & ICD-9-CM* through *Using ICD-10-CM* in Section 2.

These are diagnostic codes that create a uniform vocabulary for describing the causes of injury, illness and death. This code set was established by the World Health Organization in the late 1940s. It's been updated several times in the 60-plus years since its inception. The number following "ICD" represents which revision of the code is in use.

CLINICAL MODIFICATION

For example, the code that's currently in use in the United States is ICD-9-CM. This means it's the ninth revision of the ICD code. That "-CM" at the end stands for "clinical modification." So the technical name for this code is the International Classification of Diseases, Ninth Revision, Clinical Modification. The clinical modification is a set of revisions put in place by the National Center for Health Statistics (NCHS), which is a division of the Center for Medicare and Medicaid Studies (CMS).

The Clinical Modification significantly increases the number of codes for diagnoses. This increased scope gives coders much more flexibility and specificity, which is essential for the profession. To give you an idea of how important the clinical modification is, the ICD-10 code, (which we will discuss more thoroughly in the course *ICD-10-CM* in Section 2,) has 14,000 codes. Its clinical modification, ICD-10-CM, contains over 68,000.

ICD codes are used to represent a doctor's diagnosis and the patient's condition. In the billing process, these codes are used to determine medical necessity. Coders must make sure the procedure they are billing for makes sense with the diagnosis given. To return to our strep throat example, if a coder listed a strep throat diagnosis as the medical justification for an x-ray, that claim would likely be rejected.

ICD codes are updated by the NCHS on a regular basis. One of the biggest issues in coding—and, indeed, in the health information business at large—is the upcoming switchover from ICD-9-CM to ICD-10-CM. We'll cover this in upcoming courses, but the quick summary is that ICD-9-CM has reached its capacity of use as a coding system. ICD-10-CM provides significantly more codes and thus more flexibility and accuracy in the coding process. The entire medical system

is set to change over from ICD-9-CM to ICD-10-CM in October of 2014. For a more detailed explanation of the reasons behind this switch, and how it is being implemented, please refer to the courses *ICD-10-CM* and *HCPCS Codes* in Section 2.

Let's turn our attention now to the two types of procedure codes.

THREE TYPES OF CODES YOU'LL HAVE TO KNOW CPT

Current Procedure Terminology, or CPT, codes, are used to document the majority of the medical procedures performed in a physician's office. This code set is published and maintained by the American Medical Association (AMA). These codes are copyrighted by the AMA and are updated annually.

CPT CATEGORY I

CPT codes are five-digit numeric codes that are divided into three categories. The first category is used most often, and it is divided into six ranges. These ranges correspond to six major medical fields: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine.

CPT CATEGORY II

The second category of CPT codes corresponds to performance measurement and, in some cases, laboratory or radiology test results. These five-digit, alphanumeric codes are typically added to the end of a Category I CPT code with a hyphen.

Category II codes are optional, and may not be used in the place of Category I codes. These codes are useful for other physicians and health professionals, and the AMA anticipates that Category II codes will reduce the administrative burden on physicians' offices by providing them with more, and more accurate, information, specifically related to the performance of health professionals and health facilities.

CPT CATEGORY III

The third category of CPT codes corresponds to emerging medical technology.

For a more in-depth discussion of these categories and the ranges within the first category, please refer to the courses *Intro to CPT*, *Using CPT*, and *CPT Modifiers* in Section 2.

As a coder, you'll spend the vast majority of your time with the first two categories, though the first will undoubtedly be more common. There is a specific code for almost every conceivable medical procedure or service.

CPT MODIFIERS

CPT codes also have addendums that increase the specificity and accuracy of the code used. Since many medical procedures require a finer level of detail than the basic Category I CPT code offers, the AMA has developed a set of CPT modifiers. These are two-digit numeric or alphanumeric codes that are added to the end of the Category I CPT code. CPT modifiers provide important additional information to the procedure code. For instance, there is a CPT modifier that describes which side of the body a procedure is performed on, and there's also a code for a discontinued procedure.

We'll get into finer detail with CPT modifiers in Course *Using CPT* in Section 2.

THREE TYPES OF CODES YOU'LL HAVE TO KNOW HCPCS

Healthcare Common Procedure Coding System (HCPCS), commonly pronounced as “hick picks,” are a set of codes based on CPT codes. Developed by the CMS (the same organization that developed CPT), and maintained by the AMA, HCPCS codes primarily correspond to services, procedures, and equipment not covered by CPT codes. This includes durable medical equipment, prosthetics, ambulance rides, and certain drugs and medicines.

HCPCS is also the official code set for outpatient hospital care, chemotherapy drugs, Medicaid, and Medicare, among other services. Since HCPCS codes are involved in Medicaid and Medicare, it's one of the most important code a medical coder can use.

HCPCS LEVEL I

The HCPCS code set is divided into two levels. The first of these levels is identical to the CPT codes that we covered earlier.

HCPCS LEVEL II

Level II is a set of alphanumeric codes that is divided into 17 sections, each based on an area of specificity, like Medical and Laboratory or Rehabilitative Services. We'll discuss these sections of codes, and HCPCS in general, more thoroughly in *Human Anatomy and Medical Terminology* in Section 2.

Like CPT codes, each HCPCS code should correspond with a diagnostic code that justifies the medical procedure. It's the coders responsibility to make sure whatever outpatient procedure is detailed in the doctor's report makes sense with the listed diagnosis, typically described via an ICD code.

Now that you've got a better idea of what each of these codes is and what they do, let's start exploring each code set in a little more detail.

MEDICAL CODING VOCABULARY AND KEY TERMS

The world of medical coding features a broad dictionary of important terms. Beyond simple anatomy and medical terminology, which we'll cover in the course *Human Anatomy and Medical Terminology* in section 2, there are a number of important terms you'll want to familiarize yourself with as you learn more about coding. Let's look at some of these now.

Anesthesia (CPT): The section of the CPT code set that contains codes for anesthesia. These codes fall into the range of 00100 to 01999, and are subdivided by both the area of the body that is anesthetized and by the type of procedure being performed. There are, for example, a cluster of codes for anesthesia of the shoulder and axilla, and there are also anesthesia codes for radiological procedures.

Category (CPT): The CPT code set is divided into three Categories. Category I, which is the largest and most commonly used, describes medical procedures, technologies and services. Category II is used for performance management and additional data. Category III houses the codes for emerging and experimental medical procedures and services.

Category (ICD): In ICD, the category is the first three characters of the code, which describes the basic manifestation of the injury or sickness. In some cases, the category is all that is needed to accurately describe the condition of the patient, but more often than not the coder must list a more detailed description of the injury or illness (see "Subcategory," and "Subclassification"). In ICD-9-CM, categories are three numbers, except in the case of E- and V-codes, which are alphanumeric. In ICD-10-CM, all categories are alphanumeric.

Clinical Modification: This designation, created by the National Center for Health Statistics, is added to the ICD codes sets when they are implemented in the United States. Many countries expand and clarify ICD code sets for their national use; the US, for example, expanded ICD-10 from 14,000 codes to over 68,000 individual codes. This term is abbreviated "-CM" and is added to the end of the ICD code title. For instance, ICD-9-CM can be read "International Classification of Diseases, Ninth Revision, Clinical Modification."

CMS: The Center for Medicare and Medicaid Services. This federal agency updates and maintains the HCPCS code set and is one of the most important organizations in healthcare today.

CPT: Current Procedural Terminology. Published, copyrighted, and maintained by the American Medical Association, CPT is a large set of codes that describe what procedure or service was performed on a patient. This code is divided into three Categories, with the first Category being the most important and widely used. CPT codes are an integral part of the reimbursement process. These codes are five characters long and may be numeric or alphanumeric.

HCPCS: Healthcare Common Procedure Coding System, pronounced hick-picks. This is main procedural code set for reporting procedures to Medicare, Medicaid, and a large number of other third-party payers. Maintained by CMS (See “CMS”), HCPCS is divided into two levels. Level I is identical to CPT, and is used in the same way. Level II describes the equipment, medication, and out-patient services not included in CPT.

E-codes: E-codes are a set of ICD-9-CM codes that includes codes for external causes of injury, such as auto accidents, poisoning, and homicide.

Evaluation and Management (CPT): Evaluation and Management, or E&M, is a section of CPT codes used to describe the assessment of a patient’s health and the management of their care. The codes for visits to doctor’s office and trips to the emergency room, for instance, are included in E&M. E&M is found at the front of the CPT manual, despite being out of numerical order. The codes for E&M are 99201 – 99499.

ICD: The International Classification of Diseases is a set of medical diagnostic codes established over a hundred years ago. Maintained today by the WHO (See “WHO”), ICD codes create a universal language for reporting diseases and injury. In the United States, we use ICD-9-CM (See “Clinical Modification”), while the rest of the world uses some form of ICD-10. The US is slated to upgrade to ICD-10-CM in 2014. ICD codes are numeric or alphanumeric. They have a three-character category (See “Category (ICD)”), which describes the injury or disease, which is typically followed by a decimal point and two-to-four more characters, depending on the code set, which give more information about the manifestation and/or location of the disease.

Medical Necessity: Medical necessity is the justification of medical services as reasonable, necessary, or appropriate. Medical necessity is often “proven” using ICD codes. A coder would use the ICD code for a broken arm, for example, to demonstrate the medical necessity of an X-ray and the application of a cast.

Medicine (CPT): The final section of the first Category of CPT. This range of codes describes procedures directly related to the application of medication, medical procedures, and medical equipment to the patient. This section does not include basic patient evaluations or surgical procedures, which have their own sections (See “Evaluation and Management” and “Surgery”). The codes for Medicine are 90281 – 99199 and 99500-99607.

Modifier: A modifier is a two-character code that is added to a procedure code to demonstrate an important variation that does not, by itself, change the definition of the procedure. CPT codes have numeric modifiers, while HCPCS codes have alphanumeric modifiers. These are added at the end of a code with a hyphen, and may provide information about the procedure itself, that’s procedure’s Medicare eligibility, and a host of other important facets. The CPT modifier -51, for example, notifies the payer that this procedure was one of multiple procedures. The HCPCS modifier -LT, on the other hand, describes a bilateral procedure that was performed only on the left side of the body.

Modifier Exempt (CPT): Certain codes in CPT cannot have modifiers added to them. This is a fairly short list that can be found in the appendices of the CPT manual.

Morbidity: The rate or incidence of disease in a patient or a population. ICD codes are used to report morbidity.

Mortality: The rate or incidence of death in a patient or population.

NCHS: The National Center for Health Statistics. The NCHS is a government agency that tracks health information, and is responsible for creating and publishing both the clinical modifications to ICD codes (See “Clinical Modification”) and their annual updates.

Pathology: The science of the causes and effects of disease.

Pathology and Laboratory (CPT): The section of Category I CPT codes that pertains to laboratory testing and pathological investigations. This section includes codes for procedures used to determine the status and root cause of a patient’s illness or condition. The codes for Pathology and Laboratory are 80047-89398.

Professional Component: In CPT, a professional component refers to the services performed by a fully licensed medical professional. This is important for the reimbursement process, and is usually noted with the inclusion of modifier -26 after a procedure code (See “Modifier”). Professional services include the evaluation of a radiologic test, but not the administration of the test, which is a technical component (See “Technical component”).

Radiology (CPT): The section of the CPT manual that covers radiologic tests and procedures like X-rays, ultrasounds, and oncology. The codes for Radiology are 70010-79999.

Sequela: A condition that is the result of a previous injury or condition. You will encounter this term in ICD-10-CM in the code’s subclassifications (See “Subclassifications”).

Subcategory: In ICD codes, the subcategory describes the digit that comes after the decimal point. This digit further describes the nature of the illness or injury, and gives additional information as to its location or manifestation.

Subclassification: The subclassification follows the subcategory (See “Subcategory”) in ICD codes. The subclassification further expands on the subcategory, and gives additional information about the manifestation, severity, or location of the injury or disease. In ICD-10-CM there is also a subclassification that describes which encounter this is for the doctor—whether this is a first treatment for the ailment, a follow-up, or the assessment of a condition that is the result of a previous injury or disease (See “Sequela”). There is one subclassification character in ICD-9-CM; in ICD-10-CM there may be as many as three.

Surgery (CPT): The section of the CPT manual that covers surgical procedures

performed on patients. The largest and most complicated section of CPT's first Category, the Surgery section is divided into sections based on which part of the body the surgery is performed on, and then further subdivided based on what type of procedure is being performed. For instance, there is a section for excisions of the hand and fingers, which is itself part of the larger section of surgical procedures performed on the musculoskeletal system. The codes for Surgery are 10021 – 69990.

Technical Component: The portion of a medical procedure that concerns only the technical aspect of the procedure, but not the interpretative, or professional aspect (See "Professional component"). A technical component might include the administration of a chest X-ray, but would not include the assessment of that X-ray for disease or abnormality.

V-codes: V-codes are a special section of ICD-9-CM that describe patient visits related to circumstances other than disease or injury. This includes live-born infants, people with risk or disease due to family history, people encountering health services for specific or mandated evaluation or aftercare, and a host of other not easily classifiable situations. V-codes have been replaced in ICD-10-CM by Z-codes (See "Z-codes").

WHO: The World Health Organization. This international body, which is an agency of the United Nations, oversees the creation of ICD codes and is one of the most important organizations in international health.

Z-codes: Much like V-codes in ICD-9-CM (See "V-codes"), these codes describe circumstances outside of injury or disease that cause a patient to visit a health professional. This may include a patient visiting a doctor because of family medical history.

ICD-9 & ICD-9-CM CODES

ICD-9-CM codes are still the main way of coding providers' diagnoses in the United States. In this course, we'll teach you what an ICD-9-CM code is, what it looks like, and how the ICD-9-CM code manual is organized.

HISTORY/ HOW IT IS USED

This code was initially intended for epidemiological purposes, but has since become an integral part of the reimbursement cycle. While ICD codes are still used to track the incidence and spread of diseases and injury, their most important facet today is demonstrating medical necessity in claims. In other words, ICD codes explain to the insurance payer why the doctor performed a certain procedure.

The code that's currently in use in the United States is the Ninth Revision, Clinical Modification, or ICD-9-CM. ICD-9, the code set on which ICD-9-CM is based, was published in 1978. It was adapted for use in the United States in the same year. Note that ICD-9-CM is used only in the United States.

Initially ICD codes were to be updated every ten years, although the difficulty in updating these code sets in a timely manner led officials at the WHO to push this deadline back somewhat. Even with a more expanded revision schedule, the United States is far behind the rest of the world when it comes to ICD codes.

This outdated code set is problematic for coders and the healthcare industry at large, but the difficulty in overhauling the system to use the next code set, ICD-10-CM, is large enough that the United States has delayed it by over a decade. Canada, for example, has been using a version of ICD-10, the next revision of ICD, since 2000. We'll cover the transition from ICD-9-CM to ICD-10-CM, and the reasons for this transfer, in the courses *ICD-10-CM* and *Crosswalking*, both in Section 2.

WHAT IT LOOKS LIKE

When using ICD-9-CM codes, it's imperative to code to the highest level of specificity. That's an important phrase that you'll probably hear over and over again during this course, and it means that you should always get down to the finest grain of detail. But what does that mean for ICD-9-CM codes? The answer lies in the makeup of the codes themselves.

CODE BREAKDOWN

ICD-9-CM codes are three-to-five digit numeric and, in certain cases, alphanumeric codes. The first three digits in a code are called the "category." The category describes the general illness, injury, or condition of the patient. In many cases, the category is not specific enough to describe the full extent of the patient's condition. Take dementia, for example. The basic ICD-9-CM code for dementia is 290. These first three numbers are the category, but since dementia is such a complicated condition, you would almost never stop coding at this level.

In cases where more specificity is needed, a decimal point is added after the category and one or two more digits are added. The fourth digit of the ICD-9 code is called the "subcategory," and the fifth digit is called the "subclassification."

The subcategory describes the etiology (cause), site, or manifestation of the disease or condition. The subdivision provides even more information about the site, cause or manifestation of a disease, and is used only when the subcategory cannot provide sufficient information.

Here's the framework:

CODE TREE EXAMPLE

123 - {Disease}
 (*Category- First three digits)
 123.0 - {Disease} in Chest
 (*Subcategory -The digit after the decimal.
 It relates an important designation about the disease.)
 123.00 -... uncomplicated
 123.01 - ... with complications in cardiac system
 123.02 - ... with complications in digestive system
 (*Subclassification-Last digit. This gives even more info
 about the designation outlined in the subcategory.)
 123.0 - Disease in legs
 And so on...

If we were to select 123.02 as our code, we'd read the full code as "Disease in chest, with complications in the digestive system."

CODING DEMENTIA EXAMPLE

Now that we've got a loose idea of what the code "trees" look like, let's return to our dementia example. The doctor's report states our patient suffers from dementia and depression brought on by a series of strokes. Our patient is about 35, so not an elderly person. That's an important distinction, as dementia is a condition that frequently occurs in patients over 65 years of age.

To code this accurately, we'd look at the category 290, for dementia, and then look at the various subcategories available listed below the category and rule out the codes for senile or presenile dementia, which removes codes 290.0, 290.1, 290.2, and 290.3. 290.4, however, is the code for vascular dementia, which is dementia brought on by reduced blood flow to the brain. That's the code we're looking for.

But our imperative to code to the highest level of specificity prevents us from stopping there. If you look at the subdivisions of 290.4, you'll find four additional digits, each corresponding to an aspect of our patient's condition. If the patient's vascular dementia is uncomplicated, you would add the subdivision '0' after 290.4, creating 290.40, for "vascular dementia, uncomplicated."

If, however, the patient suffers from delusions in addition to their dementia, we'd code their condition as 290.42—vascular dementia with delusions. Let's look at the code now. We've bolded the category, subcategory, and subclassification we used in this example.

DEMENTIA CODE TREE

```

290 – Dementias
  290.0 – Senile dementia, uncomplicated
  290.1 – Presenile dementia
  290.2 – Senile dementia with delusional or depressive features
  290.3 – Senile dementia with depressive features
  290.4 – Vascular dementia
    290.40 - ... uncomplicated
    290.41 - ... with delirium
    290.42 - ... with delusions
    290.43 - ... with depressed mood
  
```

As you may be able to tell from the example above, many ICD-9-CM codes branch down into more and more specific levels. If a category has a number of subcategories, these subcategories are indented below the main category. The subclassifications specific to each subcategory are then indented below their respective subcategory.

Most ICD-9-CM codes also make use of guidelines, or conventions, which help guide the coder to the correct code for the diagnosis. These conventions may be punctuation or verbal instructions.

CONDITION & MANIFESTATION DEFINITION

Remember the difference between a “condition”—the state of the disease—and the “manifestation”—how the disease shows up. This is an important distinction in ICD-9-CM, as many symptoms or diseases are actually manifestations of an underlying condition. The condition of diabetes, for instance, has a number of different manifestations. Check out the table on Conventions in ICD-9-CM codes in the ebook.

CONVENTIONS IN ICD-9-CM

CONVENTIONS	MEANING
Brackets []	Enclose synonyms, alternative wordings, or explanatory phrases. Also used to identify manifestation codes.
Parentheses ()	Enclose supplementary words, whether absent or present, that nonetheless do not affect the code of the disease.
“Excludes”	Terms, conditions, or manifestations listed under an “Excludes” are coded elsewhere. In some cases, these “excluded” terms may not be coded with the code they are listed under.
“Includes”	Comes immediately after the three-digit code. Further defines or gives examples of the term listed in the category.
“See”	Indicates that another term or code should be referenced instead of the listed code.
“See Also”	Indicates that another term or code may prove useful in the coding process. Unlike “See,” “See Also” is not mandatory.
“Code First”	Indicates that the coder should list a particular code first. This typically happens with an underlying condition that has multiple manifestations, like diabetes. In situations like this, the underlying conditions is coded first, and then the manifestation is coded. “Code first” codes typically appear in the manifestation codes.
“Use Additional Code”	This phrase usually appears under the condition code (again, we’ll use diabetes), and informs the coder that other codes for manifestations are available.

CONVENTIONS IN ICD-9-CM CONTINUED ON NEXT PAGE

CONVENTIONS IN ICD-9-CM

CONVENTIONS	MEANING
“In Diseases Elsewhere Classified”	This note is attached exclusively to manifestation codes. It means that this manifestation is directly related to an underlying condition. A code with this note attached to it can never be used as the primary code (it could never have a “code first” note).
“Not Elsewhere Classified”	Abbreviated as “NEC,” you may find this attached to a disease or condition that is not classified in the code manual. Think of this as an unspecified code. An example of this might be category 995: “Certain adverse effects not elsewhere classified,” which includes “anaphylactic reaction due to unspecified food” and other catch-all terms.
“Not Otherwise Specified”	Abbreviated as “NOS,” you’d turn to this in cases where the doctor or reporting physician has not provided

As you can see from the abbreviations NEC and NOS, the ICD-9-CM code set takes into account its limitations. There are a number of unlisted or nonspecific codes for diagnoses that don’t ‘fit’ exactly with the medical report. Coders use these as a last resort when they can’t find the exact code they’re looking for. This is something we’ll return to in the course *ICD-10-CM* when we talk about the updated ICD code set, which is set to replace ICD-9-CM in 2014.

HOW IT IS ORGANIZED

Now that we know a little bit more about ICD-9-CM, let’s look at how the code set is organized. ICD-9-CM is divided into three volumes, but coders generally use the first two.

HOW IT IS ORGANIZED

FIRST SECTION:
TABULAR VOLUME

The first volume is the tabular volume, which lists disease descriptions and their corresponding codes. This section is divided into 17 chapters with two alphanumeric additions, called E-codes and V-codes. Each of these chapters contains a certain field of disease, and is confined to a certain numerical range.

The seventeen chapters, the diseases or maladies they cover, and their respective ranges, are listed in the table below. The numbers listed in the “Numerical Range” column are the categories for the ICD-9-CM codes. Bear in mind as well that the term “Chapter” is more of an official, organizational designation. You’ll usually find codes by their numerical range, and you won’t necessarily refer to a code as a “Chapter 1 code,” so much as a “code for infectious and parasitic disease.”

ICD-9-CM CHAPTERS

CHAPTER	TOPIC	RANGE
1	Infectious and parasitic diseases	001-139
2	Neoplasms	140-239
3	Endocrine, nutritional and metabolic diseases, and immunity disorders	240-279
4	Diseases of the blood and blood-forming organs	280-289
5	Mental disorders	290-319
6	Diseases of the nervous system	320-359
7	Diseases of the sense organs	360-389
8	Diseases of the circulatory system	390-459
9	Diseases of the respiratory system	460-519
10	Diseases of the digestive system	520-579
11	Diseases of the genitourinary system	580-629
12	Complications of pregnancy, childbirth, and puerperium	630-679
13	Diseases of the skin and subcutaneous tissue	680-709
14	Diseases of the musculoskeletal system and connective tissue	710-739
15	Congenital anomalies	740-759
16	Certain conditions originating in the perinatal period	760-779
17	Injury and poisoning	800-999
E-Codes	External causes of injury	e800-e999
V-Codes	Supplementary classification of factors influencing health status and contact with health services	v01-v91

For the most part, these divisions are relatively self-explanatory. If you were trying to code measles, for example, you'd look at the section of codes corresponding to "diseases of the skin and subcutaneous tissue," in the chapter for "Diseases of the skin and subcutaneous tissue" (Chapter 13 in table). Likewise, if you were going to code a diagnosis of hypertension, you'd look in the section for cardiovascular diseases.

E-CODES VS. INJURY CODES

E-codes and V-codes are where it gets slightly more complicated. Note that codes 800-999 correspond to injury and poisoning, while the E-codes correspond to "external causes of injury." This might seem redundant, but injury codes actually correspond to the specific type and location of injury, as opposed to the external cause of the injury. One example of an injury code is 800.01—a "closed fracture of the vault of the skull with no loss of consciousness."

In injury codes, subcategories and subclassifications are very important. A phrase like "fracture of the vault of the skull" doesn't tell us the whole story about the diagnosis. For instance, what kind of fracture is it? Is it open or closed? Did the patient suffer any brain-related injuries? Internal bleeding? Did the patient lose consciousness? The subcategories and subclassifications provide all of this important additional information.

So, injury codes describe the injury itself. E-codes, on the other hand, describe the cause of the injury. E-codes can be important for insurance purposes, and they're also extremely useful when coding for trauma centers and emergency rooms. The cause of an injury, whether it's an automobile accident, a gunshot, or a fall from a ladder, can inform the billing process and help doctors get a better picture of what happened to the patient. Some E-codes include e893, "accident caused by ignition of clothing" and e813, "motor vehicle accident involving collision with other vehicle."

There are hundreds of E-codes, each attached to seemingly every type of injury. E-codes also utilize subcategories and subclassifications to get to the highest level of specificity.

V-CODES

V-codes describe reasons that people might visit a healthcare provider outside of immediate injury or disease. There are V-codes for childbirth, screenings for hereditary diseases or congenital abnormalities, or persons at risk from exposure to communicable diseases. In other words, if there is a reason a person in good health visits a healthcare provider, you can use a V-code.

HOW IT IS ORGANIZED

SECOND SECTION: ALPHABETIC INDEX

The next volume of the ICD code manual is the alphabetic index. Coders use this index to locate codes in the tabular section. You can use the alphabetic index like you would any index. Simply search for a general term and the index will point you to any of the applicable codes.

For instance, if you look up "Leakage" in the alphabetic index, you'll find a number of items that relate to leakage, including "leakage of amniotic fluid (code: 658.1)," "leakage of amniotic fluid with delayed delivery (658.2)," and "leakage of amniotic fluid affecting fetus or newborn (761.1)." The "leakage" entry also points to codes for leakage of urine, blood, and bile.

The index also redirects coders to more accurate sections of the code set. For instance, in the leakage example above, there is an entry for “leakage: device, implant, or graft.” Instead of providing a code, the index redirects us to “Complications, mechanical.” We can then turn in the index to “Complications,” find the subsection on “mechanical,” and see where the correct code is.

This index is especially helpful if you don’t know the medical term for the condition or illness you’re coding. For instance, there’s an index entry for “cocked-up toe” (known medically as hallux rigidus). You won’t find anything that colloquial in the tabular section.

Essentially, the alphabetic index gives us directions around the tabular volume. It’s important to code from the tabular section, however. We use the alphabetic index in order to track down codes, but we always confirm in the tabular section.

The third and final section of the ICD-9-CM manual consists of procedure codes used by hospitals to report services and procedures performed in their facilities. We will not be covering this volume in depth in this course, as physicians and coding professionals do not use it to report codes.

Now that we’re familiar with what an ICD-9-CM code looks like and how it’s organized in the code manual, it’s time to look closer at how to use these codes. In the next course, we’ll show you how to use ICD-9-CM and give you more examples of the code in action. In the sections following that, we’ll talk about the new ICD code set, ICD-10-CM, that is set to replace ICD-9-CM.

HOW IT IS ORGANIZED
THIRD SECTION:
ALPHABETIC & TABULAR
INDEX OF PROCEDURES
USED BY HOSPITALS

USING ICD-9-CM

By now you know what ICD-9-CM is used for, what it looks like, and how it's organized. It's time to look at some more practical examples of this important code at work.

The coding process actually begins with the medical report. The medical report provides the coder with an immense amount of information, including the patient's demographic info, their medical history, the patient's present symptoms, the doctor's diagnosis, the procedures performed by the doctor to ascertain or confirm the diagnosis, and the prescriptions or treatments, if any, recommended by the doctor. The medical report is the full documentation of the patient's visit.

All of medical coding is derived from this important document. For the sake of simplicity, we're going to focus only on the symptoms and diagnosis portion of the report, but we'll return to this in our courses on procedure coding.

A quick note as we get started. Remember that, as coders, we always want to code to the highest level of specificity. That means reading the report carefully, taking notes, abstracting the information, looking up the code, paying attention to all of the conventions for the code, and double-checking your work. Let's begin.

THE CODING PROCESS

After reading over the medical report, a coder will take notes and abstract the information in the report. Most physicians or providers will list the patient's symptoms and then give their diagnosis in a straightforward, direct manner.

MEDICAL CODING EXAMPLE

Let's look at a quick, simplified example of a medical report.

Patient is 28-year-old Caucasian male. Self-reported height and weight 1.85m and 85 kg. Smoker. History of asthma and breathing problems as a child, though none recently.

Patient presents with hacking cough, difficulty breathing, production of mucus, fever. Suspected diagnosis of acute bronchitis. Pulmonary function test performed with spirometer. Diagnosis confirmed.

Prescribed bed rest and low dose of anti-inflammatory drugs (Prednisone) to patient.

There's a lot information here! There's the patient's height, some of his medical history, his symptoms, the procedure the doctor performed, the prescription and more. Since, however, we're looking at diagnosis codes, we have to winnow down what we're looking for.

In the case of a positive diagnosis, we don't code any symptoms. That means the only diagnostic code we're using is the one for acute bronchitis (466.0). That means you won't code for fever, hacking cough, or mucus production. You only

code for symptoms when a healthcare provider is unable to make a clear, definitive diagnosis.

You might look at the report and also see “history of asthma and breathing problems,” but since those conditions did not directly affect the patient’s visit this time, we don’t always have to code them.

ICD-9-CM CONVENTIONS

Now’s a good time to step back and take another look at some of the guidelines and rules of using ICD-9-CM.

In the previous course, we talked a little about the format of the code set and its guidelines for use. To recall, the guidelines, or conventions, include:

Brackets []	“See Also”
Parentheses ()	“Code First”
“Excludes”	“Use Additional Code”
“Includes”	“In Diseases Elsewhere Classified”
“See”	

You can think of these guidelines and additional bits of information as instructions for the code. They are typically listed below the code and tell the coder whether the code they are looking at is the right one. See the previous course for a full list of what these codes mean.

CONVENTIONS EXAMPLE

Let’s return to our bronchitis example. If we look in the ICD-9-CM manual, we’d see the code we’re looking for, 466.0. Below that, we’d also see an “Excludes” note. Under that note, you’d find the phrase “acute bronchitis with chronic obstructive pulmonary disease (491.22).”

Likewise, you’d also find an Includes note below the acute bronchitis code, which would include the following information:

Applies to:

- Bronchitis, acute or subacute
 - Fibrinous
 - Membranous
 - Pneumococcal
 - Purulent
 - Septic
 - Viral
 - With tracheitis
- Croupous bronchitis
- Tracheobronchitis, acute

These notes perform two functions. One, if you were trying code acute bronchitis with chronic obstructive pulmonary disease, and flipped to just acute bronchitis, you’d know to look elsewhere. This might seem like a minor distinction, but this can make a huge difference on an insurance claim. So, the “Excludes” note gives you a warning about what not to use.

Similarly, the “Includes” note confirms the coder’s success. By looking at the “Includes” note, a coder can double-check that the code they’re looking at is the correct one. If, however, the term you’re looking for isn’t in the “Includes” section, you may have to double back and look for a different code.

Before we go any further, we should reiterate that the following and all medical report examples listed in these courses are simplified for the ease of understanding. Many lab reports, for example, take days to complete, and medical reports for conditions as severe as kidney disease are often longer and significantly more complicated.

DISCLAIMER

In other words, don’t expect medical reports to be this cut-and-dry.

With that warning out of the way, let’s look at this example, this time focusing on manifestations and conditions. Here’s the (again simplified) medical report.

MANIFESTATION VS. CONDITION EXAMPLE

Patient is a 62-year-old African American female. Self-reported height and weight 1.65m and 75kg. has had diabetes mellitus type ii for 6 years. On a program of Metformin with insulin injections.

Patient presents with nausea, foaming/frothy urine, headache, and fatigue. Suspected diagnosis of some diabetic nephropathy (kidney disease). Tested for heightened protein in urine via microalbuminuria test. Test results positive. Performed retinopathy, which confirmed diagnosis of Kimmelstiel-Wilson syndrome (kidney disease). Discontinued program of Metformin and prescribed program of perindopril. Dialysis distinct possibility in future.

We’re looking for the doctor’s diagnosis, which is listed as Kimmelstiel-Wilson syndrome, a chronic kidney disease.

We’ll start in the alphabetic index. If we turn to the ‘K’ section and find Kimmelstiel-Wilson syndrome, that sends us to code 581.81, for “Nephrotic syndrome in diseases classified elsewhere.” That “diseases classified elsewhere” should be an immediate tip-off: that’s the phrase that’s used to describe a manifestation code, meaning it’s a manifestation of another condition.

Below code 581.81, we’d find the note “Code First.” Below that note, we’d see a number of underlying diseases, including amyloidosis, diabetes mellitus, malaria, and a few other conditions.

If you’ll recall from the last course, the “Code First” convention instructs coders to code the underlying condition before the manifestation of the disease. In this example, the Kimmelstiel-Wilson syndrome is how the patient’s diabetes manifests. In other words, the type II diabetes mellitus is the condition, and the Kimmelstiel-Wilson syndrome is the manifestation.

So now we’d look at diabetes mellitus. When we turn to the code (250), we see a number of subcategories that correspond to several types of manifestations. We’d look through and find 250.4, for “diabetes mellitus with renal complications.” Since we’re coding a diagnosis that deals with kidney disease, this is the correct code to use.

DIABETES MELLITUS CODE TREE

We'd also code down to the subclassification (remember that we have to code to the highest level of available specificity!). Let's take a look at the code tree below. We've once again bolded the correct category, subcategory, and subclassification.

```

250 Diabetes Mellitus
  250.0 Diabetes mellitus without complications
  ...
  250.4 Diabetes mellitus with renal manifestations
    250.40 – type II or unspecified type, not stated as uncontrolled
    250.41 – type I [juvenile type], not stated as uncontrolled
    250.42 – type II or unspecified type, uncontrolled
    250.43 – type I [juvenile type], uncontrolled
  
```

Because the patient is on a medical regimen (from the medical report: “patient... on a program of Metformin”), we would say their diabetes is “not stated as uncontrolled.”

So, we'd code this underlying condition first, and then we'd code for the manifestation: 581.81, “nephritic syndrome in diseases classified elsewhere.” Essentially, what this says is that the patient has a kidney disease that is the direct result of their type II diabetes mellitus.

OTHER STEPS

In certain cases, you may find something missing from a medical report. This could be a procedure, or it could be an incomplete diagnosis. (Recall that, in cases where a doctor can't come to a positive diagnosis, a coder may code the patient's symptoms). If a the listed diagnosis does not match up with the procedure or procedures performed, it's up to the coder to contact the provider to clarify the report. This can be especially difficult in medical reports on large, complicated procedures. There may also be multiple diagnoses listed in a medical report. A coder has to list every diagnosis (or set of symptoms) that's directly related to a procedure performed by the provider.

Remember, ICD codes are used to demonstrate medical necessity in insurance claims. They justify the processes performed by the doctor. If you read a report and a certain procedure is not justified by a doctor's diagnosis, you must contact the doctor to get clarification.

The final step of the coding process is the submission of codes. In the past, this was done via paper forms, but today almost all medical codes are submitted via a software system like Epic. We'll cover this a bit more in *Electronic vs. Paper Coding* in Section 2. For now, just know that when the coder has fully coded the medical report, they submit these codes to the medical biller (or medical billing agency). The medical biller then uses these codes to make the claim (we'll cover this in Section 3).

Now you know what ICD-9-CM is, and how to use it. In the following two courses, we'll talk about ICD-10-CM, which is due to replace ICD-9-CM in October of 2014. These code sets shares a lot of similarities, but have a few critical differences. We'll walk you through the format, use, and transition between the code sets in just a little bit.

ICD-10-CM

THE CHANGEOVER FROM ICD-9-CM TO ICD-10-CM

In the United States, we've been using the ICD-9-CM code set since the late 1970s. ICD codes are updated every 10 to 15 years, and typically just include expansions to existing code sets. The upgrade from ICD-9 to ICD-10, however, involved a shift in format and organization. Because of this shift in format, and the headaches that go along with reformatting every aspect of medical reporting in the industry, the United States was unwilling to upgrade to ICD-10 when it was initially published in 1999. In the years since, the deadline to upgrade to ICD-10 in the US has been pushed back repeatedly.

As a result of this, the United States' primary code set for representing diagnoses is more than 10 years out of date with the rest of the world. Canada and Australia, for instance, updated to some form of ICD-10 in the early 2000s. The US had originally intended to upgrade to ICD-10 (and its attached Clinical Modification, ICD-10-CM) in October of 2013, but this was pushed back to October 1, 2014. This is considered the "hard" deadline for the upgrade, and coders around the country are hard at work learning the ins and outs of this new, significantly larger code set.

This presents a bit of a challenge for incoming medical coders. The ICD-9-CM set is still in use today, and coders must be able to use it quickly and efficiently. But, the ICD-10-CM upgrade is looming, and coders must also be able to use that code set effectively. Adding to the complications is the fact that for two years after the upgrade, ICD-9-CM codes will still be used in a sort of transitional phase, meaning coders must be able to move between code sets freely.

With that challenge laid out, let's take a look at ICD-10-CM and discover more about this new and important element of health informatics.

THE CODE ITSELF

As we mentioned, ICD-10-CM code is similar to ICD-9-CM in what it does, but distinct in its format and layout. Where ICD-9-CM is five digits and almost entirely numeric, ICD-10-CM is seven characters and entirely alphanumeric.

This is a problem for a number of reasons. For one, the US is no longer "speaking the same language" as the other countries in the world. One of the benefits of the ICD code system is its universality. While each country that adopts ICD codes tends to tweak it in certain ways (like the United States' Clinical Modification), the roots of the codes are still the same. Not so in the US. Since we're still using a five-character, numeric code set, and the rest of the world is using a seven-character, alphanumeric system, it's hard to track

The more pressing need comes from the format of ICD-9-CM itself. To put it simply, ICD-9-CM is out of room. As the field of medicine has grown by leaps and bounds in the years since ICD-9-CM was implemented, the code set has struggled to keep up. There are now too many new diseases, diagnoses, procedures for the code set to keep up.

If we remember our mission of always “coding to the highest level of specificity,” you can see that this is a real problem. As medical practice has developed and diversified, the old ICD-9-CM code set is increasingly incapable of providing the exact right codes. While ICD-9-CM has developed a workaround in the form of “Not Elsewhere Classified” codes and other unlisted codes, it’s not ideal to work with intentionally nonspecific codes.

Enter ICD-10-CM. The code set is significantly larger than ICD-9-CM (there are 13,000 ICD-9 codes and 68,000 ICD-10 codes), and its increased number of subcategories and subclassifications (the digits after the decimal point), allow for a far greater level of specificity in coding. ICD-10-CM is also more flexible, and was designed in such a way that eases the entrance of codes for new, recently discovered, or expanded diagnoses.

LAYOUT AND ORGANIZATION

ICD-10-CM is, as we’ve mentioned, a seven-character, alphanumeric code. Each code begins with a letter. That letter is followed by two numbers. Like ICD-9-CM, the first three characters of ICD-10-CM are the “category.” The category describes the general type of the injury or disease. The category is followed by a decimal point and the subcategory. This is followed by up to two subclassifications, which further explain the cause, manifestation, location, severity, and type of injury or disease. The last character is the extension.

EXTENSIONS

The extension describes the type of encounter this is. That is, if this is the first time a healthcare provider has seen the patient for this condition/injury/disease, it’s listed as the “initial encounter.” Every encounter after the first is listed as a “subsequent encounter.” Patient visits related to the effects of a previous injury or disease are listed with the term “sequela.”

To review: the first digit of an ICD-10-CM code is always an alpha, the second digit is always numeric, and digits three through seven may be alpha or numeric. Here’s a simplified look at ICD-10-CM’s format.

```

A01 – {Disease}
  A01.0 {Disease] of the lungs
    A01.01 ... simple
    A01.02 ... complex
      A01.020 ... affecting the trachea
      A01.021 ... affecting the cardiopulmonary system
        A01.021A ... initial encounter
        A01.021D ... subsequent encounter
        A01.021S ... sequela
  
```

As you can see from the above example, ICD-10-CM branches much farther out than ICD-9-CM. ICD-10-CM allows us to code the location and manifestation of a disease or injury far more accurately, and the extensions reduce the administrative burden by documenting both the diagnosis and whether this injury or illness has been examined before.

Still, ICD-10-CM and ICD-9-CM share more similarities than you might think. Like ICD-9-CM, the ICD-10-CM code manual is divided into three volumes.

ICD-10-CM VOLUME I

Volume I is the tabular index, much like that of ICD-9-CM. Volume II is, again, the alphabetic index. Volume III lists procedure codes that are only used by hospitals. (We won't be covering ICD-10-CM Volume III codes in these courses).

Like the first volume of ICD-9-CM, ICD-10-CM is divided into ranges based on the type of injury or disease they document. ICD-10-CM's division closely follows ICD-9-CM's separation into "chapters." Here's a breakdown of the ICD-10-CM code manual.

ICD-10-CM CODE MANUAL

TOPIC	RANGE
Certain infections and parasitic diseases	A00-B99
Neoplasms	C00-D49
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	D50-D89
Endocrine, nutritional and metabolic diseases	E00-E89
Mental, Behavioral and neurodevelopmental disorders	F01-F99
Diseases of the nervous system	G00-G99
Diseases of the eye and adnexa	H00-H59
Diseases of the ear and mastoid process	H60-H95
Diseases of the circulatory system	I00-I99
Diseases of the respiratory system	J00-J99
Diseases of the digestive system	K00-K95
Diseases of the skin and subcutaneous tissue	L00-L99
Diseases of the musculoskeletal system and connective tissue	M00-M99
Diseases of the genitourinary system	N00-N99
Pregnancy, childbirth, and puerperium	O00- O9A
Certain conditions originating in the perinatal period	P00-P96
Congenital malformations, deformations and chromosomal abnormalities	Q00-Q99
Symptoms, signs, and abnormal clinical laboratory findings, not elsewhere classified	R00-R99
Injury, poisoning, and certain other consequences of external causes	S00-T88
External causes of morbidity	V00-Y99
Factors influencing health status and contact with health services	Z00-Z99

**ICD-9-CM
VS. ICD-10-CM**

You should recognize the majority of these code sections from the chapters in ICD-9-CM. ICD-10-CM has replaced E- and V-codes with their own formal sections (V, Y and Z), and there is some shuffling in the order of the chapters, but for the most part, the sections remain constant.

What's different, as you may imagine, is the levels of detail to which all of these codes can go.

Let's consider a side-by-side example.

ICD-9-CM	ICD-10-CM
Injury: Closed fracture of the distal phalanx of right index finger	Injury: Closed fracture of the distal phalanx of right index finger
Chapter 17 – Injury and Poisoning	S00-T88 - Injury, poisoning and certain other consequences of external causes
810-819 Fracture of Upper limb	S60-S69 – Injuries to the wrist, hand and fingers
816 Fracture of 1+ phalanxes of hand 816.0 Closed fracture of 1+ phalanges of the hand 816.00 ...unspecified 816.01 – closed fracture of middle or proximal 1+ phalanges of hand 816.02 – closed fracture of distal 1+ phalanges of hand	S62 Fracture at wrist and hand level S62.0 Fracture at navicular [scaphoid] bone of wrist ... S62.5 fracture of thumb S62.6 fracture of other and unspecified finger(s) S62.60 fracture of unspecified phalanx of finger S62.61 displaced fracture of proximal phalanx of finger ... S62.63 displaced fracture of distal phalanx of finger S62.630 displaced fracture of distal phalanx of r. index finger S62.630A... initial encounter for closed fracture S62.630B ... initial encounter for open fracture S62.630D ... initial encounter for fracture with routine healing ...

As you can clearly see, ICD-10-CM allows coders to code to a much higher level of specificity. ICD-10-CM introduces laterality—which side the injury or infection is on—and substantially increases the amount of information about the diagnosis. Instead of leaving off at “closed fracture of distal phalanx of hand,” as we would in ICD-9-CM, we can go into fine detail about what type of fracture, on which finger, on which hand—even which visit this is the for the particular injury.

CONVENTIONS

Aside from its format and organization, ICD-10-CM is very similar to ICD-9-CM. It includes all of the conventions you’d find in ICD-9-CM, including:

Brackets []
 Parentheses ()
 “Includes”
 “Excludes”

*There is a slight variation here: ICD-10-CM includes 2 types of “Excludes”

EXCLUDES1 & EXCLUDES2

Excludes1: lists codes that should never be coded with the code listed above. Think of this as a “hard excludes.”

Excludes2: lists other codes for conditions/injuries that may be a part of the condition, but are not included here. This is more of a “soft excludes.” An Excludes2 note functions similarly to a “See Also” note

“Code first”
 “Use Additional Code”
 “In Disease Elsewhere Classified”
 “See”
 “See Also”
 “Not Elsewhere Classified”
 “Not Otherwise Specified”

EXTENSIONS & PLACEHOLDERS

ICD-10-CM has another important convention that has to do with the code's extensions. Remember, extensions typically provide information what encounter this is for the healthcare provider with the patient. These are not always included, but in the case that they are, they cannot simply be appended to the end of whatever code is attached. Extensions are only found in the seventh character of an ICD-10-CM code.

If a coder has to include an extension for an initial encounter on a code that does not have six characters, they must add placeholder characters. Coders use an 'X' for the placeholder digit.

PLACEHOLDER EXAMPLE

If, for example, a coder needs to code an instance of poisoning by unintentional underdosing of antibiotic penicillin, the coder would use T36.0X1A. In this case, the fifth digit is empty, and so we'd use the placeholder character 'X.' Remember that placeholder characters are only used when an extension is necessary. Most ICD-10-CM codes do not include an extension for the encounter.

Now that we've got a better idea of what ICD-10-CM looks like and how it's organized, it's time to take a brief look at how to use this code. We'll cover that in our next course, and we'll talk about transferring codes from ICD-9-CM to ICD-10-CM, or 'Crosswalking,' later in Section 2.

USING ICD-10-CM

Using ICD-10-CM is a lot like using ICD-9-CM. Like ICD-9-CM, ICD-10-CM features an alphabetic and a tabular index, each of which is contained in its own volume. Coders use the alphabetic index to find the correct code, and use the tabular index to confirm it. As with ICD-9-CM, we never code from the alphabetic index.

HOW TO USE ICD-10-CM

The medical coder should approach ICD-10-CM in the exact same way as ICD-9-CM. The coding process again begins with the analysis and abstraction of a medical report. Using their notes from the report, the coder may go straight to the tabular section or may refer to the alphabetic section to find the correct code, and then confirm it in the tabular.

Let's take a look at a quick example.

USING ICD-10-CM EXAMPLE

Patient is 44-year-old Caucasian male. Self reported height and weight 1.8m and 80 kg. No notable medical history.

Patient presents with a red rash around the nose and labial folds. Some yellowish-reddish pimples. Patient complains of itching and flaking skin. Patient says rash emerged two months ago but then subsided. Diagnosed patient with suborrheic dermatitis and prescribed a topical antifungal medication.

In order to code this relatively straightforward visit, the coder would first abstract the information in the doctor's report. The patient shows one very specific symptom (a rash on the face), and the doctor is able to make a positive diagnosis: suborrheic dermatitis.

The coder could look this up in the alphabetic index, or turn to the section in the tabular index for diseases of the skin or subcutaneous tissue: L00-L99. From there the coder would look for dermatitis and eczema and find L21: "seborrheic dermatitis."

Underneath that category we'd find four subcategories. We'd select the one that best describes the condition diagnosed by the physician, which in this case would be L21.9, "Seborrheic dermatitis, unspecified." We use "unspecified" here because the other codes for seborrheic dermatitis pertain either to infants or describe an "other" serborrheic dermatitis. In this case, "unspecified" is our best option.

Let's look at the tree of codes for this diagnosis code.

L00-L99 – Diseases of the skin and subcutaneous tissue

L21 – Seborrheic Dermatitis

L21.0 – Seborrhea capitis

L21.1 – Seborrheic infantile dermatitis

...

L21.8 – Other seborrheic dermatitis

L21.9 – Seborrheic dermatitis, unspecified

You'll note that this ICD-10-CM code doesn't have any subclassifications or extensions. Remember, not all codes need to go to the level of specificity that ICD-10-CM provides. In this case, the fourth digit is all that's needed to describe the diagnosis.

FURTHER EXPLORATIONS

Let's look at another example, this time an injury. Injuries often have extensions that document the encounter because the stage of treatment (whether it has not been treated, as in an initial encounter, or has already received treatment, as in a subsequent encounter) can greatly impact the medical necessity on a claim.

USING ICD-10-CM INJURY EXAMPLE

Patient presents with bruising and a swollen nose and cheek after contact in a rugby match. Patient has not lost consciousness. Examination shows no rupture of the skin on the face. X-rays confirm a type II Le Fort fracture.*

We know right off the bat that this is an injury code, so we can start searching in the ICD-10-CM injury codes, found in S00-T88: "Injury, poisoning and certain other consequences of external causes." From there we'd winnow our search to S00- S09, "Injuries to the head."

Within that subfield of codes, we'd find S02, "fracture of the skull and facial bones." We could also go about this by looking up a Le Fort fracture in the alphabetic index. As mentioned in the note above, a Le Fort fracture can be one of three fractures to the facial bones and skull. According to the medical report, we're looking for a Type II Le Fort fracture.

Below S02, we'd find a number of subcategories, including codes for fractures of the vault and base of the skull, fractures of the nasal bones, and fractures of the orbital floor. We're looking for a very specific type of fracture, however, one that involves the maxillary and zygoma bones of the face. Thankfully, there's a specific subcategory for this: S02.4, "fracture of the malar, maxillary and zygoma bones."

*Le Fort fracture—one of three fractures of the bones in the face, including fractures the lower and mid maxillary bones and the zygomatic arch/cheek bone.

Once in this subcategory, we'd find a subclassification for Le Fort fractures (S02.4), and then three more subclassifications for each type of Le Fort fracture (S02.41). We'd select the code for our Type II Le Fort fracture: S02.412. Since this is the doctor's first encounter with this injury, we'd use the initial encounter extension 'A,' and would end up with: S02.412A, "Le Fort type II fracture, closed, initial encounter."

Now let's look at the code tree to see how we got here.

ICD-10-CM INJURY CODE TREE EXAMPLE

```

S00-T88 – Injuries, poisonings and certain
           other consequences of external causes

S02 – Fracture of skull and facial bones
      S02.0 – Fracture of vault of skull
      S02.1 – Fracture of base of skull
      S02.2 – Fracture of nasal bones
      S02.3 – Fracture of orbital floor
      S02.4 – Fracture of malar, maxillary and zygoma bones
            S02.40 – Fracture of malar, maxillary
                  and zygoma bones, unspecified
            S02.41 –Le Fort fracture
                  S02.411 Le Fort I fracture
                  S02.412 Le Fort II fracture
                        S02.412A - ... initial encounter
                              for closed fracture
                        S02.412B - ... initial encounter
                              for open fracture
                        S02.412D - ... subsequent encounter for
                              fracture with routine healing
                  Etc.
  
```

As you can see, navigating ICD-10-CM is both similar to and different from using ICD-9-CM. Because ICD-10-CM provides a much higher number of specific codes, coders must be more accurate when reading and abstracting medical reports. ICD-10-CM, for instance, includes laterality in the code set—that is, what side the disease or injury occurs on. Information like this will be in the medical report, and so it's simply up to the coder to get every last bit of pertinent information from the medical report.

CONVENTIONS

Like ICD-9-CM, ICD-10-CM makes use of a number of conventions that help guide the coder to correct diagnosis codes. Most of these conventions, as we mentioned in the last course, are the same in both code sets, and so we won't rehash them here. ICD-10-CM does have one significant upgrade, however, and it comes in the "Excludes" convention.

ICD-10-CM's Excludes notes have been divided into two 'levels.' Excludes1 informs coders that the codes listed in the note may not, in any circumstance, be listed with the code that contains the Excludes1 note. For example, you might find something that looks like this:

EXCLUDES1 EXAMPLE

A12 {Disease} A
Excludes1:
{disease} B, {disease} C

The conditions listed in an Excludes1 note are mutually exclusive with the main condition the coder is looking up. An Excludes1 note informs the coder that if the code they are looking up is in the Excludes1 note, the coder cannot, under any circumstances, use the code that houses the note. That is, if a medical coder is looking for {disease} B, but thinks the code for {disease} A would be appropriate, the Excludes1 note would direct her to look elsewhere besides {disease} A.

Excludes2 is the other new Excludes note. An Excludes2 note indicates that the code above the note does not include the other conditions listed below the note. Let's take another look at our simplified example.

EXCLUDES2 EXAMPLE

A12 {Disease} D
Excludes2
{disease} E, {disease} F

This Excludes2 note means that while Diseases E and F might be pertinent to or related to Disease D, they're not found in the same code as Disease D. Unlike Excludes1, you can code conditions found in an Excludes2 note with the condition above the note. You can think of Excludes2 as sort of like "See Also," while an Excludes1 note is more like a "See" note.

The upgrade from ICD-9-CM to ICD-10-CM is set for October 1, 2014. In the meantime, coders across the country are learning how to use this new large code set. We'll cover that process, and the process of transitioning codes from ICD-9-CM to ICD-10-CM, in *Crosswalking*, later in Section 2. For now, we're going to move on to procedure codes.

In the next few courses, we'll introduce you to CPT codes, HCPCS codes, and their modifiers. These codes, along with the ICD codes you've just learned about, make up the heart of the medical coding profession.

INTRO TO CPT

In *Learn More About Medical Coding*, we introduced you to Current Procedural Terminology, or CPT. This expansive, important code set is published and maintained by the American Medical Association (AMA), and it is, with ICD, one of the most important code sets for medical coders to become familiar with. Note also that all the codes featured in this course, and every course that touches on CPT codes, are copyrighted by the AMA.

CPT codes are used to describe tests, surgeries, evaluations, and any other medical procedure performed by a healthcare provider on a patient. As you might imagine, this code set is extremely large, and includes the codes for thousands upon thousands of medical procedures.

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).”

Like ICD codes, CPT codes are also used to track important health data and measure performance and efficiency. Government agencies can use CPT codes to track the prevalence and value of certain procedures, and hospitals may use CPT codes to evaluate the efficiency and abilities of individuals or divisions within their facility.

FORMAT

Let’s look a little closer at what these codes look like and how they’re organized. Each CPT code is five characters long, and may be numeric or alphanumeric, depending on which category the CPT code is in. Don’t confuse this with the ‘category’ in ICD. Remember that in ICD codes the ‘category’ refers to the first three characters of the code, which describe the injury or disease documented by the healthcare provider.

With CPT, ‘Category’ refers to the division of the code set. CPT codes are divided into three Categories. 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. Category II codes are supplemental tracking codes used primarily for performance management. Category III codes are temporary codes that describe emerging and experimental technologies, services, and procedures.

Note that while CPT codes have five digits, there are not 99,000-plus codes. 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.

FORMAT CATEGORY I

Here's a closer look at the three categories of CPT codes.

Medical coders will spend the vast majority of their time working with Category I CPT codes. For the sake of simplicity, we'll refer to the CPT codebook when we're describing the code set. This book, which is updated yearly by the AMA and the CPT Editorial Board, is an essential tool for every medical coder. In the next few minutes, you'll learn the basic layout, format, and instructions found in the CPT codebook. We'll cover how to use CPT codes in the next course, *Using CPT*. Most of the *Using CPT* course will be focused on Category I CPT codes.

Like the ICD code set and its division into chapters by type of injury or illness, Category I CPT codes are divided into six large sections based on which field of health care they directly pertain to. The six sections of the CPT codebook are, in order:

- Evaluation and Management
- Anesthesiology
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

CPT codes are, for the most part, grouped numerically. The codes for surgery, for example, are 10021 through 69990.

In the CPT codebook, these codes are listed in mostly numerical order, except for the codes for Evaluation and Management. These Evaluation and Management, or E&M, codes are listed at the front of the codebook for ease of access. Physician's offices frequently use E&M codes for reporting a number of their services. The code 99214, for a general checkup, is listed in the E&M codes, for example.

Note also that some codes appear out of numerical sequence but near similar procedures. This may seem slightly confusing, but having these codes clustered near similar procedures prevents having to delete and resequence codes, and so is seen as a sort of necessary evil.

Here's a quick look at the sections of Category I CPT codes, as arranged by their numerical range.

- Evaluation and Management: 99201 – 99499
- 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. If you'd like to learn more about the anatomy and physiology terms used in the Surgery section, see the course on *Human Anatomy and Medical Terminology* later in Section 2. Likewise, the Radiology section is organized into sections on diagnostic ultrasound, bone and joint studies, radiation oncology, and other fields.

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.

Like ICD codes, many CPT codes are arranged by indentation. If a procedure is indented below another code, the indented procedure is an important or noteworthy variation on the above procedure, and would replace the first code. Let's take a look at an example of an indented code.

The code for “management of liver hemorrhage; simple suture of liver wound or injury” is 47350. This is a surgical procedure, and would be found in the surgery/digestive system portion of the CPT book.

It's helpful to look at a code like this in two parts. The first, which comes before the semicolon, is the general procedure. In this case, that'd be “liver management.” The phrase that comes after the semicolon is additional, specific information. In this example, we could read the code as “liver management, with a simple suture of liver wound or injury.”

If, however, a doctor performed a more complicated procedure on a patient's liver, 47350 would no longer be the correct code to use. If we look in the CPT manual, we find the code 47360 below 47350. Code 47360 reads “complex suture of liver wound or injury, with or without hepatic artery ligation.” That phrase is meant to take the place of the phrase that comes after the semicolon in code 47350.

You could therefore read code 47360 as “liver management, with complex suture of liver wound or injury, with or without hepatic artery ligation.”

CPT codes also have a number of modifiers. These modifiers are two-digit additions to the CPT code that describe certain important facets of the procedure, like whether the procedure was bilateral or was one of multiple procedures performed at the same time. CPT modifiers are relatively straightforward, but are very important for coding accurately. For this reason, we'll cover them in a *CPT Modifiers* later in Section 2.

Like ICD codes, many CPT codes also have additional instructions featured below the code. These instructions, which are in parentheses below the code you've looked up, tell the coder that, in certain situations, another code might be better suited than the present code. We'll cover these commands in more

depth in the next course *Using CPT*. For now, just recognize that the CPT code set has a number of instructions that inform the medical coder on how to best code the procedure performed. Remember that you always need to code to the highest level of specificity, and a miscoded procedure can be the difference between an accepted and rejected claim.

The CPT code set also instructs coders on when to use multiple codes, when to use codes in tandem with one another (add-on codes), and which codes are “modifier exempt.”

This is an awful lot of information to take in regarding Category I CPT codes, so let’s review briefly.

Category I CPT codes are numeric, and are five digits long.

They are divided into six sections: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine.

Each of these sections has its own subdivisions, which correspond to what type of procedure, or what part of the body, that particular procedure relates to.

The sections are grouped numerically, and, aside from Evaluation and Management, are in numerical order. That is, the codes for Anesthesia come before, or are “lower” than the codes for Pathology and Laboratory.

Each of these sections also has specific guidelines for how to use the codes in that section.

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.

There are a few important CPT Modifiers, which provide additional information about the procedure performed. We’ll cover these in just a little bit.

Some codes have instructions for coders below them. These instructions are found in parentheses below the code, and they instruct the coder that there may be another, more accurate code to use.

**FORMAT
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.

**CATEGORY II
EXAMPLE**

Here's a quick 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:

**CATEGORY II
NUMERICAL FIELDS**

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

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

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

Example: 0503F: Postpartum care visit

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

Example: 1030F: Pneumococcus immunization status assessed

Physical Examination

Example: 2014F: Mental status assessed

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

Example: 3006F: Chest X-ray documented and reviewed

Therapeutic, Preventive, or Other Interventions –

Describes pharmacologic, procedural or behavioral therapies

Example: 4037F: influenza immunization ordered or administered

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

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

CATEGORY II
NUMERICAL FIELDS
(CONT'D)

Patient Safety– Includes codes that describe patient safety precautions
Example: 6015F: Patient receiving or eligible to receive
foods, fluids, or medication by mouth

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

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 you will not use Category II nearly 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.

FORMAT
CATEGORY III

The third category of CPT codes is made up of temporary codes that represent emergent or experimental services, technology, and procedures. In certain cases, you may find that a newer procedure does not have a Category I code. There are codes in Category I for unlisted procedures, but if the procedure, technology, or service is listed in Category III, you are required to use the Category III code.

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. If at the end of this five year period the code has not been converted to Category I, this procedure must be marked with a Category I "unspecified procedure" code. When flipping through the Category III section of the CPT manual, you'll notice that each of the codes has a phrase listing its sunset date below the code. Think of the sunset dates as expiration dates on the code.

CATEGORY III
EXAMPLE

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.

Now that you have a better idea of what CPT looks like, how it's formatted, and when to use which category of codes, let's dive a little deeper. We'll take a look at CPT codes in action in the next course, and *CPT Modifiers* later in Section 2.

USING CPT

Now you've got a basic idea of what CPT is, how it's organized, and what it's used for. Let's look at how to use CPT as a medical coder.

Two notes before we begin this course on the practical applications of the CPT code set. First, there are a number of modifiers which may be added to CPT codes and which provide important additional information about the procedure performed. Since it's helpful to have a working knowledge of CPT in action before we learn about those modifiers, we're going to learn about them after this course. See the next course, *CPT modifiers* for more information.

DISCLAIMER

Second, and most importantly, we should stress again that the completion of this course will not fully prepare you for entry into the coding workforce. This course is merely an introduction to the practice, and some of the examples that we'll use are simplified for ease of understanding.

CATEGORY I

Here's a brief refresher about the layout of the CPT code. CPT code is divided into three categories. Most coders spend the majority of their time with Category I, which describes procedures, services, and technologies administered by healthcare professionals.

Category I is divided into six sections, which are grouped, for the most part, in numerical order. The sections are Evaluation and Management (E&M), Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. These sections, with the exception of E&M, are in loose numerical order, though you may find some codes from one section referenced in another section.

CODING PROCESS

When you're coding, you first want to think about what kind of procedure you're looking at. Was it a patient visit? A surgical procedure? Did a physician administer an X-ray? Did they prescribe medication to the patient? Using that information, you can start looking at higher and higher levels of specificity. Where on the patient's body was the surgery performed? Where was the X-ray?

As a coder, your job is to use this information to find the best possible code for the procedure.

As with ICD codes, the process of procedure coding begins with a physician's report. The coder reads this reports, makes notes of the important procedures and terms used in the report, and then uses this information to determine the best CPT code to input. Let's take a look at a quick, simple example.

USING CPT EXAMPLE

A patient breaks his arm and must go to the emergency room. His injury is serious, but is not a risk to the patient's life or major physiological functions. Leaving aside the other procedures that a physician would undoubtedly perform in this situation, let's look only at the hospital visit itself as a procedure code.

Since this is an instance of Evaluation and Management (E&M), we would turn to the first section of the CPT book. We'd find the "Emergency Department

Services” subsection and look at the codes listed there. There are a number of codes for a trip to the ER, and so we have to pick the one that fits our situation best. We’d select 99282 for an “Emergency department visit” of “low to moderate severity.” There are higher and lower levels of severity, but this code fits the visit best: the patient has a moderately severe injury but is in no serious danger.

Like ICD codes, when coding with CPT we always want to code to the highest level of specificity. We never want to stop coding at a CPT code that is simply “close enough” to the procedure performed. In E&M situations, this may be a bit of a judgment call, but as the procedures get more and more specific, there is less room for interpretation.

USING CPT EXAMPLE

Here’s a slightly more complicated example. A patient requires the biopsy of a deep, intramuscular cyst in his elbow. This is a surgical procedure, so we’d find the code in the surgery section of the CPT codebook. This is also a procedure related to the musculoskeletal system, which is the first subsection of the Surgery section, so we’d flip toward the front of the section. We’d locate the correct part of the body that the surgery is performed on, the humerus (upper arm) and elbow.

From there we’d look at excision codes. The first one that comes up is the excision of soft tissue of the upper arm.

PARENT CODES

Now’s a good time to recall something we learned in the last course. There are indented, or parent codes in the CPT book. Certain procedures, like the excision of soft tissue for a biopsy in the upper arm, have important variations. In our example, there are two options for this procedure: an excision of soft tissue on the skin of the upper arm, and an excision of soft tissue deep in the arm. The latter procedure is indented below the former. The former is the parent code. The specification of the parent code comes after a semi-colon, and describes where the excision takes place.

When using the indented code, we’d replace what comes after the semicolon with the procedure listed in the indented code.

Here’s the parent code:

24065 – Biopsy, soft tissue of upper arm or elbow area; superficial.

And here’s the code we want:

24066 – Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular).

So we’d select the indented code (24066) and use that as the procedure code for the biopsy on the cyst in our patient’s elbow.

In certain cases, you may find that the procedure you’ve been asked to code cannot be found in the CPT code manual. Remember that we want to code as accurate as possible at all times. In cases where a procedure has not yet made it’s way into the CPT book, we use an unlisted procedure code and file an

additional report. This may seem like a lot of extra work, but it's your duty as a medical coder to maintain the highest level of accuracy.

OUT OF ORDER CODES

Sometimes you may find procedure codes that are out of order in the code manual. Placing codes out of numerical order allows for clustering of similar procedures, and can help the medical coder find exactly the right procedure code. These out-of-sequence codes typically have a note instructing the coder to flip to the correct code elsewhere in the book. Think of these out-of-sequence codes as road signs.

GUIDELINES

The CPT codebook is full of guidelines. Each section of Category I has guidelines specific to that section. The Anesthesia section, for example, instructs coders on how to code the duration of the anesthetic procedure. The Medicine section, for another example, tells coders how to code medicinal services that commonly occur with other medical procedures.

Many codes also have guidelines or instructions, and this is where the CPT code set can get very complex. Certain procedures, like a “photodynamic therapy of second eye” (code 67225), must be used in conjunction with another procedure. In this case, code 67225 must be coded along with code 67221, for “photodynamic therapy (includes intravenous infusion).”

Other codes may instruct you not to report this code in conjunction with a certain other code. Those procedures may contradict one another or overlap.

PARENTHESES EXAMPLE

Some codes will also have instructions, listed in parentheses, that instruct the coder to look elsewhere for a procedure. Let's say a coder receives a medical report that a patient had his the ACL in his knee reconstructed during a surgical procedure. That coder would turn to the Surgery section of the code book, then to the musculoskeletal subsection. The coder would find the section on the femur and knee joint, and look at code 27407 – “repair, primary, torn ligament and/or capsule, knee; cruciate.”

The coder would then look at the instructions below this code and see a note: “For cruciate ligament reconstruction, use 27427.” The medical coder needs to describe a reconstruction, not a repair, and so the first code—27407—would be incorrect. The coder would go to 27427, check that it is the correct procedure, and then use that code.

You can think of these instructions and guidelines a little like the “includes,” “excludes,” and “see” commands that you find in the ICD codes. They help guide the coder to the correct spot.

USING CPT EXAMPLE

These guidelines and instructions may seem redundant, highly specific, or needlessly complicated, but insurance companies need as much information as possible in order to properly gauge the authority of a medical claim. When in doubt, always follow the rules laid out by the CPT code set.

CODE SYMBOLS

Now that we've talked a little bit about using the CPT code book, it's time to get into some finer detail. A lot of CPT codes come with important distinctions about their use, placement, or history.

In an effort to save space, and save you from having to read tedious notes on each and every code, the CPT Editorial Board has instituted a number of symbols within the codebook. These symbols will tell you important information about the code. Each codebook will have a key that explains these symbols.

We won't dive fully into all of these symbols, but you should know about a few of the more common ones.

Part of the purpose of the code symbols included in the CPT manual is to tell coders which codes are new, resequenced, or revised procedure codes. The new procedures are marked with a red dot. Heavily revised procedures are marked with a blue triangle. New and revised procedure descriptions are marked with green triangles.

These code symbols also illustrate which codes must be, or cannot be, used in conjunctions with other codes. Certain codes are always paired with other codes. These are called "add-on" codes, and are noted with a boldfaced plus sign. Other codes are incompatible with the -51 modifier, and are marked with a circle with a diagonal line through it. We'll cover what a -51 modifier is in the next section—or now, just know that a procedure marked like this cannot be part of a "multiple procedure" report.

Finally, procedures that require mild sedation are marked with a circle with a dot in the center. This helps remind coders that they should be coding for an anesthesia procedure, in addition to the primary procedure.

APPENDICES

When you're using a code set as large and complicated as CPT, it helps to have a place to turn to for information specific to certain parts of the code set. The appendices at the back of the CPT manual allow you to search newly added codes, CPT modifiers, and a list of CPT add-on codes.

The manual comes with appendices A through O. You should look through these appendices, and pay special attention to Appendix A, the list of CPT modifiers, and Appendix C, which gives clinical examples for particularly confusing codes.

INDEX

Finally, we come to the index. The CPT Index can be used like any other index. You can use it to track down hard-to-code procedures, services, and tests, and you can search it by both procedure and body part.

For instance, if you weren't sure how to code an exploration of the carotid artery, you could turn to the index and look up carotid artery. The index would then redirect you to "Artery, Carotid." Upon flipping to that section, you'd find the code for an exploration of the carotid artery, 35701. As with ICD, you always flip to the code and examine it before entering it.

A trained medical coder never codes from the index. It is merely a tool for finding the right information.

Let's close this course with a quick example of a coder using the index the right way.

INDEX EXAMPLE

A patient receives an X-ray of both their femoral arteries. The medical report is passed to the coder. The coder knows this is a radiology code, but isn't sure which procedure to code. She turns to the index and finds Artery, Femoral, but can't find the proper procedure. The coder is looking for the code for a venography, which is an invasive procedure that uses a catheter filled with dye, which is injected and traced through the body via X-ray.

The coder turns instead to Venography in the index and finds the code range for venographies in the leg: 75820-75822. The coder turns to this section and finds a number of venographies, each for a specific part of the body. The coder chooses the first one, 75822, for a bilateral venography of the extremities, with radiological supervision and interpretation.

MOVING FORWARD

In the next course, we'll learn how CPT modifiers can help us code more accurately, and with a wider range of information.

CPT MODIFIERS

When a simple CPT code isn't enough, we turn to CPT 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. CPT Modifiers, like modifiers in the English language, provide additional information about the procedure. In English, a modifier may describe the who, what, how, why, or where of a situation. Similarly, a CPT 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, and lots of other information that may be critical to a claim's status with the insurance payer.

Certain modifiers may allow a healthcare provider to ask for more money from a payer. Modifiers -22 is one such modifier: If a surgeon performs a procedure that requires significantly more time to complete, due to a complication during the surgery, that procedure may be coded with a -22 at the end, for increased procedural services. Essentially, this modifier lets the payer know that the healthcare provider did more work than the basic CPT code would imply, and should be compensated for that work.

CPT Modifiers are always two characters, and may be numeric or alphanumeric. Most of the CPT modifiers you'll see are numeric, but there are a few alphanumeric Anesthesia modifiers that we'll toward the end of this course.

FUNCTIONAL VS. INFORMATIONAL 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.

There's a straightforward reason to this, too. While CMS-1500 and UB-04 forms, the two most common claim forms, have space for four modifiers, payers don't always look at modifiers after the first two. Because of this, you always want the most important modifiers to be visible. We'll return to this point in a few examples after we examine the CPT modifiers.

Bear in mind that each of the CPT modifiers you'll find in this course are A) copyrighted by the American Medical Association (AMA) and B) contingent on a number of factors and guidelines. In other words, there are rules for their use. You can't simply add a modifier to the end of a procedure code if you think it makes sense. There are, for example, a number of modifiers that state they are not compatible with Evaluation and Management (E&M) codes.

2013 APPROVED
CPT MODIFIERS

Let's look now at the CPT modifiers that have been approved for the 2013 CPT manual. The following list has all of the CPT modifiers, and a brief description of what they mean when it is not already clear.

22 – Increased procedural services

We talked about this example earlier in this course. This modifier lets the payer know that the procedure required substantially more work than would normally be expected. This code is not compatible with E&M.

23 – Unusual anesthesia

This modifier will alert the payer to the fact that a procedure that would normally not require general anesthesia does, in fact, require general anesthesia.

24 – Unrelated evaluation and management service by the same physician or other qualified healthcare professional during a postoperative period

If a healthcare provider needs to perform an evaluation during a post-operative period, but that procedure is not related to the operation just performed, this modifier is appropriate. This is used with E&M code. This modifier will alleviate appeals for denied E&M claims during a global surgical period.

25 – Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service

If a patient's condition requires a separate examination on the same day as a surgical operation, and this examination exceeds the usual pre- or postoperative evaluation required with the procedure, this modifier may be added to the CPT code that describes this additional evaluation.

26 – Professional component

A professional component is the element of a procedure performed by by a licensed medical professional. This might mean the interpretation of a diagnostic test, rather than the administration of it. This is reported separately from the technical component of the procedure code.

32 – Mandated services

This modifier describes services, consultations, or evaluations that are required by a third party, such as an examination that an insurance company requires of a patient in order to determine medical necessity.

33 – Preventive services

Medical services performed in order to prevent or detect future illness or injury, including immunizations, screenings, etc.

47 – Anesthesia by surgeon

This modifier includes general or regional anesthesia administered by the surgeon, but does not include local anesthetic. This modifier would not be used with CPT codes for anesthesia, either.

50 – Bilateral procedure

This modifier describes medical procedures performed on both sides of the body. This only applies to parts of the body that are, in fact, bilateral (eg, the kidneys). This code also typically requires that the bilateral procedure be performed in the same operating session.

51 – Multiple procedures

One of the most common modifiers, this indicates that the healthcare provider performed more than one procedure in one session. This modifier is added to the secondary (or tertiary, etc) procedure performed after the initial one.

Most payers can pay 100% for the first procedure but reduce reimbursement on subsequent procedures to 50%, sometimes lower depending on the payer.

52 – Reduced services

In the case of a procedure being reduced in scope or intensity, or in the case of a physician being unable to complete the procedure, you may use this modifier. Note that this is different from a discontinued procedure (which is modifier -53), but may be used to describe a discontinued procedure or one that is either aborted.

53 – Discontinued procedure

If extenuating circumstances demand it, a healthcare provider or surgeon may elect to stop a procedure in the middle of performing it. In cases like this, use -53 at the end of the CPT code to show that the healthcare provider prepared for and initiated the service, only to stop mid-way through.

54 – Surgical care only

If a surgeon is performing the surgery, but is not responsible for the pre- or postoperative evaluation or care, you may use this modifier.

55 – Postoperative management only

If different healthcare providers perform the surgery and the postoperative care, this modifier may be added to the postoperative care.

56 – Preoperative management only

This is identical to -55, but relates to preoperative care instead of postoperative care.

57 – Decision for surgery

If, during an evaluation and management procedure, the physician decides surgery is necessary, you may add this modifier to the evaluation and management procedure code.

2013 APPROVED
CPT MODIFIERS

- 58 – Staged or related procedure or service by the same physician or other qualified healthcare professional during the postoperative period
This modifier applies to two different circumstances related to an operation on a patient. If, during the initial surgical procedure, the healthcare provider anticipates (or stages) a postoperative procedure, you may use this modifier. Similarly, if the healthcare provider anticipates a postoperative procedure, and this procedure ends up being more extensive or time-intensive than initially expected, this modifier lets the payer know that more work was required during this procedure.
- 59 – Distinct procedural service
If two or more distinct services are performed on a patient on the same date, this modifier can be used to explain why two procedure codes are being reported.
This modifier indicates a procedure or service is independent from other procedures performed on the same day.
- 62 – Two surgeons
In the case of two surgeons operating on a patient at the same time, you may use this modifier to explain to the payer why two separate healthcare professionals are billing for the same procedure performed on the same patient.
- 63 – Procedure performed on infants less than 4kg
- 66 – Surgical team
This modifier alerts the payer to the fact that a team of more than two surgeons operated on the patient during the procedure.
- 76 – Repeat procedure or service by same physician or other qualified healthcare professional
This modifier may be used when a physician performs the same procedure twice on a patient on the same date. It may also describe multiple diagnostic procedures, like x-rays, that are performed on the same date. This modifier helps prevent claim denials based on duplicate procedures.
This is added to the procedure code with the number of units specified and payment is made for each unit billed.
- 77 – Repeat procedure by another physician or other qualified healthcare professional
This modifier is identical to -76, but applies when a different physician or healthcare professional performs the second procedure or diagnostic test.
- 78 – Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period
This modifier indicates that a second operation is performed during what would normally be the postoperative period, usually due to complications with the initial operation.
- 79 – Unrelated procedure or service by the same physician or other

qualified healthcare professional during the postoperative period

This modifier describes a secondary operation or procedure that is performed during the postoperative procedure but is not tied to the initial operation.

80 – Assistant surgeon

This is a personnel code, which describes a situation in which an assistant surgeon helped with the procedure.

81 – Minimum assistant surgeon

This code describes a procedure in which the assistant surgeon was only active for part of the procedure.

82 – Assistant surgeon (when qualified resident surgeon not available)

This code is used exclusively in teaching hospitals

90 – Reference (outside) laboratory

If a test is performed by a third party other than the treating physician or that physician's office, you may append this modifier to the end of that procedure code.

91 – Repeat clinical diagnostic laboratory test

If diagnostic tests are performed more than once in the same day, this modifier should be added to the procedure code for that test. Note that this modifier may be used when clinical tests are done twice in order to confirm a diagnosis.

92 – Alternative laboratory platform testing

This modifier describes a laboratory test performed with a portable kit that consists, either wholly or in part, of a single-use, disposable element.

99 – Multiple modifiers

Most payers only pay attention to the first two modifiers listed with a procedure code. However, there may be instances where it's important for the healthcare provider's reimbursement that the payer acknowledge several modifiers. When this happens, use the -99 modifier to show that there is more than two modifiers.

Let's take a quick look at an example of CPT modifiers in action.

CPT MODIFIERS EXAMPLE

A surgeon performs a procedure to remove a bone cyst in the upper arm of a patient. The procedure also includes obtaining a graft from elsewhere in the body. Due to minor complications, the surgeon is unable to fully excise the bone cyst.

For the procedure, we'd code 24115, for "excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining the graft)." Since the procedure was completed but not fully successful, we'd add the -52 modifier, for reduced services, to the code, and we'd end up with 24115-52.

Now let's say that a team of surgeons is performing a closed, or percutaneous,

angioplasty in a patient's renal system. For this procedure, we'd code 35471 for "transluminal balloon angioplasty, percutaneous; renal or other visceral artery," and we'd add the modifier -66 for "surgical team." So we'd end up with 35471-66.

**PHYSICAL STATUS
MODIFIER
(FOR ANESTHESIA)**

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

As we said, these are relatively straightforward, but let's look at an example that will also use some of the CPT modifiers we learned just a minute ago.

**PHYSICAL STATUS
MODIFIER EXAMPLE**

Let's return to that angioplasty example. The patient needs to be anesthetized before undergoing this procedure, so we turn to the Anesthesia section of the CPT codebook and find the code 00216 for "vascular procedures." Now, kidney problems notwithstanding, our patient is in good health, so we'd add the -P1 modifier to this anesthesia code, and end up with 00216-P1.

**MODIFIERS APPROVED FOR
AMBULATORY SURGERY
CENTERS (ASC)
HOSPITAL OUTPATIENT USE**

CPT modifiers are also used in ambulatory surgery centers (ASC). These hospital outpatient facilities specialize in procedures where the patient leaves the same day. The following CPT modifiers are also approved for use in an ASC hospital outpatient use: -25, -27, -50, -52, -58, -59, -73, -74, -76, -77, -78, -79, and -91.

Most of these modifiers were covered in the section above on general CPT modifiers except for -27, -73, and -74. Modifier -27 describes multiple outpatient hospital E&M encounters on the same date, and is relatively self-explanatory. -73 describes the discontinuation of an outpatient surgical procedure before the administration of anesthesia, while -74 describes the same thing except after the administration of anesthesia.

Note that there may be some overlap or contradiction with the set of HCPCS modifiers, which we'll cover more in depth in its own course later in Section 2.

For example, HCPCS codes, which are used to report procedures to Medicare and Medicaid, have modifiers that describe which side of the body a procedure is performed on. Naturally, these modifiers would contradict the CPT modifier -50, which is used to describe a bilateral procedure.

We won't dive much deeper than that for now, but just know that HCPCS, another important code set that shares a lot with CPT, has its own set of modifiers, and that it's important to note which format you need to use for a particular claim.

HCPCS MODIFIERS

We're jumping ahead a little bit here, but know that there are also a number of important modifiers in the Healthcare Common Procedure Coding System, or HCPCS. These modifiers describe things like which side of the body or which body part the procedure is performed on. Since we'll have to discuss HCPCS in depth before we talk about HCPCS modifiers, you'll have to wait until the course on *HCPCS Codes* before you get a full breakdown of these additional bits of code. Just know that there is significant crossover between CPT modifiers and HCPCS modifiers. The HCPCS modifier -LT, for example, often shows up to tell the payer that a typically bilateral procedure was only performed on the left side of the body. Modifiers like this are often of the "informational" variety, rather than the "functional" one, and so should be added after modifiers that directly affect reimbursement.

SUPPLEMENTAL REPORTS

Many CPT modifiers require supplemental reports to the health insurance payer. If, for instance, a payer wants to know why a surgery to repair lesions on the liver of a patient was discontinued (let's say there was a complication with one of the proximal organs), the coder would want to file a supplementary report stating this. We both want to code to the highest level of specificity and provide as much documentation as possible. If a modifier that requires justification of medical necessity is left without a supplemental report, the claim that procedure is on may very well be rejected.

HUMAN ANATOMY AND MEDICAL TERMINOLOGY

In our previous courses, you may have noticed a number of complex anatomy and physiology terms getting tossed around. It's easy to get flummoxed by medical terminology, but as a professional medical coder, you'll have to develop an easy rapport with this seemingly intimidating subject.

Thankfully, medical vocab is more bark than bite. If you can familiarize yourself with some prefixes, suffixes, and roots, you'll be well on your way to mastering the official medical language of the body.

Bear in mind, also, that medical terminology is a part of the CPC exam, which you'll most likely have to take if you want to become a certified professional coder. You can look at Section 5 for more information on the CPC exam, and for a number of tips on how to study for it.

NUMBERS

Many times you'll encounter a medical term that contains a prefix that describes a number. A few of the most common are listed in this table below.

PREFIX	MEANING	EXAMPLE
Mono-, Uni-	One	Unilateral
Bi-	Two	Bilateral
Tri-	Three	Triplicate
Quadr-	Four	Quadriceps
Hex-, Sex-	Six	Hexose
Diplo	Double	Diplococcus

DIRECTIONS & POSITIONS

In medicine, you'll often encounter terms that describe where a procedure or condition takes place on the body.

PREFIX	MEANING	EXAMPLE
Ab-	Away from	Abduction
Ad-	Toward	Adduction
Ecto-, Exo-	Outside	Ectoparasite
Endo-	Inside	Endoderm
Epi-	Upon	Epinephrine
Infra-	Below, under	Infrared
Ipsi-	Same	Ipsilateral
Meso-	Middle	Mesomorph
Meta-	After, beyond, transform	Metastasis
Peri-	Surrounding	Peridontal
Retro-	Behind, back	Retrograde amnesia
Sub-	Below	Submandibular
Trans-	Across, through	Transcutaneous

DIRECTIONS & POSITIONS

There are also a number of positional and directional medical terms that are not suffixes or prefixes, but are instead standalone words. Some of the most valuable of these are listed below.

WORD	MEANING	EXAMPLE
Anterior or ventral	At or near the front surface of the body	“Anterior nerves”
Posterior or dorsal	At or near the rear surface of the body	“Dorsal surface of the hand”
Superior	Above	“Superior (cranial) aspect”
Inferior	Below	“Inferior aspect”
Lateral	Side	“Lateral aspect”
Distal	Farthest from center	“Axons distal to the injury”
Proximal	Nearest to center	“Proximal end of the forearm”
Medial	Middle	“Medial axis”
Supine	Face up or palm up	“Laying supine”
Prone	Face down or palm down	“Laying prone”
Sagittal	Vertical body plane, divides the body into left and right	“Sagittal suture”
Transverse	Horizontal body plane that divides the body into top and bottom	“Transverse myelitis”
Coronal	Vertical body plane that divides the body into front and back	“Coronal suture”

BASIC ANATOMY TERMS

Let's look now at the basic terms for the regions of the body. These terms will help you navigate the CPT and ICD manuals, decipher doctor's reports, and give you a more thorough understanding of the medical practice in general.

WORD	BODY PART
Abdominal	Abdomen
Acromial	Point of shoulder
Antebrachial	Forearm
Antecubital	Front of elbow
Axillary	Armpit
Brachial	Arm
Buccal	Cheek
Calcaneal	Heel of foot
Carpal	Wrist
Caudal	Tail
Cephalic	Head
Cervical	Neck
Clavicular	Collar bone
Costal	Rib
Coxal	Hip
Cranial	Skull
Crural	Leg
Cubital	Elbow
Deltoid	Curve of shoulder
Digital	Fingers and toes
Dorsal	Upper back
Femoral	Thigh

BASIC ANATOMY TERMS CONTINUED ON NEXT PAGE

BASIC ANATOMY TERMS

WORD	BODY PART
Fibular	Outer side of the lower leg between the knee and ankle
Frontal	Forehead
Genital	Pertaining to the reproductive organs
Gluteal	Buttock
Hallux	Great toe
Inguinal	Groin
Lumbar	Loin (lowest part of the spine below the false ribs and between the hips)
Mammary	Breast
Manual	Hand
Mental	Chin
Nasal	Nose
Nuchal	Back of neck
Occipital	Back of head
Olecranal	Point of Elbow
Oral	Mouth
Orbital	Eye
Otic	Ear

BASIC ANATOMY TERMS

WORD	BODY PART
Palmar	Palmar
Patellar	Patellar
Pectoral	Pectoral
Pedal	Pedal
Pelvic	Pelvic
Perineal	Between the groin and the anus
Peroneal	Outer side of the calf
Plantar	Sole of foot
Pollex	Thumb
Popliteal	Back of knee
Pubic	Groin
Sacral	Between the hips
Scapular	Shoulder bone
Sternal	Breastbone
Sural	Calf
Tarsal	Ankle
Thoracic	Chest
Umbilical	Navel
Ventral	Belly
Vertebral	Spinal Column

CONDITIONS

Now that we've taken a look at the terms that describe the major regions of the body, let's turn to the conditions that may affect those body parts. Note that there are both prefixes and suffixes listed in this table.

PREFIX	MEANING	EXAMPLE
Ambi-	Both	Ambidextrous
Aniso-	Unequal	Anisocytosis
Dys-	Bad, painful, difficult	Dyslexia
Eu-	Good, normal	Eukaryote
Hetero-	Different	Heterogeneous
Homo-	Same	Homogeneous
Hyper-	Excessive, above	Hypertension
Hypo-	Lack, below	Hypoglycemic
Iso-	Equal, same	Isotope
Mal-	Bad, poor	Malnutrition
Megalo-	Large	Megalomania

CONDITIONS

SUFFIX	MEANING	EXAMPLE
-algia	Pain	Myalgia
-asthenia	Weakness (may also be a standalone term)	Neurocirculatory asthenia
-emia	Blood	Hypoglycemia
-iasis	Condition of	Elephantiasis
-itis	Inflammation	Bronchitis
-lysis	Destruction, break down	Dialysis
-lytic	Destroy, break down	Hydrolytic
-oid	Like	Haploid
-oma	Tumor	Fibroma
-opathy	Disease of	Neuropathy
-orrhagia	Hemorrhage	Metrorrhagia
-orrhea	Flow or discharge	Diarrhea
-osis	Abnormal condition of	Tuberculosis
-paresis	Slight paralysis	Hemiparesis
-plasia	Growth	Achondroplasia
-plegia	Paralysis	Quadraplegia
-pnea	Breathing	Sleep apnea

SURGICAL PROCEDURES

Let's wrap up this vocabulary blitz with a look at some of the most common surgical procedures. Since it's always imperative to list where on the body a surgical procedure was performed, these vocabulary terms are a small but useful addition to this section. Memorize the meanings of these suffixes and you'll at know instantly what kind of procedure was performed, even if you don't know exactly what the procedure did.

SUFFIX	MEANING	EXAMPLE
-centesis	Puncture a cavity to remove fluid	Amniocentesis
-ectomy	Surgical removal or excision	Hysterectomy
-ostomy	A new permanent opening	Tracheostomy
-otomy	Cutting into, incision	Gastrotomy
-orrhaphy	Surgical repair or suture	Gastrorrhaphy
-opexy	Surgical fixation	Nephropexy
-oplasty	Surgical repair	Rhinoplasty
-otripsy	Crushing or destroying	Lithotripsy

Note that you can also use your CPT manual to study human anatomy vocabulary. Current CPT manuals come with instructive illustrations, diagrams, and charts all throughout the book. In the front of the CPT manual, you should be able to find a list of anatomical illustrations. Bookmark this page and refer to it in case you're looking for an illustration of the eye or inner ear, or need to remember which artery goes where.

HCPCS

Now that we've brushed up a little bit on some critical vocabulary, let's return our attention to medical coding. In this course, we'll look at the third major code set: Healthcare Common Procedure Coding System (HCPCS), commonly pronounced "hicks-picks."

This code set is based upon CPT. In fact, the first level of HCPCS is identical to CPT. That might sound a little confusing, so let's take a step back.

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. We'll look closer at that very important piece of legislation in *HIPAA 101* in Section 3, but for now all you need to know is that HIPAA made the use of HCPCS mandatory in certain cases.

LEVEL II HCPCS CODES

Coders today use HCPCS codes to represent medical procedures to Medicare, Medicaid, and several other third-party payers. The code set is divided into three levels. Level one is identical to CPT, though technically those codes, when used to bill Medicare or Medicaid, are HCPCS codes. CMS looked at the established CPT codes and decided that they didn't need to improve upon or vary those codes, so instead they folded all of CPT into HCPCS.

To clarify: if you are coding, say, the placement of a tracheal stent for an elderly patient who is on Medicare, you would still use the CPT code 31631. However, because that code is going to Medicare, and not another payer, the code you've selected is technically a HCPCS code. For the most part this is just a technicality, but it can be confusing.

Where the real difference between CPT and HCPCS comes in is in Level II of HCPCS and the HCPCS modifiers. We'll cover Level II codes here and work on HCPCS modifiers in the next course.

LEVEL II HCPCS 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. Where CPT describes the procedure performed on the patient, it doesn't have many codes for the product used in the procedure. HCPCS Level II takes care of those products and pieces of medical equipment.

Level II codes are, like Level I, five characters long, but Level II codes are alphanumeric, with a letter occupying the first character of the code. These codes, like those in ICD and CPT, are grouped together by the services they describe, and are in numeric order.

You can generally refer to the range of codes by their initial character. J-codes, for example, are the codes for non-orally administered medication and chemotherapy drugs. J-codes are some of the most commonly used HCPCS Level II Codes.

HCPCS LEVEL II ALPHABETIC GROUPING

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

HCPCS code manuals have an index and a large table of drugs. Whenever a coder is coding the delivery of a drug or medication, they should always use the drug table. Coding for medication is one of the most important parts of using HCPCS, and the drug table will provide much more accurate information on where to find the correct code.

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.

Be aware that when coding with HCPCS, you're going to have to strive for an even higher level of specificity than with CPT. Since this code set has codes for all different variations and amounts of equipment and medicine, you'll have to stay as close to the medical report as possible to make sure you're coding the correct procedure. Look at it this way: 20 ten-mg capsules of antibiotics is going to cost more than ten ten-mg capsules, right? That's what you have to watch out for with HCPCS.

USING HCPCS EXAMPLE

Here's an example. A patient receives an injection of 20 mg of adalimumab to temporarily relieve the signs of rheumatoid arthritis. If you received this medical report, leaving aside the CPT procedure code and the ICD diagnosis code, you'd look at the amount of medication and the type of medication. You'd also know, from going over the HCPCS Level II format, that you're looking at a

J-code—a drug administered any way except orally. A lot of J-codes are injected drugs, and that’s what we’re looking at in this example.

So, you’d look up adalimumab and find the J-code J0135, “injection, adalimumab, 20 mg.” That’s your HCPCS Level II code, and that’s what you’d put in if you were creating a claim for Medicare, Medicaid, or one of the many other payers that takes HCPCS codes.

As you look through the HCPCS manual, you’ll recognize a lot of symbols from the CPT manual. Like CPT, HCPCS alerts you to which codes are new and which codes have been revised. New codes are listed with a circle, while revised codes have a triangle next to them. HCPCS is constantly being updated, and CMS, which maintains the code set, will often recycle codes. HCPCS features a number of strikethrough codes, and these let you know that a code that used to be listed there has been deleted and moved elsewhere.

You should also note that many codes in HCPCS Level II have specific guidelines for their use. Those guidelines are too various and fine grain to go over here, but you should know that with HCPCS, you always need to be paying attention. The diligent coder always takes note of the type of equipment used and the amount of medication delivered to the patient.

The other important variation HCPCS brings us is in the form of the HCPCS modifier, which we will cover in the next course

HCPCS MODIFIERS

HCPCS modifiers allow for greater accuracy in coding and can be extremely important in the reimbursement process.

Earlier in this section, we talked about CPT Modifiers. HCPCS modifiers work in almost exactly the same way. The two code sets are so similar, in fact, that you can regularly use modifiers from one set in codes from the other. The HCPCS modifier -LT, for example, is regularly used in CPT codes when you need to describe a normally bilateral procedure that was only performed on one side of the body.

HCPCS modifiers, like CPT modifiers, are always two characters, and are added to the end of a HCPCS or CPT code with a hyphen. When differentiating between a CPT modifier and a HCPCS modifier, all there's one simple rule: if the modifier has a letter in it, it's a HCPCS modifier. If that modifier is entirely numeric, it's a CPT modifier.

HCPCS modifiers, like CPT modifiers, provide additional information about a procedure or service without redefining the service provided. There are hundreds of modifiers established in the HCPCS code set. It would take far too long to list all of the HCPCS modifiers so, for the sake of simplicity, we'll stick to the list of HCPCS modifiers found in the CPT manual. They are as follows.

HCPCS MODIFIERS IN CPT MANUAL

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

GG: performance and payment of a screening mammogram
and diagnostic mammogram on the same patient, same day

GH: diagnostic mammogram converted from screening mammogram on same day

LC: left circumflex coronary artery

LD: left anterior descending coronary artery

LT: left side (used to identify procedures performed on the left side of the body)

QM: ambulance service provided under arrangement by a provider of services

QN: ambulance service furnished directly by a provider of services

RC: right coronary artery

RT: right side

(used to identify procedures performed on the right side of the body)

TA: left foot, great toe

T1: left foot, second digit

T2: left foot, third digit

T3: left foot, fourth digit

T4: left foot, fifth digit

T5: right foot, great toe

T6: right foot, second digit

T7: right foot, third digit

T8: right foot, fourth digit

T9: right foot, fifth digit

As you can see, these modifiers cover a broad scope of information. While most of the above codes correspond to parts of the body, there are also modifiers for ambulance services and mammograms. If you look at the full list of HCPCS modifiers, you'll also find modifiers that describe everything from the Medicare eligibility of a procedure to the number of wounds dressed on a single patient.

1. FUNCTIONALITY 2. INFORMATION

As with CPT codes, we always want to use modifiers for functionality first, and information second. That is, you'll want to list the HCPCS modifier that directly affects reimbursement first. Remember that while certain coding forms provide space for multiple modifiers, payers don't always look at modifiers listed after the first two.

CODING WITH CPT & HCPCS MODIFIERS

Note that certain HCPCS modifiers don't "agree" with certain CPT modifiers. The most obvious example of this would be CPT modifier -50 and the HCPCS modifiers -LT and -RT. These modifiers are mutually exclusive: CPT modifier -50 describes a bilateral procedure, while HCPCS modifiers -LT and -RT describe which side of the body a procedure is performed on.

HCPCS MODIFIERS EXAMPLE

Let's look at a simplified example of an HCPCS modifier in action.

A patient is suffering from bronchitis and asthma. This patient has difficulty breathing and calls his doctor. The doctor advises the patient go directly to the emergency room. The doctor arranges with the hospital, which in this case would be the healthcare provider, to pick up the patient in an ambulance with basic life support systems, or BLS.

In order to code this procedure on a claim, we'd look at the A-codes of HCPCS, where the ambulance codes reside. There we'd find AO428, for "Ambulance service, basic life support, non-emergency transport." That's our base HCPCS code.

Since, however, the ambulance was provided by the healthcare provider and not, say, called in via 911, we should add a modifier to explain this. This may seem like splitting hairs, but how an ambulance is called can greatly affect the amount of money owed for a procedure.

In this case, we'd look for a modifier that pertains to ambulance service. We'd find the -QN modifier, for "Ambulance service furnished directly by a provider of services"—in other words, the hospital, the service provider, sent the ambulance over to pick up our patient.

We'd end up with this code: AO428-QN for a basic life support ambulance service, non-emergency transport, furnished by the provider of services.

CPT & HCPCS MODIFIERS EXAMPLE

Let's look at another example, this time using a combination of CPT codes, CPT modifiers, and HCPCS modifiers.

A patient requires the drainage of a large, felon abscess on the tip of the middle finger of his left hand. A "felon" abscess is a complicated infection of the pulp on the distal, or last, phalanx of the hand. During the procedure, however, the patient becomes agitated and doctor decides to discontinue the procedure.

If we're coding this procedure, we'd first look at the procedure performed. This is a procedure done to a patient, so we're probably going to find it the CPT codebook. It's also a surgical procedure, so we'd find it in the Surgery section of the codebook. Specifically, this is an incision—it's drainage made via a cut to the skin.

Once in the surgery section, we'd flip to the musculoskeletal subsection and find the Hand and Fingers field of codes. There we'd find the codes for incision and see that there are two codes for drainage of a finger abscess: the parent code 26010 for "drainage of finger abscess; simple" and the indented code 26011 for "drainage of finger abscess; complicated (eg, felon)."

The abscess we're draining is complicated—it's even listed in the code as an example of a complicated abscess. So, we'd select the indented code and put 26011 as our base code.

Now we'd need to look at the additional information. What's the more important code for reimbursement: the place on the hand where the procedure took place, or the fact that the procedure was discontinued? In this case, it'd be the discontinued procedure.

We'd add the CPT modifier -53 for discontinued procedure, and then we'd look at the HCPCS modifiers for where on the body the procedure was performed. If you'll recall, some of the HCPCS modifiers we listed earlier have to do with parts of the hand. We'll look at these modifiers and find the one that fits our need: F2, for "left hand, third digit."

So our code would look like this: 26011-53-F2: a discontinued drainage of a complicated abscess on the third digit of the left hand.

Coding with HCPCS modifiers won't always be as easy as that example, but that one should give you a good idea of how these additions to the code set help us code to the highest level of accuracy.

That concludes this course on HCPCS modifiers. Like the rest of the HCPCS code set, it's easy to get overwhelmed by the number and variety of options available. Once you get the hang of HCPCS's organizational structure, though, you should be able to easily navigate this important, useful code.

CROSSWALKING

As you may have gathered from the previous courses, working in medical coding sometimes requires finding equivalencies between different code sets. The code sets CPT, HCPCS, and ICD are updated annually, and medical coders need to know how to find and map codes that may have changed between updates.

To do this, we perform a task called crosswalking. The term ‘crosswalking’ actually comes from computer science. Put simply, crosswalking is the mapping of equivalent, identical, or similar information across two or more distinct data sets. Put another way, when you crosswalk codes, you perform a coding translation between two sets, not unlike how coders translate medical reports into codes in the first place.

We crosswalk between similar code sets or code sets that perform the same, or highly similar, functions. That is, the code sets we’re translating between need to both describe the same thing. Bear in mind that crosswalking is not the process of finding the correct diagnosis code for a particular procedure. That’s the demonstration of medical necessity, and it’s an unavoidable part of the coding process. We’ll cover that in a little more depth in our Section 2 review and in Section 4.

Most crosswalking is done between two versions of the same code set. That is, a newer version and its older, now out-of-date version. For instance, the AMA updates the CPT code set every year, adding, changing the definitions or descriptions of, and deleting codes. In certain cases you’d to find older CPT codes. For the most part, CPT and HCPCS make this easy for you by listing deleted and updated codes in appendices in the back of each code manual.

The real crosswalking challenge for the medical coder is between ICD-9-CM and ICD-10-CM. As we mentioned in our introduction to ICD-10-CM, ICD-9-CM is out of date and no longer able to effectively represent new medical diagnoses. ICD-10-CM, its long overdue upgrade, is significantly larger and more flexible than its predecessor, thanks to its new format.

CROSSWALKING BETWEEN ICD-9-CM & ICD-10-CM

To review, ICD-9-CM has five characters and is primarily numeric, with a few alphanumeric codes used in certain situations. ICD-10-CM, on the other hand, is seven characters long and entirely alphanumeric. Where each ICD-9-CM code could have one subcategory and one subclassification, an ICD-10-CM code can have one subcategory and two subclassifications, in addition to an alpha extension that provides information as to which visit, or encounter, this is with the patient’s particular illness or injury.

ICD-10-CM is obviously a much more extensive, detail-oriented code set, but its new format and organization presents coders with a challenge. As we mentioned in Course 2-6, ICD-10-CM is going into effect on October 1, 2014. Coders will need to be fluent in both ICD-9-CM and ICD-10-CM, as they may need to translate codes back and forth from one set to the other. If, for instance, you were helping analyze certain diagnoses from the 2014 calendar year (which,

again, will see both code sets in use), it may be easier to crosswalk new ICD-10-CM codes to ICD-9-CM codes, in order to have a uniform data set.

Or, if in 2015 you are looking at a patient's medical history from before 2010, it may be necessary to crosswalk those ICD-9-CM codes forward to ICD-10-CM to comply with contemporary coding standards.

The new ICD-10-CM format makes this crosswalking process difficult. Remember, as coders, we always to be as exact as possible. But because of the increased number of subclassifications, the higher specificity (including ICD-10-CM's use of laterality and information regarding location on the body), and ICD-10-CM's organization, less than a quarter of ICD-10-CM codes have an exact match in ICD-9-CM.

So how should we approach the crosswalking process? The best place to start is by breaking down the types of matches there are between code sets. The AMA has classified four types of matches between ICD-9-CM and ICD-10-CM. Let's take a look at them now.

ONE-TO-ONE EXACT MATCHES

In these matches, one code set (the source) has an exact match, down to the wording, in the other code set (the target). An example of this would be the ICD-9-CM code 416.0 ("primary pulmonary hypertension") and ICD-10-CM Vcode I27.0 ("primary pulmonary hypertension"). Only five percent of codes in ICD-10-CM map directly from ICD-10-CM to ICD-9-CM, and 24 percent map directly in the other direction.

ONE-TO-ONE APPROXIMATE MATCHES WITH ONE CHOICE

Notably more common than exact matches, approximate matches with one choice make up a majority of the crosswalking procedure. 82.6 percent of ICD-10-CM codes can be crosswalked back to ICD-9-CM as approximate matches with one choice, and 49.1 percent can be mapped in the other direction. Matches like this describe a "close-enough" pairing for two codes. For instance, ICD-9-CM code 422.91 ("idiopathic myocarditis") is an approximate match for I40.1 ("isolated myocarditis"). These are not an exact match, obviously, but they are close, and there's only one choice in each code set that works with both.

ONE-TO-ONE APPROXIMATE MATCHES WITH MULTIPLE CHOICES

While exact and approximate matches with only one choice make up the majority of crosswalked codes, coders will occasionally run into coding crosswalks that are less specific. The first of these is an approximate match with multiple choices. In instances of multiple-choice matches, a coder may find two or more options in one code set that correspond to a single code in another set. For instance, the ICD-10-CM codes C22.0 ("liver cell carcinoma") and C22.2 both correspond to the ICD-9-CM code 155.0 ("malignant neoplasm of the liver, primary"). In situations such as this, it's up to the coder to decide which of the choices of codes works best for the particular claim.

ONE-TO-MANY MATCHES

This is the most difficult and time-consuming type of ICD-10-CM/ICD-9-CM crosswalk. In one-to-many matches, a code in the source set must be created out of multiple codes in the target set. This happens primarily when moving from ICD-9-CM to ICD-10-CM (remember, ICD-10-CM is more specific, and many broad diagnoses in ICD-9-CM have been subdivided into separate codes into

ICD-10-CM). For instance, the ICD-9-CM code 800.10 (closed fracture of vault of skull with cerebral laceration and confusion, state of consciousness unspecified) is a one-to-many match with two different ICD-10-CM codes: S02.0XXA (“fracture of the vault of the skull, initial encounter for closed fracture”) and S06.339A (“contusion and laceration of the cerebrum, unspecified, with lost of consciousness of unspecified duration, initial encounter”).

In one-to-many matches, a single code in one set must be crosswalked to a “cluster” of codes in the other set. Clusters are always between two and four codes. There may be multiple target clusters for a single source code. It’s up to the coder to look at and abstract all of the concepts in the single source code, and find their corollaries in the target code set. This process of crosswalking by cluster requires diligence and a lot of review, as a missing code from one of the clusters can drastically affect the status of a claim or report.

NO MATCH

In certain cases, there is simply no match between code sets. This typically only happens in cases of crosswalking ICD-10-CM back to ICD-9-CM. In these instances, coders may use the phrase “NoDX” to show that there is no target diagnosis code that matches the source code.

GENERAL EQUIVALENCY MAPPINGS (GEMs)

Crosswalking between ICD-10-CM and ICD-9-CM is one of the most important skills a coder can learn as the changeover date approaches. In order to help coders, the National Center for Health Statistics has created a set of tools, called General Equivalency Mappings, or Gems. GEMs are like guides that list a code from one set and its exact, possible, or appropriate match in the other set.

Like many aspects of the crosswalking process, GEMs can be very intimidating, and they’re difficult to fully understand without a thorough knowledge of the medical coding practice itself. For reasons of brevity and space, we won’t be discussing them in great detail in this course, other than in general terms. If you’d like to learn more about GEMs, how they work, and how to use them, you can find a thorough, comprehensive guide here: ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2013/

MAIN RULE OF CROSSWALKING

One of the main things we learn from looking at GEMs is which codes can be transferred from one set to another. One of the main rules of crosswalking is: You can code from a specific injury to a general one, but you cannot code from the general to the specific.

CROSSWALKING EXAMPLE

For example, you could crosswalk the ICD-10-CM code S11.014 (“puncture wound with foreign body of larynx”) to ICD-9-CM code 874.1 (“open wound of larynx and trachea, complicated), but you could never reverse that crosswalk. That is, you can’t infer specific pieces of information from a more general diagnosis code and then apply them to a more specific code in another set.

Because crosswalking requires a thorough understanding of both ICD-10-CM and ICD-9-CM, we won’t dive much deeper than that in this course. As you train to become a medical coder, you’ll want to take extra courses that instruct you how to map codes effectively between the two sets. Having a fluency in the crosswalking process will make you a more desirable hire, especially as the changeover date of October 1, 2014 approaches.

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 majority of the medical coding profession uses some type of coding software.

Software programs like Epic, Centricity, AdvancedMD, Flash Code, Eclipse, and others have fields where coders can enter the correct procedure and diagnosis codes. These 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.

Epic is considered by many to be the gold standard and one of the more complicated programs. Coders who familiarize themselves with the Epic software program should be well suited to mastering other coding programs. These programs are often paired with medical billing programs.

Because these programs are copyrighted, and because using them requires a more complete understanding of the coding process and its day-to-day requirements, we won't be covering them in great depth in this course. Instead, we'll look at some of the things you'll be able to do with coding software.

BENEFITS OF CODING SOFTWARE

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. Software like Epic and Eclipse can help coders keep track of their lag time for codes, allowing for better organization and a faster turnaround in the reimbursement cycle. Many coding programs also check, automatically, for compatible codes, though the onus is always on the coder to check and double-check using their coding manuals.

A good coding software program should meet the needs of your practice or coding organization. Coding software should also be compliant with CMS-1500 forms and all HIPAA regulations (we'll cover both of these in *More About Insurance and the Insurance Claims Process* and *HIPAA 101* in Section 3, respectively). Put simply, CMS-1500 is the general form used to send claims to Medicare, Medicaid, and many other third-party payers, and HIPAA is a law that created a set of standards for electronic billing and coding in the mid-1990s.

Bear in mind that most coders won't get to select the software they use, unless they start their own coding business. That usually doesn't happen until a coder has five to ten years of professional experience.

MEDICAL CODING REVIEW

By now, you should have a decent grasp on the basics of the medical coding practice. Before we wrap up the section with a quiz, you can use this course to review some of the basic information we've covered. (You can find the Section 2 Review Quiz on our website at: www.medicalbillingandcodingcertification.com)

After completing the quiz, you can move on to Section 3 and learn more about medical billing, or check out Section 4 for some real-life examples of medical coding in action.

INT'L CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM)

ICD-9-CM is the primary diagnostic code set in use in the United States today. Despite being more than ten years out of date, it's still the primary way coders represent illness and injury in a patient. It's used in the reimbursement cycle to demonstrate medical necessity. That is, ICD-9-CM codes show the insurance payer why the provider had to perform a certain medical service.

CODE SET BREAKDOWN

ICD-9-CM codes are three-to-five characters long, and are primarily numeric. The code set is divided into "chapters," each of which focuses on a certain type of illness or injury. For example, Chapter 1 contains diagnosis codes for Infectious and Parasitic Diseases, Chapter 2 contains codes for Neoplasms, Chapter 5 has codes for Mental Disorders, and so on.

CODE BREAKDOWN

The first three digits, with the exception of E-codes, of an ICD-9-CM code is called the "category." There is always a category in ICD-9-CM. The category describes the general type of injury or disease that's being described in the code. A decimal point follows the category. The digit after that is called the "subcategory." The subcategory provides additional information about the illness or injury described in the category—what type of disease is it? What type of injury? The final digit in an ICD-9-CM code is the "subclassification." This further expands on the subcategory, and provides even more information about the code. A subclassification might provide information on where an injury is or what may have caused the diseases described in the category.

E-CODES & V-CODES

There are alphanumeric codes in ICD-9-CM. These are called E-codes and V-codes, as they begin with those letters. E-codes describe external circumstances, such as car accidents, that caused the injury. E-codes are the only ICD-9-CM codes that have a letter and then three digits in the "category." V-codes, on the other hand, describe external circumstances that are not life threatening or injury or disease related that nevertheless cause a person to go see a healthcare provider. One such example would be a family medical history of a particular disease, or exposure to a disease-inducing chemical at a workplace.

INT'L CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION (ICD-10-CM)

ICD-10-CM is the update to ICD-9-CM. Published by the World Health Organization (WHO) in 1999, it features a revised format and more than four times as many codes as ICD-9-CM. It's organization and format is based on ICD-9-CM, but is different enough that a major training movement is underway to prepare the medical industry for the shift from ICD-9-CM to ICD-10-CM in October of 2014.

CODE SET BREAKDOWN

ICD-10-CM is three-to-seven characters long, and is entirely alphanumeric. Like ICD-9-CM, it's organized into "chapters" or sections based on the type of disease or condition shown in the diagnosis. For instance, Chapter 1 in ICD-9-CM is now the set of A- through B-codes: A00-B99, Certain Infectious and Parasitic Diseases.

CODE BREAKDOWN

ICD-10-CM codes all have three-character categories and one-digit subcategories. The subcategory once again follows the decimal point after the category. ICD-10-CM codes feature up to three subclassifications. These extra subclassifications allow ICD-10-CM to feature much more specific information about the disease or injury described in the diagnosis. ICD-10-CM, for example, has codes for laterality—which side of the body the injury or illness is on.

EXTENSIONS & PLACEHOLDERS

ICD-10-CM codes also feature alphabetic extensions. These extensions can only occupy the seventh and final character of an ICD-10-CM code, and describe the episode of care for the injury or illness. In other words, extensions show which visit this is for a particular condition. These may be broadly divided into categories of "initial encounter" (the first visit for a condition), "subsequent encounter" (A follow-up for the same condition), or "sequela" (a visit for a condition stemming from a prior condition). Extensions are typically used in codes for Injury and codes for Childbirth, though they may show up elsewhere. In the case of adding an extension to a code that does not go to the final subclassification, codes use placeholders, typically the letter X.

WHY ARE WE SWITCHING FROM ICD-9-CM TO ICD-10-CM?

Put simply, ICD-9-CM is out of room. As medical technology advances and we are able to make new, more nuanced diagnoses, we need a code set that is more adaptable. ICD-9-CM's foundation of numeric categories makes it very difficult to add new types of diseases, and its lack of specificity can make inaccurate and inefficient.

ICD-10-CM has more "room" for new codes, and its focus on specific iterations of certain conditions make it a far more data-rich code set for health organizations, health providers, and insurance companies.

Additionally, the rest of the world is already using some version of ICD-10-CM. This means that tracking health data from diagnoses in the US is a difficult task. Upgrading to ICD-10-CM means the United States will once again use "universal" diagnosis codes.

CROSSWALKING

We transfer between ICD-9-CM and ICD-10-CM through a process called crosswalking. Crosswalking entails the mapping of similar information across similar but distinct data sets. You could think of translating between two languages as a sort of crosswalking: 'bread' in English is 'pan' in Spanish.

You can crosswalk between any two code sets, but for the sake of simplicity we'll confine it to ICD-9-CM and ICD-10-CM.

Crosswalking entails finding exact, approximate, or appropriate matches between the two code sets. Since there are far more codes in ICD-10-CM than ICD-9-CM, it's generally much easier to find an appropriate match for

an ICD-9-CM code in ICD-10-CM than the other way around. We call the code in the first set the “source,” and the code to which we’ll match the source the “target.” When crosswalking, you may go from the specific to the general, but you may never infer specific information from a general diagnosis. That is, you could crosswalk a diagnosis of “closed fracture of distal phalanx of great toe on left foot” to “fracture of distal phalanx of great toe,” but you could never crosswalk those diagnosis codes in the opposite direction.

Crosswalking is not an exact science. Less than a quarter of ICD-10-CM codes have exact matches in ICD-9-CM. The goal of crosswalking is to facilitate the transfer between these two code sets and allow better data tracking. In order to assist coders, the National Center for Health Statistics (NCHS) has created a set of General Equivalency Mappings (GEMs). These list appropriate matches between the two code sets, and are invaluable resources as you move further in crosswalking.

CURRENT PROCEDURE TERMINOLOGY (CPT)

ICD codes describe the why of a medical procedure. CPT codes describe the what. CPT codes correspond to almost every medical procedure performed by a healthcare provider, and are the primary way that providers inform payers of their services.

CATEGORY I

CPT codes are divided into three Categories. These Categories are different than the categories in ICD, of course. CPT Categories refer to the division of the CPT code manual: Category I is the larger and more important Category. Category I contains the codes for procedures in the six major fields of health care. Category II contains supplementary codes that may be used to add or track data, and are often used in performance management.

Category I CPT codes are five digits long and entirely numeric. (Category II is alphanumeric, but we’ll focus our attention on Category I here). Category I is divided into six sections, each corresponding to a major field of medicine. The sections are: Evaluation and Management, Anesthesiology, Surgery, Radiology, Pathology and Laboratory, and Medicine. These sections are, for the most part, ordered numerically. (Evaluation and Management is out of order and placed at the front Category I for ease of access—E&M codes are used frequently by most practices).

Each section in Category I is broken down into further subsections. For example, the Surgery section is subdivided into sections based on where on the body the surgery is performed. Those subsections are then further divided by what kind of surgical procedure (an incision vs. an excision, for example) is being performed.

Many Category I CPT codes are procedures that are based on a general, “parent” procedure. The parent procedure is often a basic or simplified version of the procedure, while the codes indented below it describe variations on that procedure that are too specific to be included in the parent code.

CATEGORY II & III

Let’s look briefly at Category II and III codes. Category II codes are optional codes that are added to Category I or Category III codes. Category II codes

describe things like patient management, patient history, and the results of certain diagnostic or screening tests. Category II codes are supplemental and may never take the place of a Category I or Category III code.

Category III contains temporary codes for emerging and experimental procedures. CPT is updated annual to keep up with new and emerging medical procedures and technologies, and Category III is the place where new procedures go for their “test run.” Before a procedure can be added to Category I, it needs to be performed a certain number of times by a certain number of different providers. Category III is where the codes that are not yet official, but are being tested out, reside.

CPT MODIFIERS

CPT modifiers are an important part of coding with CPT. These two-digit, entirely numeric modifiers are added to the end of a CPT code with a hyphen, and may describe the what, the who, the where, and the how of a particular procedure. There are modifiers for things like multiple surgeons, discontinued procedures, and increased procedural services. These modifiers are integral in the reimbursement cycle, as they tell the payer that a provider had to work more (or less) during a particular procedure.

Because these modifiers can be very important to the billing process, we order them in such a way that the most important, or “functional” modifier goes first. That is, if there is a modifier for “increased procedural services” (-22) and one for “bilateral procedure” (-50) we’d code the -22 modifier first, as it tells the payer that the provider had to perform extra work.

The reason for this is simple: despite the fact that most claims have room for up to four modifiers for each procedure, many third party payers sometimes ignore modifiers after the first two. For this reason, it’s important the modifiers directly related to the reimbursement cycle come first.

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

The final of the three critical code sets used by medical coders is HCPCS (pronounced hick-picks). Developed by the Center for Medicare and Medicaid Services (CMS), HCPCS is the primary way that billers describe procedures to Medicare, Medicaid, and a host of other third-party payers.

LEVEL I

HCPCS is based on CPT. So much so that the first section (Level) of HCPCS is identical to CPT. It’s a bit technical, but when you use CPT, but submit it to Medicare, Medicaid, or one of the third-party payers that accepts HCPCS, those CPT codes become HCPCS codes. You don’t have to enter anything differently. Since the code sets are the same, payers simply recognize Category I CPT codes and Level I HCPCS codes as interchangeable.

LEVEL II

The code sets diverge with HCPCS Level II. HCPCS Level II describe the various non-physician services administered or prescribed by healthcare providers that aren’t covered in CPT. It’s a broad swath of codes—so broad that HCPCS is sometimes referred to as the “hall closet of medical coding.” It’s got a little bit of everything in there.

These codes are five characters long and alphanumeric. The code set is divided by area of focus and assigned a letter, which doubles as the first character of the code. For instance, B-codes are for Enteral and Parenteral Therapy, E-codes are Durable Medical Equipment, P-codes are Pathology and Laboratory, and so on. Level II Codes include dosages of non-orally administered medicine (like injections) and each specific type of splint, so the code is extremely specific.

Coders use HCPCS Level II just as they would CPT. If there is equipment, certain professional services, injected medication, or any number of things listed on the report that aren't found in CPT, the coder should use HCPCS Level II.

HCPCS MODIFIERS

Like CPT, HCPCS has a set of two-character modifiers that provide important additional information about the code. These modifiers are added to the end of either CPT or HCPCS Level II codes with a hyphen. You may use HCPCS modifiers alongside CPT codes and CPT modifiers. You can tell whether a modifier is a HCPCS or CPT modifier quite easily: CPT modifiers are always numeric, and HCPCS modifiers are always alphanumeric.

There are significantly more HCPCS modifiers than CPT modifiers. HCPCS modifiers may describe everything from the type of ambulance service performed to the location on the body a procedure was performed.

USING CPT & HCPCS MODIFIERS

Bear in mind that certain HCPCS modifiers do not “agree” with certain CPT modifiers. The most common of these mutually exclusive relationships is the HCPCS modifiers -LT and -RT, which describe which side of the body a procedure is performed on, and the CPT modifier -50, which describes a bilateral procedure. Obviously something can't be performed on the left side of the body and be a bilateral procedure.

As with CPT modifiers, coders should always order functional HCPCS modifiers first, and informational modifiers second.

That concludes our review for Section 2. Before taking the review quiz, feel free to rewatch any course videos and look at our downloadable materials for extra information.

INTRODUCTION TO MEDICAL BILLING

By now you've got a good idea about the practice of medical coding. But we still don't know much about what those codes are used for.

While it's true that we can use diagnosis and procedure codes to track the spread of disease or the effectiveness of a particular procedure, their main use in the United States is in the reimbursement process. In other words, codes help us bill accurately and efficiently.

WHY WE BILL

Going to the doctor may seem like a one-to-one interaction, but in reality it's part of a large, complex system of information and payment. While the insured patient may only have direct interaction with one person or healthcare provider, that check-up is actually part of a three-party system.

The first party is the patient. The second party is the healthcare provider. The term 'provider' includes hospital, physicians, physical therapists, emergency rooms, outpatient facilities, and any other place where medical services are performed. The third and final party is the insurance company, or payer.

It's the medical biller's job to negotiate and arrange for payment between these three parties. Specifically, the biller ensures that the healthcare provider is compensated for their services by billing both patients and payers. We bill because healthcare providers need to be compensated for the services they perform.

In order to do this, the biller collects all of the information (found in a "super-bill") about the patient and the patient's procedure, and compiles that into a bill for the insurance company. This bill is called a claim, and it contains a patient's demographic information, medical history, and insurance coverage, in addition to a report on what procedures were performed and why.

MORE ABOUT INSURANCE

Let's take a quick step back to talk briefly about the insurance process. Health insurance is insurance against medical expenses. Put simply, people with health insurance, sometimes called 'the insured' or 'subscribers,' pay a certain amount in order to have a degree of protection against medical costs.

Health insurance comes in a number of forms, including:

Indemnity: Or pay-for-service insurance, in which the patient may choose any provider they like. This insurance is typically costlier, but grants the insured person more flexibility. As healthcare prices rise, indemnity insurance is becoming less and less popular.

Managed care organizations (MCO): This is a blanket term that includes organizations like Healthcare Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Patients have fewer options as to which providers they can see, but their premiums and deductibles are fixed and are generally lower. Essentially, managed care insurance restricts patient's options but also lowers the cost of having health insurance. This is the most popular form of health insurance in the United States today.

Consumer-driven health plans (CDHP): This plan is similar to a PPO, but it also features a savings account, which subscribers pay into regularly and which is used to pay medical bills before the deductible has been met. CDHPs have high deductibles and low premiums, and are an increasingly popular option.

We'll look more at health insurance in just a bit, and we'll look even deeper into the insurance claims process in *More About Insurance and the Insurance Claims Process* later in Section 3.

With each of these types of insurance, there are procedures and services that are covered, and some that are not. It's the medical biller's job to interpret a patient's insurance plan (or plans) and use this information to create an accurate claim.

MORE ABOUT CLAIMS

The creation of the claim is where medical billing most directly overlaps with medical coding. Medical billers take the procedure and diagnosis codes used by medical coders and use them to create claims. If you'll remember from Section 2, it's the coder's job to translate the medical report accurately into numeric and alphanumeric codes.

Procedure codes, whether Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS), tell the payer what service the healthcare provider performed. Diagnosis codes, documented using ICD codes, demonstrate medical necessity. In other words, **procedure codes** tell the *what* of a patient's visit, and the **diagnosis codes** tell the *why*.

The biller adds information about the patient and the patient's visit, along with the cost of the procedure or procedures performed, to the claim. So the claim now has a what, a why, a who, a when, and a how much.

CROSSWALKING

At this point, the biller also checks to make sure a claim is compliant. That is, the claim is factually and formally correct. This is a complicated process, as the biller must know what.

The claim allows the payer to fully evaluate the procedure and decide how much they will reimburse the provider. If the claim is approved, it's sent back to the biller with the amount the payer is going to pay. The biller then takes the amount, called the balance, and sends it on to the patient.

We'll take a closer look at *The Medical Billing Process* and the claims process specifically in *More About Insurance and the Insurance Claims Process* in this section.

DAY-TO-DAY ACTIVITIES

Now that you've got a little more information about the overall process, here's a quick look at the day-to-day activities of a professional medical biller.

WORKING WITH PATIENTS

When a patient receives medical services from a healthcare provider, they're typically presented with a bill at the end of their services. The biller creates this bill by looking at the balance (if any) the patient has, adding the cost of the procedure or service to that balance, deducting the amount covered by insurance, and factoring in a patient's copay or deductible.

Billers also work daily with a patient's medical records. Like coders, billers abstract a large amount of information from medical documents. Where coders use medical reports to accurately translate medical services into code, billers abstract information from patients' medical records and insurance plans to create accurate medical bills.

WORKING WITH COMPUTERS

Computer programs are invaluable tools in the world of medical billing. Today, almost every doctor's office in the country uses some form of practice management software. This software keeps track of patients, helps schedule visits, stores important medical information and generally helps the practice run smoothly. Medical billers use practice management software to generate reports on the status of claims, record payments from payers and patients, create statements for patients, and much more.

CREATING CLAIMS

The majority of a medical biller's day is spent creating and processing medical claims. Billers need to be familiar with what type of claim an insurance payer accepts, and adjust their claim creation accordingly. Billers may also work frequently with insurance clearinghouses to streamline the claims process. Billers also have to check that each claim is compliant. Ideally, every claim a biller sends out will be "clean." A clean claim contains no errors, and will be processed speedily by the payer, ensuring that the healthcare provider gets reimbursed quickly and efficiently.

NOTIFICATION AND COMMUNICATION

A biller is constantly in communication with insurance payers, clearinghouses, providers, and patient. Since the biller acts as the waypoint for the reimbursement process, they frequently have to clarify and follow-up with all parties of the healthcare process.

Billers also explain and notify patients of their bill. Billers are in charge of issuing Explanations of Benefits (EOBs) to patients, which list which procedures are covered by the payer and why. Billers must also follow up with patients about paying the balance on their medical bills. This may lead to collections.

COLLECTIONS

In the case of a patient with delinquent bills, a medical billing specialist may have to arrange for collections on that debt. This is not necessarily a "day-to-day" activity, as one would hope that a provider's patients were not ignoring their medical bills on a daily basis, but it is something to be aware of.

In the courses that follow, we'll learn more about the steps of the medical billing process, the insurance claims process, Medicare and Medicaid, HIPAA and more.

MEDICAL BILLING VOCABULARY

The profession of medical billing has its own specific vocabulary. Learn about some of the key terms and concepts in the medical billing field. We'll expand on a number of these topics in later courses, so just try and take in the general idea behind these terms.

Allowed Amount: The amount an insurance company will pay to reimburse a healthcare service or procedure. The patient will typically pay the balance if there is any remainder.

Ancillary Services: A service administered in a hospital or other in-patient facility beyond simple room and board. This includes physical therapy, consultations, diagnostic tests and other important medical procedures.

Appeal: The process by which a patient or provider attempts to persuade an insurance payer to pay for more (or, in certain cases, pay for any) of a medical claim. The appeal on a claim only occurs after a claim has either been denied or rejected (See "Rejected Claim" and "Denied Claim").

Applied to Deductible (ATD): The amount of money a patient owes a healthcare provider that goes to paying their annual deductible (See "Deductible"). A patient's deductible varies, and depends on that patient's insurance policy.

Assignment of Benefits (AOB): Insurance payments paid directly to the healthcare provider for medical services administered to the patient. The assignment of benefits occurs after a claim has been successfully process.

Authorization: In certain cases, a patient's insurance plan requires them to get permission from the payer before receiving a certain medical service. If a patient ignores this authorization, the claim for that procedure may be denied and the patient will be saddled with the entire bill.

Beneficiary: The person who receives benefits or insurance coverage. Beneficiaries are not always the ones paying for the plan, as in the case of children on their parent's healthcare plans.

Capitation: An arrangement between a healthcare provider and an insurance payer that pays the provider a fixed sum for every patient they take on. Capitated arrangements typically occur within HMOs (See "Health Maintenance Organization (HMO)"). HMOs enlist patients to service providers, who are paid a certain amount based on the patient's health risks, age, history, race, etc.

Clean Claim: A claim received by an insurance payer that is free from errors and processed in a timely manner. Clean claims are a huge boon to providers, as they reduce turnaround time for the reimbursement process and lower the need for time-consuming appeals processes. Many providers send their claims to third parties, like clearinghouses (See "Clearinghouse"), that specialize in creating clean claims.

Clearinghouse: A third-party organization in the billing process, and separate from the healthcare provider and the insurance payer. Clearinghouses review, edit, and format claims before sending them to insurance payers. This process is sometimes called “scrubbing.”

Centers for Medicare and Medicaid Services (CMS): A federal agency that manages and oversees healthcare coverage through Medicare and Medicaid. CMS, if you remember from Section 2, also maintains HCPCS codes. CMS directly affects the healthcare of over 100 million Americans, and this number is growing every day. (See “Medicare” and “Medicaid”).

CMS 1500: A paper form used to submit medical claims to Medicare and Medicaid. Many commercial insurance payers also require providers to submit their claims using a CMS 1500, making this one of the most common and important tools in the medical billing process.

COBRA Insurance: A federal program that grants a person recently terminated to retain health insurance with their former employer for 18 months, and up to three years if the former employee is disabled.

Co-insurance: A type of insurance arrangement between the payer and the patient that divides the payment for medical services by percentage. While this is sometimes used synonymously with a co-pay (See: “Co-pay”), the arrangements are different: while a co-pay is a fixed amount the patient owes, in a co-insurance, the patient owes a fixed percentage of the bill. These percentages are always listed with the payer’s percentage first (eg a 70-30 co-insurance).

Coordination of Benefits: When a patient is covered by more than one insurance companies, those companies arrange themselves into a hierarchy. One payer becomes the primary carrier, and the remaining companies will assume the roles of secondary or tertiary carriers. These secondary or tertiary carriers may cover what costs are left over after the primary carrier reimburses the healthcare provider for the services rendered.

Co-pay: The amount a patient must pay to a provider before they receive any medical service. Co-pays are distinct from deductibles (See “Deductible”) and are slightly different from co-insurances. The co-pay for a patient may change depending on the patient’s plan and the medical service to be administered.

Crossover Claim: When a claim is sent from a primary insurance carrier to a secondary carrier, or vice versa, this is called a crossover claim.

Deductible: The amount a patient must pay before an insurance company extends their coverage. This number, which you can think of as a threshold of payment, varies depending on a patient’s insurance plan. A patient with a \$200 deductible, for example, would have to pay the first \$200 of a \$500 procedure, after which his insurance company would cover the rest. Note that this is distinct from a co-pay (See “Co-pay”), and that patients may often have to pay both their deductible and their co-pay before receiving a service.

Electronic Claim: A claim sent electronically using a provider’s billing software. Electronic billing is a rapidly expanding field, but you should note claims must still adhere to billing regulations laid out by the federal government.

Explanation of Benefits (EOB): A document attached to a processed claim that explains to the provider and patient which services an insurance company will cover. EOBs may also explain what is wrong when a claim is denied.

Electronic Remittance Advice (ERA): A digital version of the EOB, this document describes how much of a claim the insurance company will pay and, in the case of a denied claim, explains why the claim was returned.

Financial Responsibility: Financial responsibility describes which party—insurance payer or patient—owes money to the healthcare provider. Financial responsibility is outline in the patient’s healthcare insurance agreement.

Fiscal Intermediary (FI): A Medicare representative who processes Medicare claims.

Guarantor: An individual paying for the insurance plan who is not also the patient. Parents are the most common examples of guarantors. You may also see guarantors referred to as “responsible parties.”

Health Insurance Portability and Accountability Act (HIPAA): An law passed in 1996 that has lasting effects on the healthcare industry today. Title I of the act protects workers’ health insurance when they change or lose jobs. Title II of the Act established standards and best practices in electronic health care. (Refer to *HIPAA 101* and *HIPAA and Medical Billing* later in Section 3.)

Health Maintenance Organization (HMO): A network of healthcare providers that offer coverage to patients for medical services exclusively within that network. (We’ll cover this type of insurance more thoroughly in *More About Insurance and the Insurance Claims Process* later in Section 3.)

Indemnity: Also known as fee-for-service insurance, this type of insurance allows patients to receive care from any healthcare provider in exchange for higher fees and deductibles. Unlike an HMO, this plan allows for greater flexibility on the patient’s part, but it does cost significantly more.

Independent Practice Association (IPA): A professional organization of physicians or healthcare providers who have a contract with an HMO. HMOs contract IPAs to provide services to patients within the HMO’s network, but their individual practices do not have to be part of the HMO network.

Managed Care Plan: A type of insurance plan wherein patients are only eligible to receive health care within the insurance company’s network. HMOs and IPAS (See “Health Maintenance Organization (HMO)” and “Independent Practice Association (IPA)”) are examples of the managed care system.

Medicare: A government insurance program, founded in 1965, that provides healthcare coverage for persons over 65 years old and for people with disabilities. Medicare provides coverage to more than 50 million people in the United States today, and is one of common places you'll send your medical claims to.

Medicaid: Medicaid provides insurance coverage to low-income families and individuals. It is essentially an insurance program for those who cannot afford full insurance coverage. Medicaid is funded at state and federal levels, but each state has its own version of Medicaid that must operate above the minimum requirements established by federal law.

Non-covered Charge (N/C): These are procedures or services on a claim that are not covered by a person's insurance plan.

Patient Responsibility: This is the amount a patient owes the healthcare provider after an insurance payer reimburses their portion of the claim. This may also be called the balance of the bill.

Primary Care Physician (PCP): The physician that provides basic medical services for the patient, like general evaluation, low-level injuries and non-serious illnesses. The PCP may also recommend other healthcare providers to the patient. In HMOs, many PCPs act as "gatekeepers," assessing patients in the network and then sending them to the appropriate specialist in the HMO network.

Point of Service (POS) Plan: In this insurance plan, a patient in an HMO network can go to a physician outside of their network if they are referred there and pay a higher deductible. Think of this as a cross between an HMO and basic indemnity insurance (See "Health Maintenance Organization" and "Indemnity").

Preferred Provider Organization (PPO): A plan similar to an HMO, except that the insurance company, rather than the HMO itself, decides who is in the acceptable provider network. This is a common, subscription-based type of managed care.

Premium: This is the amount a patient regularly pays to an insurance company in order to receive coverage. Premiums are typically paid on a monthly or yearly basis.

Provider: Any healthcare facility that administers healthcare to an individual. Physicians, specialists, clinics, hospitals, general practitioners, and outpatient facilities are all considered providers.

Specialist: A provider, either an individual or an office, that focuses on one type of healthcare. Oncologists, physical therapists, and ophthalmologists are all examples of specialists. In many cases, a patient needs to be referred to a specialist by a primary care physician (See "Primary Care Physician (PCP)") before seeing a specialist for the first time, especially if that patient is a member of a managed care network (See "Managed Care").

Subscriber: The person who is covered under a group policy. Members of

managed care networks are subscribers to that network (See “Managed Care”).

Superbill: Used by healthcare providers, this is an itemized account of the provider’s encounter with a patient. The superbill is the main source of data for creating the medical claim, and may include demographic information, insurance information, diagnoses, and procedures performed.

Supplemental Insurance: A secondary or auxiliary insurance policy that covers a patient’s healthcare cost after they receive coverage from their primary coverage. Supplemental insurance may also be called secondary or, in the case of a patient having more than two policies, tertiary coverage. These supplemental insurance plans are often put in place to help patients cover high deductibles or co-pays.

Triple Option Plan (TOP): Sometimes called a “cafeteria plan,” this plan provides individuals who sign up the option of choosing between an HMO, PPO, or POS coverage (See “Health Maintenance Organization (HMO),” “Preferred Provider Organization (PPO),” and “Point of Service (POS) Plan”).

TRICARE: Formerly known as CHAMPUS, this is a federal health insurance plan for active service members, retired service members, and their families.

UB04: Similar in format to the CMS 1500 (See “CMS 1500”), this is another one of the most common claim forms.

Untimely Submission: Claims must be filed within a certain timeframe. Think of this as an expiration date. If a claim is not sent to an insurance company within the designated timeframe, this claim is labeled an untimely submission and will be denied.

Utilization Limit: Medicare places a yearly limit on certain medical services. If a patient passes this threshold, known as the utilization limit, they may be ineligible for Medicare coverage for that procedure.

Worker’s Compensation: When a company pays for the health insurance of an employee who becomes injured or ill while performing their job’s routine duties. Most states require companies to provide worker’s compensation to their employees.

THE MEDICAL BILLING PROCESS

Medical billing might seem large and complicated, but it's actually a process that's comprised of eight simple steps.

These steps include: Registration, establishment of financial responsibility for the visit, patient check-in and check-out, checking for coding and billing compliance, preparing and transmitting claims, monitoring payer adjudication, generating patient statements or bills, and assigning patient payments and arranging collections.

REGISTER PATIENTS

Bear in mind that there is a difference between "front-of-house" and "back-of-house" duties when it comes to medical billing.

Register Patients

When a patient calls to set up an appointment with a healthcare provider, they effectively preregister for their doctor's visit. If the patient has seen the provider before, their information is on file with the provider, and the patient need only explain the reason for their visit. If the patient is new, that person must provide personal and insurance information to the provider to ensure that that they are eligible to receive services from the provider.

CONFIRM FINANCIAL RESPONSIBILITY

Financial responsibility describes who owes what for a particular doctor's visit. Once the biller has the pertinent info from the patient, that biller can then determine which services are covered under the patient's insurance plan.

Insurance coverage differs dramatically between companies, individuals, and plans, so the biller must check each patient's coverage in order to assign the bill correctly. Certain insurance plans do not cover certain services or prescription medications. If the patient's insurance does not cover the procedure or service to be rendered, the biller must make the patient aware that they will cover the entirety of the bill.

PATIENT CHECK-IN & CHECK-OUT

Patient check-in and check-out are relatively straight-forward front-of-house procedures. When the patient arrives, they will be asked to complete some forms (if it is their first time visiting the provider), or confirm the information the doctor has on file (if it's not the first time the patient has seen the provider). The patient will also be required to provide some sort of official identification, like a driver's license or passport, in addition to a valid insurance card.

The provider's office will also collect copayments during patient check-in or check-out. Copayments are always collected at the point of service, but it's up to the provider to determine whether the patient pays the copay before or immediately after their visit.

Once the patient checks out, the medical report from that patient's visit is sent to the medical coder, who abstracts and translates the information in the report into accurate, useable medical code. This report, which also includes demographic information on the patient and information about the patient's medical

history, is called the “superbill.”

SUPERBILL

The superbill contains all of the necessary information about medical service provided. This includes the name of the provider, the name of the physician, the name of the patient, the procedures performed, the codes for the diagnosis and procedure, and other pertinent medical information. This information is vital in the creation of the claim.

Once complete, the superbill is then transferred, typically through a software program, to the medical biller.

PREPARE CLAIMS / CHECK COMPLIANCE

The medical biller takes the superbill from the medical coder and puts it either into a paper claim form, or into the proper practice management or billing software. Biller’s will also include the cost of the procedures in the claim. They won’t send the full cost to the payer, but rather the amount they expect the payer to pay, as laid out in the payer’s contract with the patient and the provider.

Once the biller has created the medical claim, he or she is responsible for ensuring that the claim meets the standards of compliance, both for coding and format.

The accuracy of the coding process is generally left up to the coder, but the biller does review the codes to ensure that the procedures coded are billable. Whether a procedure is billable depends on the patient’s insurance plan and the regulations laid out by the payer.

While claims may vary in format, they typically have the same basic information. Each claim contains the patient information (their demographic info and medical history) and the procedures performed (in CPT or HCPCS codes). Each of these procedures is paired with a diagnosis code (an ICD code) that demonstrates the medical necessity. The price for these procedures is listed as well. Claims also have information about the provider, listed via a National Provider Index (NPI) number. Some claims will also include a Place of Service code, which details what type of facility the medical services were performed in.

Billers must also ensure that the bill meets the standards of billing compliance. Billers typically must follow guidelines laid out by the Health Insurance Portability and Accountability Act (HIPAA) and the Office of the Inspector General (OIG). We’ll discuss HIPAA and its effect on medical billing in Course 3-8 and 3-9. OIG compliance standards are relatively straightforward, but lengthy, and for reasons of space and efficiency, we won’t cover them in any great depth here.

TRANSMIT CLAIMS

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all health entities covered by HIPAA have been required to submit their claims electronically, except in certain circumstances. Most providers, clearinghouses, and payers are covered by HIPAA.

Note that HIPAA does not require physicians to conduct all transactions electronically. Only those standard transactions listed under HIPAA guidelines must be completed electronically. Claims are one such standard transaction.

Billers may still use manual claims, but this practice has significant drawbacks. Manual claims have a high rate of errors, low levels of efficiency, and take a long time to get from providers to payers. Billing electronically saves time, effort, and money, and significantly reduces human or administrative error in the billing process.

In the case of high-volume third-party payers, like Medicare or Medicaid, billers can submit the claim directly to the payer. If, however, a biller is not submitting a claim directly to these large payers, they will most likely go through a clearinghouse.

A clearinghouse is a third-party organization or company that receives and reformats claims from billers and then transmits them to payers. Some payers require claims to be submitted in very specific forms. Clearinghouse eases the burden of medical billers by taking the information necessary to create a claim and then placing it in the appropriate form. Think of it this way: A practice may send out ten claims to ten different insurance payers, each with their own set of guidelines for claim submission. Instead of having to format each claim specifically, a biller can simply send the relevant information to a clearinghouse, which will then handle the burden of reformatting those ten different claims.

MONITOR ADJUDICATION

Once a claim reaches a payer, it undergoes a process called adjudication. In adjudication, a payer evaluates a medical claim and decides whether the claim is valid/compliant and, if so, how much of the claim the payer will reimburse the provider for. It's at this stage that a claim may be accepted, denied, or rejected.

A quick word about these terms. An accepted claim is, obviously, one that has been found valid by the payer. Accepted does not necessarily mean that the payer will pay the entirety of the bill. Rather, they will process the claim within the rules of the arrangement they have with their subscriber (the patient).

REJECTED CLAIM

A **rejected claim** is one that the payer has found some error with. If a claim is missing important patient information, or if there is a miscoded procedure or diagnosis, the claim will be rejected, and will be returned to the provider/biller. In the case of rejected claims, the biller may correct the claim and resubmit it.

DENIED CLAIM

A **denied claim** is one that the payer refuses to process payment for the medical services rendered. This may occur when a provider bills for a procedure that is not included in a patient's insurance coverage. This might include a procedure for a pre-existing condition (if the insurance plan does not cover such a procedure).

Once the payer adjudication is complete, the payer will send a report to the provider/biller, detailing what and how much of the claim they are willing to pay and why. This report will list the procedures the payer will cover and the amount payer has assigned for each procedure. This often differs from the fees listed in the initial claim. The payer usually has a contract with the provider that stipulates the fees and reimbursement rates for a number of procedures. The report will also provide explanations as to why certain procedures will not be covered by the payer.

SUPERBILL

(If the patient has secondary insurance, the biller takes the amount left over after the primary insurance returns the approved claim and sends it to the patient's secondary insurance).

The biller reviews this report in order to make sure all procedures listed on the initial claim are accounted for in the report. They will also check to make sure the codes listed on the payer's report match those of the initial claim. Finally, the biller will check to make sure the fees in the report are accurate with regard to the contract between the payer and the provider.

If there are any discrepancies, the biller/provider will enter into an appeal process with the payer. This process is complicated and depends on rules that are specific to payers and to the states in which a provider is located. Effectively, a claims appeal is the process by which a provider attempts to secure the proper reimbursement for their services. This can be a long and arduous process, which is why it's imperative that billers create accurate, "clean" claims on the first go.

GENERATE PATIENT STATEMENTS

Once the biller has received the report from the payer, it's time to make the statement for the patient. The statement is the bill for the procedure or procedures the patient received from the provider. Once the payer has agreed to pay the provider for a portion of the services on the claim, the remaining amount is passed to the patient.

In certain cases, a biller may include an Explanation of Benefits (EOB) with the statement. As we learned in the previous course, an EOB describes what benefits, and therefore what kind of coverage, a patient receives under their plan. EOBs can be useful in explaining to patients why certain procedures were covered while others were not.

FOLLOW UP ON PATIENT PAYMENTS AND HANDLE COLLECTIONS

The final phase of the billing process is ensuring those bills get, well, paid. Billers are in charge of mailing out timely, accurate medical bills, and then following up with patients whose bills are delinquent. Once a bill is paid, that information is stored with the patient's file.

If the patient is delinquent in their payment, or if they do not pay the full amount, it is the responsibility of the biller to ensure that the provider is properly reimbursed for their services. This may involve contacting the patient directly, sending follow-up bills, or, in worst-case scenarios, enlisting a collection agency.

Each provider has its own set of guidelines and timelines when it comes to bill payment, notifications, and collections, so you'll have to refer to the provider's billing standards before engaging in these activities.

MORE ABOUT INSURANCE AND THE INSURANCE CLAIMS PROCESS

Health care is, as many have noted, one of the largest and fastest-growing sectors of the American economy. Americans spend almost \$8,000 annually per capita on healthcare, and a significant portion of that sum is spent on health insurance.

HOW HEALTH INSURANCE WORKS

Health insurance is insurance against medical expenses. Essentially, health insurance subscribers enter into an arrangement with a health insurance company in order to reduce the impact of the cost of medical expenses. There are many different types of insurance coverage plans, and even more ways of paying for them.

Most plans share a few basic similarities. Most insurance plans require subscribers to pay premiums, which are essentially subscription fees. These may be assigned monthly or annually.

EXAMPLE

Many plans also have deductibles, which are monetary limits after which the health insurance company assumes the cost of the medical procedure or service. For instance, if a person has an insurance plan with a \$100 deductible, he will pay up to \$100 for a medical procedure, and his insurance company will pay for the remaining amount (provided that procedure is valid and within their insurance arrangement).

Subscribers may also have a copay or coinsurance arrangement with their insurance company. A copay is a relatively small, fixed sum that must be paid before any medical service is rendered. The co-pay does not count against the deductible. So, if that same patient has a \$100 deductible and a \$25 co-pay for a particular procedure, the patient will have to pay the \$25 co-pay first, and then the \$100 deductible, after which point the insurance company will pay the rest.

A co-insurance is a type of arrangement with the insurance company that divides the responsibility for payment by percentage. Co-insurances are listed with the payer (insurance company)'s portion listed first, and then the subscriber's. For instance, if a subscriber receives a \$300 medical procedure, and has a 80-20 co-insurance agreement with his or her insurance company, the subscriber would owe 20% of the bill (\$60). The insurance company would pay the rest.

Co-insurances also come with deductibles. Looking at the example above, let's say the subscriber has a \$100 deductible in addition to his 80-20 co-insurance plan. If he received a \$300 procedure, he'd have to first pay his deductible, and then 20% of the remaining figure.

Here's a breakdown:

$$\begin{array}{r} \$300 \text{ (total cost of procedure)} \\ -\$100 \text{ (deductible)} \\ \hline \$200 \text{ (remaining amount left to pay)} \end{array}$$

$$20\% \text{ of } \$200 \text{ (subscriber's co-insurance rate)} = \$40$$

So the subscribers total amount would be \$140. The insurance company would pay the remaining 80% of the \$200, which would come to \$160.

Now that we've got an idea of how some of the basic aspects of health insurance work, let's take a look at the different types of health insurance.

INDEMNITY

We covered indemnity insurance briefly in Course 3-1, but let's return to it now for the sake or review. Indemnity is the most basic and straightforward kind of insurance, in that you pay a premium to an insurance company to insulate you from medical expenses. You'll likely have a deductible and, depending on your insurance plan, a co-pay or co-insurance. Subscribers to indemnity plans have no restrictions on which providers they can see, but indemnity plans are typically much more expensive than managed care options, which we'll review now.

MANAGED CARE

We touched briefly on managed care and managed care organizations in our introduction to this section. Let's revisit these now. Managed Care Organizations (MCOs) are groups, organizations, or other bodies that seek to reduce the cost of healthcare and increase the efficacy or health services through a number of means.

Managed care organizations, for instance, may confine the providers the subscriber may see to a specific network of doctors and facilities. In general, MCOs have fixed costs that are lower than most indemnity plans, but restrict the options a patient has for where to get treatment.

There are three main types of MCO, which we'll discuss below. Bear in mind that these are simplified descriptions of these managed care organizations.

MANAGED CARE ORGANIZATIONS

Health Management Organization (HMO)– At one time, HMOs were the most popular MCO option. HMOs operate by providing subscribers with a low premium and a strict network of providers a subscriber can see. If a subscriber sees a provider outside fo this network, they may have to cover all of the expenses from that service out of pockets. HMOs are often among the cheapest MCOs, but are also the least flexible. HMOs also often make use of primary care physicians (PCPs), who may act as “gatekeepers.” Subscribers often need to be referred to specialists by PCPs.

Preferred Provider Organization (PPO) – PPOs recently over took HMOs as the most common MCO. Unlike an HMO, subscribers to a PPO may see any doctor, physician or other provider, but they pay less if they see a provider within the PPO's network (hence “preferred”). PPOs generally have higher premiums, but allow for more flexibility for subscribers.

MANAGED CARE ORGANIZATIONS

Point of Service (POS) – A slight variation on the HMO model, subscribers to a POS plan fulfil most of the medical needs in-network, but are allowed to go out-of-network if they pay a higher fee. Many POS plans are tiered, so that a subscriber pays more if they see a specialist out-of-network, but less if they are referred to that specialist by an in-network PCP.

Consumer-Driven Health Plan (CDHP) – A relatively recent development in the world of MCOs, CDHPs enable subscribers to receive PPO-like benefits only after they've paid a certain deductible. This deductible is usually quite high, but comes with low premiums and a "savings account" that works like a retirement fund. Subscribers may put money into the account to help pay for out-of-pocket expenses.

Why do we need to know about all these different types of insurance coverage? Because each of these affects the way we create claims.

BILLING EXAMPLE

Let's say we're billing for a procedure that cost \$1500. The patient who received the procedure has a CDHP with a deductible of \$1000. In order to create an accurate claim, we'd look at the patient's coverage plan, and assign the \$1000 deductible to the patient, and then pass the \$500 on to the payer.

Likewise, if we're looking at a patient with coverage under an HMO, but that patient sees a provider out-of-network, we need to know that we can't send a claim to that HMO, but must instead bill the patient directly. (Recall that HMO subscribers cannot receive insurance coverage if they see providers out of their network).

Knowing the ins and outs of insurance plans—what type of coverage they provide, how much to deduct and send to the payer—is an integral part of the billing process.

CLAIM FORMS

Let's talk briefly about electronic and manual claim forms. HIPAA regulations mandate that most claim transmissions be completed electronically. (We'll cover this more thoroughly in *HIPAA 101* and *HIPAA and Medical Billing* later in Section 3) That doesn't mean that all claims are submitted electronically, though that would probably be ideal. Billers do use paper claims from time to time, and it's

CMS-1500 & UB-04 FORMS

The two most common claim forms are the CMS-1500 and the UB-04. These two forms look and operate similarly, but they are not interchangeable. The UB-04 is based on the CMS-1500, but is actually a variation on it—it's also known as the CMS-1450 form. CMS-1500 forms are used for non-institutional healthcare facilities (e.g., private practices), while UB-04 (CMS-1450) forms are generally used in institutional healthcare facilities, such as hospitals.

Both CMS-1500 and UB-04 have a number of lines where billers can input the procedure code, the diagnosis code, and cost of the procedure. As in medical coding, every procedure listed must have an appropriate diagnosis code listed with it. In instances where a provider performs a long list of procedures or medical services, and this list is too long for a single form, billers simply complete

multiple CMS-1500 or UB-04 forms until they've listed the full number of medical procedures.

Under HIPAA regulations, standard transactions like claims are required to be submitted electronically. There are some exceptions to this rule, however. For one, a practice under 10 employees may use manual claims. Also, a practice that has experienced a power outage may submit claims manually if those claims are time-sensitive.

The process of billing an insurance company or other third-party payer is difficult to summarize because so much of it depends on variables. These variables include things like the patient's insurance plan, the payer's guidelines for claim submission, and the provider's contract with the payer. Our goal in these courses is to prepare you for formal training in medical billing, not give you fine-grain detail on the various technicalities inherent in the claims process. That said, we will provide you with a number of working examples in Section 4, and, in the following courses, we'll learn about two of the most important aspects of the medical billing profession and its relation to third-party payers: Medicare and Medicaid, and HIPAA.

MEDICARE AND MEDICAID

You may have noticed in the last course that we didn't touch on Medicare or Medicaid. These two government programs are two of the largest payers in the country. While they share the payer designation with a number of insurance companies, they're different enough that they've earned their own set of courses.

Both Medicare and Medicaid are large federal healthcare programs. They're maintained by the Centers for Medicare and Medicaid Services (CMS). More than 80 million Americans today use Medicare and Medicaid as their primary payer, making them two of the most important bodies in the healthcare industry. Let's take a closer look at each.

MEDICARE

Created in 1965 with the passage of the Social Security Act, Medicare provides health coverage to American citizens 65 years of age or older, and to citizens with certain debilitating diseases.

The basic principle of whether Medicare does or does not cover a service depends on whether the service is "medically necessary." This necessity is affected by federal laws, national regulations, and local coverage decisions.

The program itself is divided into four sections, or Parts. It's easier to understand Medicare when we break it up into these four Parts. Each of these Parts has its own set of monthly premiums, and coverage under these often comes with a fixed deductible as well.

MEDICARE SECTIONS

Part A – Confined mostly to inpatient services. This coverage may extend from overnight stays based on pressing medical concern all the way to hospice care and other long-term stays in a hospital or nursing facility. In order to contain costs and encourage higher quality healthcare, Part A comes with a number of restrictions and criteria. For instance, if a patient needs to return to a hospital within 30 days for an identical procedure, Medicare will not pay the provider for this service.

Part B – Provides medical insurance for procedures and services not covered in Part A. This includes physician services like x-rays and some kinds of nursing care, along with durable medical equipment like canes and walkers (which you may remember from HCPCS). Along with Part A, Part B of Medicare makes up the basic Medicare coverage package. (Part B may also be deferred if the person receiving Medicare coverage is still working).

Part C – Also known as the Medicare Advantage plan, Part C allows Medicare subscribers to receive the entirety of their coverage through a private organization. Medicare Advantage is offered by private HMO and PPO organizations. Subscription to Part C does not require subscription to Parts A and B. Under the Medicare Advantage, the federal government reimburses the private payer, and no claims are filed to Medicare under this program. Part C often comes with Part D.

Part D – The most recent addition to the Medicare, Part D was instituted after the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Part D provides coverage for prescription drug costs during healthcare. Patients must actively enroll in Part D (and thus pay its monthly premiums) if they are to receive coverage from this portion of Medicare.

In order to qualify for Medicare benefits, a person must be: 65 years of age; a United States citizen; and be enrolled in Social Security. Medicare makes exceptions for persons under 65 with end-stage renal failure (which requires regular dialysis treatment), and persons under 65 who have other certain disabilities or illnesses (like Lou Gehrig’s Disease).

MEDICAID

Medicaid is a joint state and federal healthcare program that provides care to persons who might not otherwise be able to afford it. Medicaid provides coverage to low-income families and individuals, disabled individuals, and certain elderly persons.

Unlike Medicare, which is a federal program with universal standards, Medicaid regulations and restrictions vary by state. Each state has to maintain its own Medicaid program (like California’s Medi-Cal or Wisconsin’s BadgerCare). Each of these state-based Medicaid programs still has to meet certain standards established by the federal government, but you should expect to see a wider range of variation in Medicaid policies than Medicare policies.

Since some states’ Medicaid coverage is more extensive than others, let’s focus only on the minimum requirements for the program, as laid out by the CMS and the federal government.

Below you’ll find seven of the basic services covered by Medicaid.

**BASIC SERVICES
COVERED BY MEDICAID**

- Family planning care
- Prescription drug costs
- Inpatient/outpatient hospital services
- Pediatric services
- Mental health care
- Occupational, speech, and physical therapy
- Dental healthcare and related service

BASELINE CRITERIA FOR MEDICAID COVERAGE

Like the services provided by Medicaid, a person's eligibility for Medicaid may vary by state. Still, there are some relatively common baseline criteria for coverage, including:

- Adults with children earning less than a certain income level (varies by state and number of children)
- Individuals earning up to 133% of the poverty line* (this provision is part of the Affordable Care Act, and will go into effect in January of 2014)
**Individuals who earn slightly more than the minimum threshold, may still qualify for Medicaid if they pay an additional premium*
- Individuals suffering from chronic disabilities
- Individuals who receive Social Security benefits may also qualify for Medicaid

These are not hard and fast criteria for enrollment. Medicaid accepts subscribers on a categorical level. That is, their income is not the sole determining factor of their eligibility. Instead, a patient's eligibility depends on how they fit into a certain category, which might include pregnant or nursing mothers, poverty-stricken individuals, or disabled persons.

Like Medicare, Medicaid acts as a third-party payer that reimburses providers for the health services they perform. Unlike Medicare, a majority of Medicaid subscribers are enrolled in some sort of managed care program through Medicaid. Under this program, subscribers must pay a monthly premium. Poorer elderly individuals are more likely to use the basic fee-for-service Medicaid program, while younger Medicaid recipients are more likely to use the managed care option.

Those are the bare bones of Medicare and Medicaid. In the next course, we'll show you how medical billers bill to Medicare and Medicaid.

MEDICARE, MEDICAID AND MEDICAL BILLING

Billing Medicare and Medicaid is one of the more involved, important tasks a medical biller can take on. In this course, we'll show how these important, far-reaching programs interact with medical billing.

Like billing to a private third-party payer, billers must send claims to Medicare and Medicaid. These claims are very similar to the claims you'd send to a private third-party payer, with a few notable exceptions.

As you'll remember from our Courses on HCPCS, whenever a procedure code is sent to Medicaid or Medicare, these procedure codes are automatically listed as HCPCS. The first Level of HCPCS is identical to CPT, so even the only thing that's really changing is the code's designation as a HCPCS code, rather than a CPT code.

Like many other third-party payers, Medicare and Medicaid are covered by HIPAA. This means that standard transactions like claims must be sent electronically, except in certain circumstances. In instances where a paper claim must be sent, billers should use either the CMS-1500 or the UB-04 forms described in the previous course. (Which form to use may depend on what type of procedure was performed by the provider). We'll cover HIPAA in greater depth in the next two courses.

Since these two government programs are high-volume payers, billers send claims directly to Medicare and Medicaid. That means billers do not need to go through a clearinghouse for these claims, and it also means that the onus for "clean" claims is on the biller.

BILLING FOR MEDICARE

Before we get into specifics with Medicare, here's a quick note on the administrative process involved. When a claim is sent to Medicare, it's processed by a Medicare Administrative Contractor (MAC). The MAC evaluates (or adjudicates) each claim sent to Medicare, and processes the claim. This process usually takes around 30 days.

When billing for traditional Medicare (Parts A and B), billers will follow the same protocol as for private, third-party payers, and input patient information, NPI numbers, procedure codes, diagnosis codes, price, and Place of Service codes. We can get almost all of this information from the superbill, which comes from the medical coder.

If a biller has to use manual forms to bill Medicare, a few complications can arise. For instance, billing for Part A requires a UB-04 form (which is also known as a CMS-1450). Part B, on the other hand, requires a CMS-1500. For the most part, however, billers will enter the proper information into a software program and then use that program to transfer the claim to Medicare directly.

Parts C and D, however, are more complicated. Because Part C is actually a private insurance plan paid for, in part, by the federal government, billers are not allowed to bill Medicare for services delivered to a patient who has Part C coverage.

Only those providers who are licensed to bill for Part D may bill Medicare for vaccines or prescription drugs provided under Part D. If the provider is not a licensed Part D provider, the biller must assign that total directly to the patient (or the patient's secondary insurance, if they have it, and if it covers that procedure or prescription).

When a Part A claim is processed by Medicare, Medicare pays the provider directly for the service rendered by the provider. On the other hand, in a Part B claim, who pays depends on who has accepted the assignment of the claim. If the provider accepts the assignment of the claim, Medicare pays the provider 80% of the cost of the procedure, and the remaining 20% of the cost is passed on to the patient. You should recognize that 80-20 breakdown: it's a classic example of coinsurance.

In certain cases, the provider will decline the assignment of the claim, and Medicare will assign payment directly to the patient. In cases like this, the patient, as opposed to the payer, must reimburse the provider for their services.

You should be aware, as well, that Parts A and B of Medicare have monthly and annual premiums, in addition to coinsurance arrangements depending on what kind of service the patient receives. These deductibles, premiums, co-pays, and coinsurance rates are fixed by CMS, but they can vary greatly between patients and procedures. Part of the challenge of filing a claim with Medicare is getting the proper number for each patient.

BILLING FOR MEDICAID

Creating claims for Medicaid can be even more difficult than creating claims for Medicare. Because Medicaid varies state-by-state, so do its regulations and billing requirements. As such, the claim forms and formats the biller must use will change by state. It's up to the biller to check with their state's Medicaid program to learn what forms and protocols the state follows.

In general, the medical biller creates claims like they would for Part A or B of Medicare or for a private, third-party payer. The claim must contain the proper information about the place of service, the NPI, the procedures performed and the diagnoses listed. The claim must also, of course, list the price of the procedures.

Be aware when billing for Medicaid that many Medicaid programs cover a larger number of medical services than Medicare, which means that the program has fewer exceptions.

One final note: Medicaid is the last payer to be billed for a service. That is, if a payer has an insurance plan, that plan should be billed before Medicaid.

In general, it's much too difficult to describe the full process of billing Medicaid without going into an in-depth description of specific state programs. As this is just a basic introductory course, we won't go into much more depth than this.

As you can see from this Course, billing for services covered by Medicare and Medicaid is a complicated, involved process. Billing these two payers requires an incredible amount of diligence and patience. Creating claims for these two programs is a valuable skill. It's one that you'll learn more thoroughly when you train formally for a career in medical billing.

POTENTIAL BILLING PROBLEMS AND RETURNED CLAIMS

The goal of the medical biller is to ensure that the provider is properly reimbursed for their services. In the pursuit of this goal, errors, both human and electronic, are unfortunately unavoidable. Since the process of medical billing involves two incredibly important elements (namely, health and money), it's important to reduce as many of these errors as possible. In these brief course, we'll introduce you to some common errors in the medical billing practice.

Before we jump into that discussion, however, let's review the difference between a rejected and denied claim.

DENIED AND REJECTED CLAIMS

As you'll recall from previous Courses, a rejected claim is not the same as a denied one. A rejected claim is one that contains one or many errors found before the claim is processed. These errors prevent the insurance company from paying the bill as it is composed, and the rejected claim is returned to the biller in order to be corrected. A rejected claim may be the result of a clerical error, or it may come down to mismatched procedure and ICD codes. A rejected claim will be returned to the biller with an explanation of the error. These claims are then corrected and resubmitted.

Clearinghouses employ a process colloquially called "scrubbing" in order to avoid rejected claims. The end goal, for billers and clearinghouses, is a "clean" claim.

Denied claims, on the other hand, are claims that the payer has processed and deemed unpayable. These claims may violate the terms of the payer-patient contract, or they may just contain some sort of vital error that was only caught after processing. Payers will include an explanation for why a claim is denied when they send the denied claim back to the biller. Many times, these claims can be appealed and sent back to the payer for processing, but this process can be time-consuming and, therefore, costly. For that reason, it's important to try and get as many claims "clean" on the first go, and not waste any time billing for procedures that are incompatible with a patient's coverage.

SIMPLE ERRORS

Now that we've reviewed denied and rejected claims, let's look at some of the basic errors that can get a claim returned to the biller.

- Incorrect patient information
 - Sex, name, DOB, insurance ID number, etc.
- Incorrect provider information
 - Address, name, contact information, etc.
- Incorrect Insurance provider information
 - Wrong policy number, address, etc
- Incorrect codes
 - entering confusing ICD, CPT, or HCPCS codes; entering confusing Place of Service codes; attaching conflicting or confusing modifiers to HCPCS or CPT codes; entering too few or too many digits to an ICD, CPT, or HCPCS codes

- Mismatched medical codes
 - Entering confusing ICD codes with CPT codes, or vice versa, etc
- Leaving out codes altogether for procedures or diagnoses
- Duplicate Billing
 - This occurs when someone at the provider's office submits a claim for a procedure without checking whether that service has been paid for/ reported. Duplicate billing can create a huge headache for billers and payers alike, because it may appear that a patient received two identical x-rays on one day, which would effectively double the amount sent to the payer.

Like medical coding, we're always striving for the highest level of accuracy in our codes, and we're also required to provide as complete a picture as possible of the medical procedure(s). If you can cut down on these simple errors in your medical billing, you'll have a much higher number of clean claims.

MORE BILLING ERRORS

The above are some of the most frequent errors a medical biller comes across. These errors directly affect the status of a claim, which makes them very important to watch out for.

But there are other errors to watch out for as you go through your day as a medical biller. Some of these are, regrettably, out of the biller's hands, but they're important to watch out for nonetheless.

- Undercoding
 - Undercoding occurs when a provider intentionally leaves out a procedure code from a superbill, or codes for a less serious or extensive procedure than the patient received. Undercoding may be done to avoid audits for certain procedures, or to try and save money for the patient. This process is illegal, and counts as a type of fraud.
- Upcoding
 - Like undercoding, this is a fraudulent process wherein the provider intentionally misrepresents the work they performed on a patient. In upcoding, a practice enters codes for services a patient did not receive, or codes for more intensive procedures than the provider actually performed. Upcoding is typically done in an attempt to receive more money from a payer. This, like undercoding, is a fraudulent practice, and should be noted and reported immediately.
- Poor documentation
 - While not a fraudulent practice like upcoding or undercoding, poor documentation can also negatively affect the claims process. If a provider has provided incorrect, illegible, or incomplete documentation of a procedure or patient visit, it's difficult to make an accurate or complete claim. In cases of sloppy documentation, the biller should contact the provider and ask for more information.
- No EOB on denied claim
 - In certain cases, the payer may fail to attach the Explanation of Benefits (EOB) to a denied claim. In cases like this, it's difficult to note the error on a denied claim, which slows down the (already slow) appeals process.

FIXING ERRORS BEFORE THEY HAPPEN

It's always important to be proactive when you're medical billing. Here are a couple of things you can do to catch medical billing errors before they happen.

- **Stay Current**
 - Billers need to stay up-to-date on billing and coding trends. Coding especially will change as new codes are introduced and older ones phased out. It's important to check on new protocols in medical coding regularly. Study new codes and be aware of how they affect billing.
- **Be Diligent**
 - You should always double check your work when you're creating a claim. Simple clerical errors like missing digits or misspelled names can be the difference between an approved and a rejected claim, so go over each claim you create before you send it off.
- **Communicate**
 - Part of reducing medical billing errors comes down to coordinating effectively within the provider's office. Make sure you communicate regularly and effectively with other personnel in the provider's office, including the physician, and don't be afraid to ask questions about possible errors on the claim.
- **Follow Through**
 - After you send a claim in to a payer, you can follow up with a representative working on that claim. They may be able to alert you to any errors they've already caught, in which case you can begin work on making a new, error-free claim. (Wait until they send it back to you, of course!)

HIPAA 101

By this point, you've probably seen a few mentions of the Health Insurance Portability and Accountability Act (HIPAA). In previous courses, we've talked about HIPAA in regards to its regulation of standard transmissions between providers and payers. These standard transmissions include claims, meaning HIPAA regulates a huge portion of the medical billing process.

But what, exactly, is HIPAA? In this course, you'll find out. In the course following this one, we'll show you how HIPAA affects medical billing.

WHAT IS HIPAA

Created in 1996, HIPAA is an act of Congress that protects the health insurance of workers and their families if they lose their jobs. HIPAA also protects the privacy of children 12 to 18 years of age and establishes a number of regulations for the electronic transfer of healthcare data. This last point is where we'll spend the most time in our summary, but let's look at the whole Act in brief first.

HIPAA is divided into five sections, or Titles. For the sake of this course, we'll focus only on the first two Titles, which are the largest and most far-reaching.

TITLE I

Title I establishes rules for how group health organizations (like managed care organizations) interact with patients. Title I limits the restrictions a group health organization can put into place based solely on a pre-existing condition.

Title I also limits the amount of time it takes to get coverage for that pre-existing condition. Specifically, once a person has coverage under a group health organization, that person must receive coverage for their pre-existing condition within 12 months (or 18 months in certain circumstances).

Title I also provides protection to individuals and their families when that individual changes or loses their job. If an individual has health insurance under their old job, they are allowed to keep that insurance until the point when their new health care coverage kicks in. There are a few caveats to this, of course, and HIPAA does not provide permanent health insurance. It does, however, ensure that persons out of work can continue their health care coverage while in between jobs.

As you may be able to tell, this Title of HIPAA affects insurance companies and their interactions with patients much more than it does medical billers. Title II is where we'll see HIPAA affect medical billing more directly.

TITLE II

When HIPAA was passed, an increasing number of medical transactions were being performed electronically. While electronic transactions (like claims) were faster, more cost-efficient, and less error-prone, they also caused some patients and regulators to worry about the privacy of the personal medical records. Title II addresses these concerns and establishes standards and guidelines for these types of transactions.

PRIVACY AND SECURITY

Title II lays out a set of security guidelines that ensure the safety of both physical and electronic records. These regulations limit who can view medical information, and also dictate how this information is transferred.

Title II also established a set of rules limiting who can distribute your medical information, and when. These rules give patients more control over their medical records, including who can access them and at what times. These rules prevent anyone—including providers, payers, or government agencies—from viewing or distributing a patient’s medical information for anything not related to treatment for the patient. For instance, on a worker’s compensation claim for a broken finger, a biller would not include the patient’s history of heart disease.

TITLE II AND MEDICAL BILLING

Title II and Medical Billing

The passage of HIPAA added an “Administrative Simplification” (AS) to a portion of the Social Security Act. With that AS, Title II established a set of regulations and guidelines for the electronic transmission of healthcare data, and sets up guidelines for the code sets used in medical billing and coding.

You’ve actually already learned about many of these code regulations: HIPAA formalized the use of ICD codes, CPT codes, and HCPCS codes for use in creating claims.

The goal of the AS was to establish a regular, uniform method of communication for any party involved in healthcare, such as insurance payers, providers, clearinghouses, and government agencies. All bodies covered by HIPAA (and this includes most providers and payers, including Medicare and Medicaid) must adhere to these standards of transactions.

Under Title II, all electronic transactions must be performed as a type of Electronic Data Interchange (EDI). (An EDI is a standardized form of electronic transaction. It’s widely used in all types of commerce. An ATM withdrawal, for example, uses an EDI). For healthcare transactions, providers and payers must use the EDI approved by the Accredited Standards Committee X12 (ASC X12). Currently, that form is the ASC X12 005010. Under ASC X12 005010, each type of medical transaction gets its own code number. A claim, for example, is an X12 837. A health care eligibility inquiry is a 270. We’ll talk a bit more about this in the next course.

That may all sound a little complicated, so let’s break it down a bit. Under Title II, each medical transaction has to adhere to a certain format. HIPAA dictates that those electronic transactions follow the format laid out by the ASC X12. This form is the ASC X12 005010. Included in that form are various subforms, each of which corresponds to a certain type of medical transaction.

Again, we’ll discuss more of how HIPAA Title II affects medical billing in the next course. Let’s close out this section with a brief overview of what else Title II does.

Title II establishes the mandatory use of National Provider Identifier (NPI) numbers. You should remember NPIs from our discussion of creating medical claims. These NPIs are ten characters long, may be alphanumeric, and are never re-used (except in very particular situations). Like ICD or CPT codes, NPIs provide an efficient universal shorthand for identifying a crucial part of the healthcare process.

In addition to establishing the above regulations and rules, Title II also outlines a number of offenses related to healthcare. Title II prescribes the civil and criminal punishments for these fraudulent offenses.

HIPAA AND MEDICAL BILLING

In the previous course, we introduced you to HIPAA. In this course, we'll show you how it affects the practice of medical billing.

HIPAA affects medical information in its myriad forms. Title II of HIPAA grants a greater degree of privacy and agency to the patient, and requires providers to follow a number of important regulations regarding the electronic transfer of medical information.

Whether you know it or not, you're actually already familiar with many of the provisions laid out by HIPAA. One of the most readily felt impacts of HIPAA is the standardization of medical codes used by coders and billers.

As we discussed in the last Course, HIPAA formalized the use of ICD codes for diagnosis and CPT and HCPCS codes for procedural reporting. We use these codes every day in medical billing to create claims.

Another one of the simple ways HIPAA regulations affects the creation of claims is the National Provider Identifier (NPI). As you'll recall from last Course, the NPI is a ten-character number (it may be alphanumeric) that corresponds to a unique healthcare provider. NPIs are required on every claim submitted under HIPAA regulations.

HIPAA establishes and manages electronic medical transactions. As we covered in the last course, Title II of HIPAA requires all providers and billers covered by HIPAA to submit claims electronically using the approved format. This format is known as ASC X12 005010. You may encounter the shorthand for this form as "HIPAA 5010." (An important side note: the 5010 format was created with ICD-10-CM in mind, and has the ability to accept both ICD-9-CM and ICD-10-CM codes.)

It's important to remember that HIPAA 5010 does not necessarily prescribe the format of a claim, so much as the way it is transferred. You can think of HIPAA 5010 transactions as vehicles with uniform exteriors. They all must look the same, but each vehicle might carry different passengers in different arrangements (in this case, medical information).

Within ASC X12 005010, each type of transaction gets its own code set number. Let's look at these code set numbers, and the type of transactions they correspond to, now. You'll see that each code set number is preceded by an "X12." This is to remind you that the code set is monitored and maintained by the ASC X12. Each of these transactions takes the form of a particular Electronic Data Interchange (EDI).

HIPAA FORMS AND THEIR CODE SET NUMBERS

Each of these types of transaction forms has their own rules and formats. For simplicity's sake, we've focused expressly on the health care claim (the first code set number listed below), and we'll continue to do so for the rest of the courses. The additional forms, and their code set numbers, are listed for your general knowledge, and to give you a better idea of the scope of the medical biller's responsibilities.

- Health Care Claim Transaction
 - Code set number: X12 837
 - The health care claim is the most basic and common type of electronic medical transaction. Billers use claims to request reimbursement on the behalf of providers. Claims include information about the patient, the provider, the patient's health insurance plan, in addition to codes for the procedure and diagnosis.
- Health Care Claim Payment/Advice Transaction
 - Code set number: X12 835
 - This code set can be used to transmit a payment, an Explanation of Benefits, remittance advice. Forms in this code set only go directly from a payer to a provider.
- Benefit Enrollment and Maintenance
 - Code set number: X12 834
 - These forms can be used by employers, government agencies, unions, and other bodies to enroll an individual with a health insurance payer.
- Health Care Claim Status Request
 - Code set number: X12 276
 - These forms are used by billers to ask after the status of a particular health care claim.
- Health Care Claim Status Notification
 - Code set number: X12 277
 - These forms are used by payer to notify providers and/or patients of the status of their claim. Forms issued via this format may include information about an individuals eligibility with the payer.
- Health Care Service Review Information
 - Code set number X12 278
 - Can be used to transmit all of the information present on a claim (patient, demographic, diagnosis, procedure, etc) for the purposes of a study or review.

HIPAA regulations require billers making transactions like the ones above to use the prescribed form. Just as medical coders have to use the appropriate code set to describe a procedure or diagnosis, so too do medical billers have to use the right type of EDI to perform a certain billing task.

As you can see, HIPAA's impact extends to almost every aspect of the medical billing process, from how records are stored and accessed to how codes are used in creating claims. As you pursue your formal training in medical billing, you'll learn even more about HIPAA and the ways its affects medical billing. For this course, however, we'll leave you with this overview and continue to the Section Review and Section Quiz.

MEDICAL BILLING REVIEW

By now you should have a good idea of the general parameters of medical billing. In order to review for the quiz, we'll go back through this section and touch on some of the most important aspects of the medical billing process. Use this review to study for the Section 3 Quiz, and go back over the *Medical Billing Vocabulary* Course in Section 3 to sharpen your skills.

WHO PARTICIPATES IN MEDICAL BILLING

Medical billing is the process of ensuring a provider is paid for their services. In the healthcare process, there are three principal parties: the patient, the provider, and the payer.

- The patient is the person receiving medical services.
- The provider is the healthcare facility, doctor, physician, or practice that administers the medical services.
- The payer can be a health insurance company, organization, or government agency (like Medicare or Medicaid) that reimburses the provider for their services, so long as the patient has a contract or agreement with the payer.
- The medical biller acts as a sort of financial conduit between these three parties, ensuring that the provider is reimbursed by the payer for the services it (the provider) performed on the patient.

THE MEDICAL BILLING PROCESS

Let's look at this another way: the patient has an agreement with the payer (let's say it's a Health Maintenance Organization, or HMO) that provides that patient, or subscriber, with health insurance. That patient comes down with the flu and goes to see the doctor (provider). The provider diagnoses the flu in the patient and prescribes some medication.

The provider has now provided medical services to the patient, and needs to be reimbursed. The provider's office generates a medical report, which is then coded (by the medical coder) and transferred to the biller. The biller looks at the patient's insurance agreement with the payer (the patient's HMO) and figures out how much the payer is contractually obligated to pay the provider.

The biller puts the diagnosis codes, procedure codes, patient information, provider information, and cost of the procedures into a document called a claim. This claim can be manual (paper) or electronic. Today, most billers send claims electronically.

The biller sends the claim to the payer, who then evaluates ("adjudicates") it, and decides whether they will approve, deny, or reject the claim. In many cases, a biller will send the claim, or information to create the claim, to a clearinghouse, which is a third-party organization that specializes in creating error-free, or "clean," claims. Creating clean claims is imperative, because if a claim is returned with errors, it may take more time to correct and re-process.

If the claim is approved, it's sent back to the biller with an explanation of what, and how much of, each procedure the payer will pay for. The biller subtracts that number from the total cost of the procedure and comes up with the balance. The balance is then passed on to the patient, who is responsible for the remainder of the balance.

The above is fairly simplified version of the medical billing process. There are a number of caveats and complications that can arise in the process of creating a health care claim, and many of them stem from the way payers interact with patients and providers.

MORE ABOUT INSURANCE

When a person is subscribing to an insurance policy, they're faced with a number of options. There are many different kinds of insurance, and many different levels of coverage within each kind. This variation naturally affects how we pursue medical billing. Different levels of coverage, different deductibles, and different kinds of coinsurance or co-pay arrangements all play large parts in how we create claims.

The most basic type of insurance is indemnity insurance. Under this kind of insurance, a subscriber (the patient) can go to any provider they wish. Indemnity insurance typically has higher premiums (the monthly or annual membership fees charged by the insurance company) and deductibles, but offers patients more flexibility.

A deductible is the amount of money a patient must pay before their insurance coverage kicks in. For example, if a patient has a \$200 deductible and receives a \$600 medical procedure, that patient has to pay the \$200 before the payer will cover the cost of the medical service.

Managed care is a larger, more popular type of insurance. In managed care, certain restrictions are placed on what providers the patient may see, in exchange for lower premiums and deductibles. The most popular types of managed care are the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service (POS), and Consumer-Driven Healthcare Plans (CDHP).

With an HMO, a patient must see a provider within a prescribed network. Seeing an out-of-network provider will not be covered by the HMO. In a PPO, patients are allowed to see any provider, but will pay less if they see a provider in a certain ("preferred") network. With a POS model, a subscriber typically receives most of the care in-network, but can see an out-of-network physician if they pay a higher fee, making it much like a PPO.

Finally there is the Consumer-Driven Healthcare Plan (CDHP). CDHPs allow patients to receive PPO-like benefits after they've paid a certain (high) deductible. A "savings account" is included in the CDHP, which allows subscribers to save up untaxed earnings to pay for future healthcare. In general, the CDHP is designed to give consumers (that is, subscribers/patients) more control over their health-care coverage.

While many of these insurance plans differ, they each have similar mechanics. Those include premiums and deductibles (both of which we just discussed) and co-pays and coinsurances.

A co-pay is a small amount that the subscriber must pay before any medical service is rendered. The amount for a co-pay is fixed and depends on what type of medical procedure is performed.

A coinsurance, on the other hand, is a type of arrangement between the payer and patient/subscriber which breaks down the amount owed by the payer along a percentage. An example would be a 70-30 coinsurance. In this agreement, the payer owes 70% of the medical expense, while the patient/subscriber must pay the other 30%. The payer is always listed first in the coinsurance.

So how does this affect medical billing? When we create claims, we include the cost of the total procedure in the claim we send the payer. Each insurance plan features deductibles, copays, and/or coinsurances. This means that the amount a biller sends to a payer will differ based on each patient's insurance plan.

Let's look at a brief example. A patient receives a \$800 medical procedure. The patient has an insurance plan with a 70-30 coinsurance and a \$200 dollar deductible. In order to properly bill for this procedure, we'd first subtract the deductible from the \$800, giving us \$600. We'd then divide that \$600 into portions of 70% and 30%. Under this agreement, we'd bill the payer for \$420, and we'd bill the patient for \$180.

MEDICARE & MEDICAID

Many people in the United States receive their health insurance coverage from the large, government-funded payers known as Medicare and Medicaid.

Medicare is a social insurance program designed to help elderly people and individuals with certain disabilities and diseases pay for their health care. American citizens over the age of 65, who have registered for Social Security are eligible for Medicare coverage, along with people with Lou Gehrig's disease or end-stage renal failure.

Medicare is divided into four main parts, each of which covers a certain type of healthcare. Part A of Medicare covers medically necessary health services like hospital stays and treatment at inpatient facilities. Part B covers other necessary services, and also extends coverage for preventive services and general health maintenance.

Part C, also known as the Medicare Advantage, allows subscribers to receive private insurance, which is then funded by the government. Part D covers prescription drug costs. Parts A and B together make up what's known as Original Medicare, which is still the most common type of Medicare coverage.

Medicaid is a government program that provides healthcare coverage to poverty-stricken individuals and families, along with disabled persons. Unlike

Medicare, which is run by the federal government, Medicaid differs from state to state. Each state has to meet certain minimum requirements for coverage, but there is no universal Medicaid plan.

Both Medicare and Medicaid require claims to be submitted in a certain format. The manual version of this form is the CSM-1500. This form has a digital equivalent, as well. Billers always send claims directly to Medicare and/or Medicaid, bypassing any clearinghouses.

HIPAA

The vast majority of claims today are sent electronically. Electronic claims are faster, more cost-efficient, and reduce human error significantly. As more people age and require medical treatment, cutting down on administrative tasks like filing claims manually is very important to an efficient medical system.

The government has acknowledged and standardized electronic claims through the Health Insurance Portability and Accountability Act (HIPAA). This act does a number of things in addition to regulating electronic medical transactions.

HIPAA...

- Protects the insurance coverage of workers after they lose or change their job
- Protects the privacy of patients' medical information
- Establishes standards for electronic medical transactions
- Sets up rules and punishments for fraudulent medical reporting practices

HIPAA, in fact, standardized the medical codes we learned about in Section 2. HIPAA also establishes the Electronic Data Interchange (EDI) form that we use to send claims electronically. This EDI, called ASC X12, has a number of types, each of which corresponds to a certain type of transaction between (typically) a provider and a payer.

HIPAA also sets standards for how providers interact with and store the information of their patients.

WEBSITE

You can find the Section 3 Review Quiz on our website at:
www.medicalbillingandcodingcertification.com

TRY MEDICAL CODING

Now that we've learned the basics about medical coding and medical billing, it's time to look at some examples of how we'd code medical procedures in the real world.

Please note that these scenarios, medical reports, and coding examples are all theoretical. Some of them may have been simplified for space. They are presented solely as teaching examples.

EXAMPLE 1

Let's start off with a relatively straightforward visit to the doctor's office. Here's some context: our patient is in his late 20s and has not seen this doctor before. He's had a fever, a cough, some slight chest pain, and difficulty breathing.

Here's the hypothetical medical report.

"Patient is a 27-year-old white male. Not an established patient. Height is 74 inches, weight 220 lbs. Patient states he is allergic to penicillin, but has no other outstanding medical history. Does not smoke, exercises moderately.

Patient presents with chills, headache, cough, fever (101 degrees), difficulty breathing. Examination via stethoscope yields heavy rales. Percussion test on thorax suggests buildup in lungs. Streptococcal pneumoniae suspected.

Obtained blood sample for Antistreptolysin O titer. Results yield level of ASO above 200. Diagnosis of streptococcal pneumoniae confirmed.

Prescribed patient two weeks of 500mg azithromycin (Zithromax), and scheduled follow-up for next week."

Let's start abstracting the information from this medical report. We can start right away with the most straightforward code: the diagnosis. The doctor has diagnosed streptococcal pneumoniae in this patient. (Remember, we always code the definitive diagnosis, meaning we wouldn't code the cough, fever, or any of the other symptoms unless the doctor could not come to a definitive diagnosis).

So, in order to get the proper diagnosis code, we turn to the ICD-9-CM manual. We'd turn to Chapter 8, in the range 460 – 519, for Diseases of the Respiratory System. In that section we'd find "481 – pneumococcal pneumonia [streptococcus pneumoniae pneumonia]," which is the code we're looking for: pneumonia caused by streptococcal bacteria. In this case, there are no subcategories or subclassifications. 481 is our diagnosis code.

(Bear in mind that you could also just look up Streptococcus Pneumoniae in the alphabetic index of ICD-9-CM. We're taking the long route for the sake of instruction).

Now we get into the procedure codes. There are a couple here. Firstly, since a new patient is coming into the doctor's office with an as-yet unspecified condition, we know it's an Evaluation and Management (E&M) procedure. Secondly, we see that the doctor performed a test on the patient to confirm the diagnosis. That's a pathology and laboratory test.

Let's start with the E&M codes. You may think that the prescription of medication by the doctor falls into yet another category of procedure, but prescribing a medication is actually part of the E&M process. So too are the basic examinations the doctor performed (the thoracic percussion and the use of the stethoscope). Those are each part of the History, Exam, and Medical Decision-Making portions of E&M codes, often abbreviated to HEM. The doctor asked the patient about his history, he performed various exams, and he made a medical decision to prescribe antibiotics.

When you're selecting E&M codes, you look at the intensity of the evaluation and patient management. We can do this by the time spent with the patient, or we can do it by evaluating the amount of work that goes into the HEM.

E&M codes will list the level of intensity (and the time) of the procedure in their description. In our example, since the patient is new, there will be a more involved 'history' section of HEM. This would go with a thorough examination. The medical decision-making of prescribing antibiotics by oral administration is relatively low-risk, so this E&M procedure would probably be of low to moderate complexity.

Since the patient is a new patient, we'd look for codes in that subsection of E&M. We'd find code 99203, which includes a "detailed history; a detailed examination; medical decision making of low complexity." That's our E&M code.

But the doctor also performed a test that confirmed his diagnosis. How do we code that? Since the doctor took a sample from the patient to test, we know it's in the Pathology Section of the CPT Manual.

A little medical background here: the test in the medical report was an Antistreptolysin O, or ASO, titer. A titer is a type of test. ASOs are antibodies the immune system creates to combat streptococcal bacteria. The human body typically has around 200 units of ASO as a baseline. If a test confirms a heightened level of ASO, that's usually a definitive sign of the presence of strep bacteria.

We can find the test for ASO in the immunology subsection of Pathology. We could also look up antistreptolysin in the index at the back of the CPT manual. Both methods would lead us to the CPT code 86060, "antistreptolysin; titer." That's our Pathology code.

Now what about the medication the doctor's prescribed to our patient? We'd include that as part of our medical decision making process—the prescription of antibiotics is the decision the doctor made for the patient. However, if we wanted to add it to the E&M code to give the payer more information, we can do that pretty easily.

Previously, we talked about Category II CPT codes as useful for administrative and performance management purposes, but they can also be used in informational settings. These Category II codes are optional, and are added to Category I codes with a hyphen. We'd look up the proper Category II code in the index under “antibiotic administration.” That would point us to 4120F, “antibiotics prescribed or dispensed.” We'd flip there in Category II to confirm.

So we'd add the Category II CPT code 4120F to our extant E&M code 99203 to get 99203-4120F, which is a new patient visit of low complexity, with the prescription or dispensation of antibiotics.

So our codes would be...

PROCEDURE

99203-4120F (E&M)

86060 (Pathology)

DIAGNOSIS

481

We'd enter these into a superbill that would include...

- The patient's information
- height, weight, name, DOB, demographic info, insurance info, policy number, balance on their account, etc
- The provider information
- National Provider Index number (NPI), resident physician's name, phone number, address
- Procedure information
- Procedure codes, date of procedure, price of procedure,
- Diagnostic information
- Diagnosis code(s)

We'd then send that superbill on to the medical biller so that they could create the medical claim.

Let's look at another hypothetical situation, this time involving surgery.

EXAMPLE 2

We'll jump right in with our medical report. This one, you'll note, is different in format from the previous one. There's no uniform style of medical report, so coders should be prepared to abstract information from a whole variety of reports.

“CHIEF COMPLAINT: Pain and swelling in abdomen

HISTORY OF PRESENT ILLNESS: Patient is a 67-year-old female presents to the emergency room with sharp, shooting pain in her lower abdomen and pronounced swelling. Patient is nauseous, has vomited, and has a fever. Abdomen is firm and slightly distended. Patient states she has no history of abdominal problems, disease, or hernia.

PAST MEDICAL HISTORY: Patient is on a program of anti-depressants, but is otherwise physically sound. States she has never been admitted for any abdominal problems.

CURRENT MEDICATIONS: Wellbutrin, 5 mg daily

ALLERGIES: None

SOCIAL HISTORY: Used to smoke (using Wellbutrin to quit) and does not drink

REVIEW OF SYMPTOMS: As above

PHYSICAL EXAMINATION:

Vital Signs: Blood pressure is 150/88, with a fever of 102 degrees.

Skin: Warm and dry and normal, except in lower abdomen, where it is swollen and tight

Chest: no respiratory problems detected

Cardiac: regular rhythm

Back: No abnormalities detected

Abdomen: is firm above the pelvic bones. Patient experiences pain upon palpation.

Blumberg sign elicits painful response, as does a forced cough. Abdomen is tight and swollen.

INTERVENTION: Physical examination suggests appendicitis. Ultrasound test ordered, and diagnosis of appendicitis is confirmed. Patient is rushed to surgery and is prepped for general anesthesia. Once anesthetized, patient receives appendectomy via laparoscopy. Exploration during surgery reveals no signs of peritonitis, local or general. Following surgery, patient is taken to observation room, and then to hospital room. Patient responds well to surgery, and is discharged later that night with a prescription for pain medication.

Diagnosis: Acute appendicitis”

As you can tell, this medical report is significantly more involved than our first one. Thankfully, it's a pretty direct procedure, so we can dive right in. Let's start with the diagnosis.

As listed above, the diagnosis is acute appendicitis. To find this in ICD-9-CM, we'd look at Chapter 9, Diseases of the Digestive System. In that chapter we'd find the code for acute appendicitis: 540. Under that code we'd find three subcategories: for acute appendicitis with generalized peritonitis, peritoneal abscess, and with no mention of peritonitis. As we saw in the medical report, there was no sign of any peritoneal complications, so we'd select 540.9, acute appendicitis with no mention of peritonitis. That's our diagnosis code.

Let's move on to procedure codes. We'll start again with E&M. This is an emergency department services code. Emergency codes, like outpatient or office codes, are coded depending on the intensity/risk of the procedure. When our patient checks in, she's not in directly life-threatening danger, but if the appendicitis goes septic, it could endanger her life. With that in mind we'd pick the E&M code 99284, a visit for a condition that "requires urgent evaluation by the physician.... but [does] not pose an immediate significant threat to life or physiological function." So, 99284 is our E&M code.

Of course, our procedure coding doesn't stop there. As we saw from the medical report, the emergency department performed an ultrasound to confirm their diagnosis, and performed a surgical procedure with general anesthesia. This means we need three more codes: a Radiology code (for the ultrasound), a Surgery code (for the appendectomy), and an Anesthesia code (for the general anesthesia).

Let's start with the ultrasound. Diagnostic ultrasounds are found after diagnostic radiology (e.g. x-rays) in the Radiology Section. We'd look for a diagnostic ultrasound for the abdomen and find 76700, for "This means it's an ultrasound for the entire abdomen. That's close, but not exactly what we want. Below 76700 you'll see code 76705, for a limited abdominal ultrasound of a single organ or quadrant. That's what we want. So 76705 is our Radiology code.

Let's move to Surgery. The Surgery Section is relatively straightforward. We find the procedure we want by the area of the body it's performed on. In our case, we'd turn to the digestive system (recall that the appendix is attached to the large intestine). There we'd find codes for the appendix, including incision, excision, and laparoscopy. We're looking for an appendectomy done via laparoscopy, so we'd look at laparoscopy codes, and we'd select 44970, laparoscopy, surgical, appendectomy. That's our Surgery code.

With every surgery we'll need some sort of Anesthesia code. Per the medical report, the patient received general anesthesia, but we select Anesthesia codes based on the location of the procedure performed under the anesthetic. So the Anesthesia code would be located under "Lower Abdomen" in the Anesthesia Section. Specifically, we'd choose 00840, Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified." Remember also that with every Anesthesia code, you need to add a physical status modifier. These are found in the Anesthesia section, and are added to the Anesthesia code to describe the condition of the patient.

In our example, the patient is a P3—the patient has a severe systemic disease (since appendicitis can go septic, and thus potentially life-threatening, it's regarded as severe). So our Anesthesia code is 00840-P3.

Here's what we'd end up with:

PROCEDURE

99284 (E&M)

76705 (Radiology)

44970 (Surgery)
with 00840-P3 (Anesthesia)

DIAGNOSIS

540.9 – Acute appendicitis without mention of peritonitis

We'd include that information in a superbill, along with the provider information (in this case it'd be a hospital), patient information, and prices. We'd send those on to the medical biller, whose work we'll explore in the next Course.

TRY MEDICAL BILLING

In the last course, we looked at medical coding in the real world. Now we'll turn our focus to medical billing. In this course, we'll go through a few examples and show you how to create claims

EXAMPLE 1

Let's start off by looking at the first example from our previous course on everyday medical coding. If you'll recall, the patient in that situation was a 27-year-old male who went to the doctor with a hacking cough, fever, and difficulty breathing. After examining the patient and performing a pathology test, the doctor diagnosed the patient with streptococcal pneumoniae and prescribed a two-week regimen of antibiotics.

From that medical report we got these codes.

PROCEDURE

- 992013-4120F, new patient visit of low complexity, with the prescription or dispensation of antibiotics
- 86060, antistreptolysin O titer (Pathology)

DIAGNOSIS

- 481, pneumococcal pneumonia [streptococcus pneumoniae pneumonia]

The coder would also pass us all of the relevant information for the claim in the superbill, and we'd then enter that into a medical claim. We're going to be working with a simplified version of the CMS-1500 form for this Course.

33 ELEMENTS OF CMS-1500 FORM

The CMS-1500 form has 33 "elements," or fields where the biller must enter in data about the patient, the patient's insurance, the provider, the procedures, and the cost of the procedures, among other things.

Elements 1 through 20 are informational fields that include spaces to list the patient's name, ID number, DOB, address, insurance policy number, and other vital information. These elements also include fields that indicate whether the patient is the subscriber (the person paying for insurance) or is merely covered by that insurance (as in the case of children on their parent's insurance). For the most part, these fields are self-explanatory, and the information you need to fill them in will be provided by the superbill. For the sake of brevity, we'll move right to the most important section of the claim.

Once we get to Element 21 we start getting into the meat of the claim. Billers enter the diagnosis codes into Element 21. The next relevant Element is Element 24. Element 24 is divided into six horizontal rows. In these rows, you enter the date of the procedure, the procedure code, and you re-enter in the procedures codes and re-enter the diagnosis codes from Element 21, next to their relevant procedure code. Remember, diagnosis codes on claims are used to demonstrate medical necessity. Element 24 is where we put the what (the procedure) and the why (the diagnosis) of the medical service. Element 24 also includes a column where the biller can list the charges for each procedure. We're going to get to a

visual representation of Element 24 in just a moment, but first, let's look at the last few important Elements.

Element 25 is the field where the biller will enter the patient's taxpayer ID. Element 26 is the patient's account number with the provider. We'll skip to Element 28, which includes the total charge of the procedure. Element 29 includes the amount paid by the health insurance. This is the amount the biller is asking the payer to pay, not the amount the payer has already paid.

Element 30 is the balance due for the procedure, which is arrived at by subtracting the amount paid (Element 29) from the total cost of the procedure (Element 28). The Balance is the amount that will be passed on to the patient.

Elements 31 and 32 are fields where the biller can put in information about the provider (including the service facility location and the NPI). The final Element, Element 33, is a space where you must enter the information about the provider/billing party.

Let's take a look at a simplified table of Element 24. We'll use our first example to enter in the codes. (Note that we're actually leaving off a few columns to the left of Column F. For the sake of this simplicity, we won't be getting into the information there).

**SIMPLIFIED VERSION
OF ELEMENT 24**

24 A. Dates of Service	B. Place of service	C. Type of service	D. Procedures, Services, or Supplies	E. Diagnosis code	F. Charges
10/1/2013	XXXX	E&M	99203-4120F	481	???
10/1/2013	XXXX	Path	86060	481	

You'll see that we attach the diagnosis codes to both of the procedures we enter. That's because we need to justify the medical necessity for both procedures.

Before we get into more detail about this example, we'll have to discuss charges. Private practices may set the cost of their procedures, but they should align closely to the Medicare costs of a procedure. The Medicare cost of a procedure is determined by evaluating the Relative Value Units (RVU) of the procedure. These RVUs depend on the amount of time the procedure takes (the Work RVU), the cost of that time (called the Practice RVU) and the likelihood of complications for that procedure (the Malpractice RVU). These are each multiplied by a geographic practice cost index and added up. These in turn are multiplied by a conversion factor, which is the dollar amount per RVU.

So, for the sake of this example, let's say the cost of the E&M procedure is \$200. The cost of the Pathology procedure is \$300. We'd put each of those in Column F next to their respective procedure.

That brings the total cost of the procedure to a nice round \$500. That's what we'd put in Element 28.

ELEMENT 28

25. Federal Tax ID	26. Patients Acct #	27. Accept assignment?	28. Total Charge	29. Amount Paid	30. Balance Due
XXX-XX-XXXX	XXXX	--	500	???	???

How much the payer pays depends on the subscriber’s insurance agreement. For this first example, let’s say the our patient with pneumonia has a basic indemnity agreement, for which he owes a \$200 deductible, and a \$50 co-pay. After he’s paid that amount, his insurance will cover the rest of the procedure. The deductible and the co-pay have already been assigned to the patient, so the first \$250 will be left off the bill. Instead, the amount paid by the pay will be listed as \$250, and the balance will be zero.

ELEMENT 24-30

24 A. Dates of Service	B. Place of service	C. Type of service	D. Procedures, Services, or Supplies	E. Diagnosis code	F. Charges
10/1/2013	XXXX	E&M	99203-4120F	481	200
10/1/2013	XXXX	Path	86060	481	300

25. Federal Tax ID	26. Patients Acct #	27. Accept assignment?	28. Total Charge	29. Amount Paid	30. Balance Due
XXX-XX-XXXX	XXXX	--	500	250	0

That, in a very simplified way, is what a medical claim looks like. This gets sent to the payer and, if its approved, gets sent back to the biller for their records.

Let’s look at our second example, and throw in a few new elements.

EXAMPLE 2

Our second patient is the 67-year-old female with appendicitis. If you’ll recall, this example involved a lot more codes, because it was a much more complicated set of procedures. The codes we came up with in the last example were...

PROCEDURE

- 99284, (Emergency department visit for a condition that requires urgent evaluation by the physician... but [does] not pose an immediate significant threat to life or physiological function);
- 76705, ultrasound, abdominal, real time with image; limited (e.g. single organ)
- 44970, laparoscopy, surgical, appendectomy
- 00840-P3, Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified; patient with severe systemic disease

DIAGNOSIS

- 540.9, Acute appendicitis without mention of peritonitis

Now that we’ve reviewed the codes, let’s just jump right into entering the information in the proper elements.

24 A. Dates of Service	B. Place of service	C. Type of service	D. Procedures, Services, or Supplies	E. Diagnosis code	F. Charges
9/30/2013	XXXX	E&M	99284	540.9	400
9/30/2013	XXXX	Radiology	76705	540.9	300
9/30/2013	XXXX	Surgery	44970	540.9	595
9/30/2013	XXXX	Anesthesia	00840-P3	540.9	600

25. Federal Tax ID	26. Patients Acct #	27. Accept assignment?	28. Total Charge	29. Amount Paid	30. Balance Due
XXX-XX-XXXX	XXXX	--	1895	???	???

In order to determine the amount and balance due, we have to know what kind of coverage our patient has. Our patient is 67 years old, which means she qualifies for Medicare. And, sure enough, she's on traditional Medicare, which covers hospital services like the procedure above. Let's say she has \$400 left to cover her deductible. We'd take that our right away, so the amount left to cover is \$1,495.

Medicare Part A can work as a co-insurance. For our example, let's say the patient has a 80-20 coinsurance. That means Medicare owes 80 percent of the cost of the procedure, while she'll owe the remaining 20 percent.

So we take 80 percent of the 1495 (\$1,196) and put that in Element 29. That makes the balance for the procedure (i.e., what the patient owes), \$299. Let's look at the completed Elements.

COMPLETED TABLE OF ELEMENTS

25. Federal Tax ID	26. Patients Acct #	27. Accept assignment?	28. Total Charge	29. Amount Paid	30. Balance Due
XXX-XX-XXXX	XXXX	--	1895	1196	299

And there you have our second claim, or at least the parts of it that are most relevant to the reimbursement process.

As you can see, the billing process requires a working knowledge of what codes are and how they work, in addition to proficiency in the monetary side of health-care. You'll need to know what codes are, how they work, but you'll also need to know how much procedures cost, and how to tailor each claim to a specific patient's insurance agreement.

COMMON PROBLEMS IN MEDICAL CODING

In *Potential Billing Problems and Returned Claims* in Section 3, we introduced you to some common medical billing problems. In this Course, we'll talk about some of the most common coding problems and how to avoid them. Reducing the error rate in your coding is imperative if you want to succeed and advance in the profession, so keep an eye out for these common missteps.

NOT CODING TO THE HIGHEST LEVEL

As we've mentioned ad nauseam in the previous courses, the coder's job is to code to the highest level of specificity. This means abstracting the most information out of the medical reports from the provider and taking accurate notes. It also means knowing the medical terminology for both procedures and diagnoses. Coding to a general level, or undercoding (which we'll discuss in a moment) can lead to a rejected or denied claim.

BAD DOCUMENTATION/ MISSING DOCUMENTATION

Of course, not coding to the highest level isn't always the coder's fault. In certain cases, the provider won't give the coder enough information about the procedure they've performed. Providers may leave important details of the procedure out of the report, or they may provide illegible medical reports. This problem is exacerbated by the next trouble spot on the list.

NOT HAVING ACCESS TO THE PROVIDER

Ideally, every coder would be in constant contact with the provider they're coding for. Unfortunately, that's not always the case. Providers aren't always available to consult on difficult-to-understand claims. Coders have to do the best with what they have in these situations, but you should still try and clarify the report as best as you can.

FAILING TO USE CURRENT/ UPDATED CODE SETS

The organizations that maintain the three principal medical coding code sets (the WHO for ICD, the AMA for CPT, and the CMS for HCPCS) update these manuals yearly. It's up to coders to learn any new or reorganized codes as they come out, and use them correctly. This is partly why professional organizations like the AAPC and AHIMA require every member to complete a certain amount of educational credits every two years. Keeping your skills sharp is imperative.

UNDER- AND OVERCODING

Undercoding is the purposeful reportage of less expensive medical services than were performed, while overcoding is the reportage of more expensive procedures than were performed. Both of these are fraudulent, and can lead to audits and investigations. These aren't errors, per se, but we're obligated to mention them here as something you absolutely must avoid.

UNBUNDLING

Like under- and overcoding, unbundling is not so much of an error as it is a fraudulent practice. Unbundling is closely related to upcoding, in that it involves false reporting designed to earn the provider a higher payout from a payer. Unbundling means separately coding procedures that would normally be included in one umbrella code.

BE DILIGENT

Your work as a medical coder will be detail-oriented and full of tiny choices to make every day. You can avoid a lot of medical coding errors just by double-checking your work. Read over every medical report twice (at least), and never let yourself get “too familiar” with a particular code set or set of procedure codes.

COMMUNICATE OFTEN

It’s not always possible to talk frequently with your provider (especially if you’re working for an off-site coding agency). Still, you should work to develop relationships at each provider’s office, and try and communicate with them regularly. This will make it easier for you to ask them for clarification on any particularly thorny medical reports.

STAY SHARP

Every year, you’ll have to update your coding manuals with their latest versions. In many cases, brand new manuals will be provided by your employer as part of a work expense. If not, it’s worth it to buy new ones every year yourself. These manuals include new codes and new, revised guidelines, and having the latest edition is imperative if you want to stay up-to-date.

WHAT IS THE CPC EXAM?

Once a soon-to-be medical coder has completed their formal training, they should start thinking about certification. Certification is the process wherein a designated third party confirms the quality of performance or knowledge of an individual. The benefits of certification are numerous, including higher pay on average and

Certification also typically comes with membership in a professional organization, which is advantageous to the coder looking to stay up-to-date on new trends and developments in the field.

There are a number of certifying bodies for the medical coder, but the American Association of Professional Coders (AAPC) remains the largest and most influential of these. The AAPC's Certified Professional Coder (CPC) exam is currently the gold standard of coding certifications. In this and the following twenty-plus courses, we'll show you more about the

WHAT IS IT?

The CPC exam is comprised of 150 multiple-choice questions. The test takes five hours and 40 minutes to complete, making it fairly rigorous. There are two breaks in the middle of the test. The CPC exam costs \$300 to take, but only \$260 if the test-taker is a member of the AAPC (annual dues are \$125 for individuals and \$70 for students).

The CPC exam thoroughly tests a coder's grasp of the entire coding process, from medical terminology to code sets and beyond. Per the AAPC's website, the CPC exam covers 24 subject areas, including...

24 SUBJECTS OF THE CPC EXAM

Anesthesia	Radiology
Medicine	Nervous System
Endocrine System	Digestive System
Urinary System	Musculoskeletal System
Evaluation and Management	Anatomy and Physiology
Mediastinum and Diaphragm	Practice Management
Male/female Genital	Hemic and Lymphatic
Maternity and Delivery	Eye and Ocular Adnexa
ICD-9-CM	HCPCS Level II

24 SUBJECTS OF THE CPC EXAM CONT.

Coding Guidelines	Medical Terminology
Pathology	Integumentary
Respiratory	Laboratory

You should recognize a number of these (like Evaluation and Management, or Radiology) as sections of the CPT code manual. Others, like Anatomy and Physiology, are parts of the coder's everyday skill set. The CPC

You should note that the questions on the exam are not divided or identified by the topic they are related to. That is, questions on the CPC exam will test you on all of the above 24 fields of medical coding, but they won't outright say, "This is an anesthesia question." Instead they'll just ask you about anesthesia, or surgery, or human anatomy.

During the test, you'll be presented with a number of test cases pertaining to the practice of coding. These test case questions will present you with a condensed medical report and ask you to select the correct set of codes from the answers below.

For instance, a test case question might read:

"Sarah, a 45-year-old patient, visits the doctor and presents symptoms including a sore throat, swollen lymph nodes, and a fever. After performing a rapid strep test, the doctor confirms a diagnosis of streptococcal sore throat. The doctor prescribes an Amoxicillin as an antibiotic. Which of the following are the correct codes for this diagnosis, procedure and prescription?"

There are also general knowledge questions, like "Which types of joints are synovial?" that don't have an attached test case. That question's related to the musculoskeletal system, but the test won't come right out and say so. You'll have to rely on your knowledge of code sets, medical terminology, best practices, and the coding process in general to pass.

Individuals who earn a score of 70 percent or better (105 correct questions) will pass the CPC exam. If you fail your first test, you are allowed one free retake.

GETTING CERTIFIED

Once you pass the CPC exam, you are not officially certified by the AAPC until you fulfill a few other criteria. In order to complete a CPC certification, you must become a member of the AAPC. Certification is also limited to coders with two years of professional experience or those willing to complete an apprentice program.

As such, the CPC exam is recommended for individuals who have already started their coding career. That won't prevent us from going over the basics of this important exam.

You should bear in mind, however, that none of the courses in this Section or this e-book will fully prepare you for the exam, nor will the completion of this e-book. Because the AAPC copyrights all of the information in the test, along with past tests, the best way to prepare for these exams is to take a course administered by the AAPC itself.

Unfortunately, the prep course and materials offered by the AAPC cost a fair amount of money, and so some coders find it worthwhile to track down less expensive third-party preparation outfits. You can often find these in the form of “crash courses,” which review large amounts of information in just a few days as a sort of guided cram session.

In the next course, we’ll give you some basic study strategies for the test.

GENERAL PREPARATION AND TEST STRATEGIES FOR THE CPC EXAM

As we mentioned in the last course, the AAPC has a number of preparation materials for the Certified Professional Coding (CPC) exam. These are available through the AAPC's website, but they're fairly expensive.

You'll learn everything you need to pass the CPC exam in a coding course at a university or community college. You should only purchase the AAPC's training materials if you're very far out of practice.

You should, however, consider taking the AAPC's CPC practice exams.

PREP STRATEGIES

Since the CPC exam covers so many topics, it's easy to get overwhelmed in the preparation stages. Here are a couple ways of to cope with this large, intimidating exam.

During the exam, you'll spend the most time with the CPT manual. While there are some questions on ICD-9-CM codes and HCPCS, there are far more questions that relate to the CPT code set, so it's good to focus your study efforts there. Know the manual back to front, and be comfortable navigating it and using its numerous appendices.

Most people take the exam only after they've been working in coding for a little while (to be certified, the CPC requires a passing score and two years of professional experience, or the educational equivalent). If you've amassed that experience, you should be relatively familiar with medical terminology and anatomy and physiology. Still, it's a very good idea to brush up with this through flash cards or review courses.

There will be questions on the exam that explicitly reference medical or anatomical terminology (questions like, "What kind of joint is this?"), but having a strong medical vocabulary will help you in deciphering other questions as well.

Once you've studied up, be sure to take advantage of as many practice exams as you can. Treat these exams like real tests: study extensively for them, time yourself as you take them, and then note which questions, and more importantly what type of questions, you regularly get wrong. On your first test, did you struggle with the Anesthesia codes? Go back over that section. Were you sloppy with your ICD-9-CM codes? Review the ICD-9-CM manual. A number of private companies have practice CPC exams, but the AAPC's practice exams are probably your best bet.

Don't treat practice exams as formalities or wastes of time. Many practice exams can be easier than the actual exam, but you should still take them seriously. You should try and score at least an 80% on a practice exam before you take the real CPC exam.

TAKING THE TEST

When you take the CPC exam, you're allowed to bring in each of the code manuals (the ICD, CPT, and HCPCS manuals). You're allowed to have notes in the margins of these manuals, but these notes can't contain any test-specific information. You are also not allowed to tape anything into these manuals.

It's a good idea to mark the important or frequently used sections of your code manuals. The 2013 CPT manual, for instance, comes with a number of tabs you can place in the book to mark certain important places. Use these to mark off where code sections begin (like the Surgery or Medicine sections in the CPT manual), and where to find certain appendices.

When you're taking the CPC exam, you'll be asked to perform though you were coding at your regular coding job, so set up your manual in the way that makes the most sense for you.

Also be aware that each manual has loads of helpful information beyond the codes. The CPT manual has a number of diagrams of the human body, including illustrations of the ocular system and adnexa, the musculoskeletal system, the nervous system and much more. Mark these pages and refer to them during the test if you're stumped on a question pertaining to anatomical terminology.

TIME MANAGEMENT

When you're taking a test like the CPC exam, which is almost six hours long and consists of 150 questions, it's a good idea to break things down to make them more manageable. Separate the questions into blocks of time, and work on one block of questions for a fixed amount of time before moving on to the next set.

For example, you can divide the CPC exam into five groups of 30 questions. Take one hour for every thirty questions. Or you could try and take on 10 questions every 20 minutes. As soon as your designated block of time is up, skip to the next block of questions. That is, if you've divided the test into five, hour-long blocks of 30 questions, and you are on question 25 after the first hour elapses, just skip ahead to question 31. If you finish a block of questions early, go back and fill in questions you skipped.

In a test as long as the CPC, it's important to keep your momentum as you take the test. You don't want to spend too much time on any one questions. Make it your goal to read and, if possible, answer every question on the test.

It's a good idea to bring a timer to the exam. This can be a kitchen timer or a watch. Just make sure you don't have a distracting alarm set on it, and you should be fine. (Your proctor won't let you use your cell phone, for obvious reasons).

KNOW YOUR GOALS

In order to pass the CPC exam, you need to get a 70% or better on the test. Always keep that in mind when you're taking the test. The long, multi-part questions that might have you look up three, four, or five codes are worth the same as the general knowledge questions. If you're stuck on a question, don't be afraid to skip it and come back to it later.

Another good way of managing your goals and your time is to remember that your objective in the test is to pick the best available answer. This test is not an exact duplication of what you'll see in everyday coding. These are hypothetical situations that may be shortened or simplified for space, so you'll waste precious time getting lost in the details of each questions. Pick the best possible answer and move on.

Remember as you take the test that you can get 45 questions wrong. Don't waste a lot of time on a question that's totally stumping you. Instead, move on and try and regain your momentum with easier, less time-intensive questions. If you've got extra time, go back to the more difficult questions after you've completed the easier questions.

CPC EXAM: ANESTHESIA

For the CPC exam, 'Anesthesia' refers to the Anesthesia section of the Current Procedural Terminology (CPT) code manual. Anesthesia is the second section in the manual, after Evaluation and Management and before Surgery.

Anesthesia codes are found in the 00100 - 01999 and 99100 - 99150 number ranges. Here's a look at the different subsections of the Anesthesiology section, and the ranges for these codes.

SUBSECTIONS OF THE ANESTHESIOLOGY SECTION

FIELD	RANGE	FIELD	RANGE
Head	00100 - 00222	Neck	00300 - 00352
Thorax	00400 - 00474	Intrathoracic	00500 - 00580
Spine and spinal cord	00600 - 00670	Upper abdomen	00700 - 00797
Lower abdomen	00800 - 00882	Perineum	00902 - 00952
Pelvis (except hip)	01112 - 01190	Upper leg (except knee)	01200 - 01274
Knee and popliteal area	01320 - 01444	Lower leg	01462 - 01522
Shoulder and axillary	01610 - 01682	Upper arm and elbow	01710 - 01782
Forearm, wrist and hand	01810 - 01860	Radiological procedures	01916 - 01936
Burn excisions or debridement	01951 - 01953	Obstetric	01958 - 01969
Other procedures	01990 - 01999	Qualifying circumstances for anesthesia	99100 - 99140
Moderate (conscious)	99143 - 99150		

On the exam, you'll see approximately ten questions on Anesthesia. (Please note that this is not an exact figure, as the AAPC has copyrighted their exam and has not publicly released the exact amount of questions on each subject since 2004).

There are three main types of anesthesia: General, local, and conscious sedation. General anesthesia is the most dangerous, as it involves a person becoming entirely unconscious. When a person is put under general anesthesia, the physicians (and anesthesiologist) must maintain all of the patient's bodily functions, including respiration.

Local anesthesia refers to the numbing of a particular body part or region of the body. Conscious sedation refers to the process of heavily sedating, but not totally anesthetizing, a patient. Under conscious sedation a patient is able to respond verbally to questions and commands, and does not require any intervention to maintain their bodily functions (eg, cardio or respiratory).

Anesthesia codes are always tied to surgery codes. After all, we wouldn't just anesthetize someone for the thrill of it! Whenever a surgical procedure is performed that requires anesthesia (which is most of them), we must always have an Anesthesia code with the surgery codes. This Anesthesia code corresponds to where on the body the surgery is performed.

Anesthesia codes are "bundled." That is, each Anesthesia code contains a number of things within it, including the pre- and post-operative visits from the anesthesiologist, the monitoring of bodily functions (in the case of general or large-scale local anesthesia), the administration of the anesthetic, etc. That means you won't find specific procedure codes for the evaluation of the patient and the administration of an intravenous anesthetic—both are included in the larger Anesthesia code.

In the case of multiple surgical procedures performed under one instance of anesthesia (one administration of general anesthesia, for example), we'd only use one Anesthesia code.

During the CPC exam, the most useful resource is the set of guidelines at the beginning of the Anesthesia section. Be sure to tab this and refer to it in case you're feeling confused. The guidelines will tell you the proper way use Anesthesia codes (like how to list an Anesthesia code with a Surgery code).

Time reporting is a very important part of using Anesthesia codes. The longer the patient is under anesthetic, the more expensive (and risky) the procedure will be. An Anesthesia procedure begins the moment the anesthesiologist preps the patient, and ends when the anesthesiologist hands the patient over to the nurse or physician who is handling the patient's recovery. The Anesthesia section of the CPT manual has guidelines for time reporting.

So a two hour procedure may require three hours of anesthesia: a half hour before the procedure, the anesthesiologist preps the patient and administers

the anesthetic, the patient is under for the duration of the procedure, and then the anesthesiologist monitors the patient following the operation until handing them off to the nurse.

Physical status modifiers are alphanumeric modifiers specific to Anesthesia codes. Every Anesthesia code must have a physical status modifier. These inform the payer of the patient's condition, and thus the risk (and therefore cost) of the procedure.

To review, these physical status modifiers are...

PHYSICAL STATUS MODIFIERS

P1 – A normal, healthy patient

P2 – Patient with a system disease (A systemic disease is something that could adversely affect the anesthesia, such as hypertension)

P3 – Patient with severe systemic disease

P4 – Patient with a severe systemic disease that is a constant threat to life

P5 – Moribund (fatally ill or wounded) patient who is not expected to survive without a surgical procedure

P6 – Brain-dead patient whose organs are being retrieved for donor purposes (In P6 cases, anesthesia is administered not to prevent pain, but to keep the organs alive for their extraction)

CPC EXAM: RADIOLOGY

Radiology is one six sections of Category I of the Current Procedural Terminology (CPT) manual. Radiology contains codes for x-rays, MRIs, diagnostic ultrasounds, nuclear medicine and radiation oncology, among several other procedures.

Radiology is the fourth section of the CPT manual, and occupies the 70010 – 79999 numerical range of codes.

On the CPC exam, you will probably see around ten questions on Radiology. (Note that this number is approximate, as the AAPC has not published how many types of questions are on the CPC exam since 2004).

RADIOLOGY SECTION

FIELD	RANGE	FIELD	RANGE
Diagnostic Imaging	70010 – 76499	Diagnostic Ultrasound	76506 – 76999
Radiologic Guidance	77001 – 77032	Breast Mammography	77051 – 77059
Bone/joint Studies	77071 – 77084	Radiation Oncology	77261 – 77999
Nuclear medicine	78000 – 79999		

These fields and ranges can be informally arranged into four groups. Those groups are: Diagnostic, Ultrasound, Radiation Oncology, and Nuclear Medicine. Bear in mind that these are not official groupings laid out by the AAPC or by the AMA. They're just there to help you visualize the section.

Diagnostic is by far the largest, and covers everything not listed in the Diagnostic Ultrasound (76506 – 76999), Radiation Oncology (77261 – 77999), and Nuclear Medicine (78000 – 79999) ranges.

For Diagnostic Radiology, we need to know the procedure codes for x-rays, computer tomography (CT) scans, and Magnetic Resonance Imagery (MRI). Diagnostic also covers mammograms, and studies of bones and joints.

You'll also need to know about contrast materials. Contrast materials are substances used to enhance the contrast of images taken with x-rays, MRIs, and ultrasounds. These materials, like barium or iodine, help make certain elements of the body show up more starkly in the radiological exam. Some contrast materials may be injected, while others are swallowed or delivered by enema.

This can become complicated, because many procedure codes in Radiology mention procedures with or without contrast. In cases where a patient drinks or receives the contrast medium via enema, do not code with contrast. If the contrast medium is injected into the patient, you should code with contrast. Think of it in terms of the skill of administration. A doctor does not need to do anything special to have a patient drink barium. A doctor does need to use some skill to inject the contrast medium into the patient.

Ultrasound radiology is fairly straightforward. In ultrasound, sound waves are used to create images of the body. Coders should watch out for the different levels of procedure codes when it comes to ultrasounds of a pregnant uterus. There are different codes based on what trimester the patient is in.

Radiation Oncology involves using radiation to attack or corral cancer cells in a patient. Some procedure codes measure radiation oncology in units (called “fractions”) of treatments: so many units of treatment in a month, for example.

In nuclear medicine, you should be looking out for key terms that describe a “scan.” A lot of nuclear medicine is diagnostic in nature, but the type of equipment (and material used in the equipment) is expensive enough to differentiate it from the general Diagnostic Radiology.

The other part of nuclear medicine is the introduction of radioactive material as therapeutic material. These codes are listed by the way the material is introduced to the body.

Radiology can also get very tricky when it comes to CPT modifier -26. If you’ll recall, -26 is the modifier for a “professional component.” Radiologists are sometimes called on to examine or interpret the results of radiological exams (like x-rays). If a radiological exam or other Radiology procedure is performed in a radiology facility, that facility would act as the provider and would bill for the procedure using one code.

If, however, the radiologist was called on to interpret an x-ray or MRI at a hospital, which is not a standalone radiological facility, that radiologists interpretation would be reported with a -26 modifier, to indicate that an additional professional component was needed to interpret the x-ray or MRI.

For question on Radiology, you want to make sure you know the planes and views of the body. Think about it: when a doctor prescribes an x-ray or CT scan, they need to look from specific angles, or possibly from multiple angles. Knowing where the, say, palmar side of the hand is, as opposed to the dorsal side, is very important.

You should find a number of diagrams for views of the body in the front of the CPT manual. Be sure to make some note of where these diagrams are so you can refresh yourself during the test, if need be.

CPC EXAM: MEDICINE

The next section of the CPC exam we'll cover is Medicine. Medicine is the most diverse section of the Current Procedural Terminology (CPT) manual. The Medicine section covers everything from vaccination to acupuncture, making it often very difficult to navigate. You'll want to rely on your table of contents and your coding guidelines, both found at the front of the Medicine section.

There will only be around ten questions specifically related to Medicine on the CPC exam, meaning the AAPC has to condense a large and complicated section of the CPT manual into only a handful of questions.

Medicine takes up the 90281 – 99199 and 99500 – 99607 ranges of the CPT code manual, and makes up the final section of the manual before CPT Category II and Category III.

Individuals taking the exam should know the sections of the Medicine section and when to use which sections. For example, an injection of medication is not the same as a vaccination.

We bring up the issue of injection versus vaccination because it leads us to another important element of the Medicine section: the Medicine section is one of the only places in the CPT manual where you'll find codes for a product (the substances that's being injected) instead of a service. Remember, the majority of the time we code for a product, we use HCPCS. In the Medicine section you'll find a few exceptions to that rule.

The Medicine section is made up of 33 different subsections, each pertaining to a different field of medicine. They are...

33 SUBSECTIONS OF MEDICINE

FIELD	RANGE	FIELD	RANGE
Immune globulines, serum or recombiant prods	90281-90399	Immunization administration for vaccines or taxoids	90565-90474
Vaccines, toxoids	90476-90749	Psychiatry	90801-90899
Biofeedback	90901-90911	Dialysis	90935-90999
Gastroenterology	91000-91299	Ophthalmology	92002-92499
Special otorhinolaryngology services	92502-92700	Cardiovascular	92950-93799

33 SUBSECTIONS
OF MEDICINE CONT.

FIELD	RANGE	FIELD	RANGE
Noninvasive vascular diagnostic studies	93875-93990	Allergy and clinical immunology	95004-95199
Endocrinology	95250-95251	Neurology and neuro-muscular procedures	95803-96020
Central nervous system assessments/tests	96101-96125	Health and behavior assessment/intervention	96150-96155
Hydration, therapeutic, prophylactic, diagnostic injections and infusions, and chemotherapy and other highly complex drug or highly complex biologic agent administration	96360-96549	Photodynamic therapy	96567-96571
Special dermatological procedures	96900-96999	Physical medicine and rehabilitation	97001-97799
Medical nutrition therapy	97802-97804	Acupuncture	97810-97814
Osteopathic manipulative treatment	98925-98929	Chiropractic manipulative treatment	98940-98943
Education and training for patient self-management	98960-98962	Non-face-to-face non-physician services	98966-98969
Special services, procedures and reports	9000-99091	Qualifying circumstances for anesthesia	99100-99140
Moderate (conscious) sedation	99143-99150	Other health services and procedures	99170-99199
Home health services and procedures	99500-99602	Medication therapy management	99605-99607

As you can see, that's a lot of ground to cover. Since the Medicine section is so large and since, unlike Surgery, it covers so many different types of medical procedures, it's important to zero in on certain key terms while taking the exam. (Surgery, while a very large section, is divided generally by where on the body the procedure takes place, making it easier to navigate).

A question may come out and say, explicitly, that the patient received dialysis for end-stage renal failure. If you spot the key term "dialysis," you'll know you're looking for a code in the 90935 to 90999 range.

Likewise, if a question describes a catheterization of the heart, you'll know to look either in the "Cardiovascular" subsection or the "Noninvasive vascular diagnostic studies." From there you can look at the question and ask: was surgery required to perform this catheterization? That is, was it invasive? If it wasn't, you can look for the code in the 93875 - 93990 ("Noninvasive vascular...") subsection. In questions involving Medicine, it's important to find as many landmarks as possible.

Like Anesthesia codes, many Medicine codes work as de facto Evaluation and Management codes. For example, if a patient comes in expressly to have an injection of a certain vaccine or medication, we wouldn't need to use an E&M code for that procedure. The evaluation portion before the injection would be covered in the Medicine code already.

Medicine is one of the trickiest sections to work with in the CPC exam. It helps to have a very strong base in medical terminology and anatomy and physiology. Test-takers should take heart, however—in creating a test for such a broad, diverse topic as Medicine, the AAPC often errs on the side of broader, more general questions. Only rarely will you see a fine-grain question about Medicine on the CPC exam.

CPC EXAM: THE NERVOUS SYSTEM

There will be approximately ten questions, in total, on the nervous system, endocrine system, eye and ocular adnexa, and ear. Procedures on these fall into to the 60,000 range of the Surgery section of the CPT Manual. In this course we'll just look at the nervous system, but know that it's linked, in a way, to those other areas of the body.

Codes for surgical procedures on the nervous system are located in the 61000 - 64999 numerical range, toward the front of the Surgery section.

On the CPC exam, you'll be tested primarily on surgical procedures performed on the spine, skull, meninges and brain. Let's look briefly at each of these things now.

The cerebral cortex of the brain has four lobes: the frontal lobe, parietal lobe (in the middle toward the rear), the temporal lobe (to the sides) and occipital lobe (at the rear). The brain is coated by three meninges: the pia mater, the arachnoid, and the dura mater. The pia mater is the soft casing closest to the brain itself. The arachnoid is the web-like intermediary in between the pia mater and the dura mater, and the dura mater is the hard outer layer in between the brain (and meninges) and the skull.

The nervous system extends from the brain, down the spine and spinal column, and throughout the body in a network of nerves. Again, for the CPC exam, you'll be tested mostly on your knowledge of the central nervous system (the skull, brain, meninges and spine) and the procedures that are performed on it.

As with all Surgery procedure codes, it's imperative that you know the vocabulary of surgery. You need to know the difference between an -ectomy (cutting away) and an -otomy (cutting into). You should commit the surgical suffixes and prefixes (like 'ad-' for away, or 'trans-' for across) to memory.

You'll also need to know the anatomy of the brain, and the directional suffixes that describe where, in relation to certain parts of the body, a procedure is performed. For example, the tentorium is the fold in the dura mater that creates a crease between the cerebrum (the anterior, or front, section of the brain) and the cerebellum (the posterior, or back of the brain). You may need to code a supratentorial craniectomy. If we break this down, we see that it's the cutting away (-ectomy) of matter above the tentorium (supra-).

You should also expect at least one question on surgical procedures performed on the base of the skull. This is a complicated area of surgery, one in which the approach is often more difficult than the removal or alteration of the problem there. Because the base of the spine is where the brain connects to the spine, it's an incredibly problematic area. In the case of procedures performed on the base of the skull, the approach is usually done by one surgeon, while the procedure (the excision, let's say) is done by another. In this special case, no "two surgeons" CPT modifier is needed, as the procedure is generally regarded as requiring two professionals.

You're going to need to master the vocabulary of the skull as well. Because the nervous system effectively encompasses the entire skull, surgical procedures on the nervous system are identified by where inside the skull they take place.

When it comes to the spine and the Nervous System, we're concerned more with the spinal cord than the spinal column. We're coding for the thing that transmits information through the spine (the nerves in the spinal cord), not the things that physical support it (the vertebrae).

That doesn't mean you won't have to know your anatomy terminology when it comes to the spine, however. Surgical procedures on the spinal cord are identified by where on the spinal cord they take place: A discectomy, for example, would be identified by where in the spine the disc is being removed. Is it between the first and second lumbar vertebrae? The second and third cervical vertebrae?

You'll also need to know the codes for injections into the nervous system, especially injections into the spine and spinal cord. This may include the injection of diagnostic agents (dyes, for example), treatments, or anesthesia.

To review for your review: In order to nail your CPC exam question on the Nervous System, you'll need to know the anatomy of the brain, meninges, skull, and spine. You need to be able to navigate the nervous system based on the location on the body. You should be familiar with surgical prefixes and suffixes.

Note that in your CPT manual, you can find informative diagrams of the skull, spinal column, and nervous system. Make a master list of pages that feature anatomical diagrams and refer to them during the test in case you get stuck.

CPC EXAM: THE ENDOCRINE SYSTEM

The endocrine system is a system of glands found throughout the body that secrete various chemicals into the blood stream. Among these chemicals are a number of hormones, which regulate growth, metabolism, sleep, and mood, among many other bodily functions.

In terms of questions on the CPC exam, there will be approximately ten questions on codes in the 60,0000 range of Surgery section, which encompasses procedures on the nervous system, endocrine system, eye, and ear. That's a lot of information to cover in only a handful of questions, so you can expect to see broader questions on procedures related to the endocrine system.

That doesn't mean you can breeze through the endocrine system, however. Let's take a look at it now.

Surgical procedures on the endocrine system are found in the 60000 – 60699 numerical range, toward the end of the section.

The endocrine system is made up of a number of highly important glands. Many of these, like the pineal gland, are integral parts of other major systems in the body. The pineal gland is located inside the brain (and thus the nervous system), while the pancreas is located in the digestive system.

These glands secrete hormones through the bloodstream or, in certain cases, the nervous system. These hormones are slow-acting, long-lasting chemical agents that affect and monitor everything from growth to mood. Unlike the nervous system, which carries rapid, short-term electrical impulses, hormones secreted by the endocrine system may have an effect for weeks or longer.

Here's a quick breakdown of the endocrine system, what each gland (or set of glands) does, and where they're located.

ENDOCRINE SYSTEM BREAKDOWN

PREFIX	MEANING	EXAMPLE
Hypothalamus	Monitors growth, affects lactation, interacts with pituitary gland	In the brain, below the thalamus, above the brain stem
Pineal body	Monitors circadian rhythms (24-hour cycle of the body, commonly cited with regard to sleep)	In the brain, above the cerebellum, part of the thalamus
Pituitary gland	Affects growth (releases human growth hormone),	At the base of the brain, in the

ENDOCRINE SYSTEM
BREAKDOWN CONT.

PREFIX	MEANING	EXAMPLE
	affects pain perception, stimulates the production of sperm and eggs, stimulates thyroid gland	hypothalamus
Thyroid	Affects oxygen and energy consumption (metabolism) and bone construction	In the neck, below the thyroid cartilage (Adam's apple)
Pancreas	Affects intake of glucose and lipids, and inhibits production of insulin	In the abdomen, by the duodenum
Adrenal glands (made up of Adrenal cortex and adrenal medulla)	Cortex: stimulates the breakdown of fat, inhibits protein synthesis, inhibits immunological responses, affects kidney function Medulla: produces adrenaline and noradrenaline (stimulate "fight or flight" response), boosting the supply of oxygen to the brain; increases heart rate and regulates pain	In the abdomen, immediately superior to the kidneys
Reproductive glands (Ovaries and testes)	Testes: creates testosterone, which affects muscle growth and bone density, along with development of sex organs, deepening of voice, etc. Ovaries: creates progesterone and estrogen, which support pregnancy, affect growth, metabolism, increase bone formation, and many other functions	In or below the abdomen

You can find an anatomical drawing of the endocrine system in your CPT manual. It's helpful to refer to this if you get stuck.

It's important to note that a number of other organs interact with and affect the endocrine system. These include, but are not limited to, the stomach, duodenum, liver, and kidneys, all of which can be classified as the 'alimentary system.' Since each of these organs is an integral part of other, larger systems, we won't be covering them here.

Because so many of the endocrine glands are found in other systems of the body, the Endocrine System subsection of the Surgery section focuses mostly on the thyroid gland. The thyroid is a butterfly-shaped gland located in the neck, and is the largest gland in the endocrine system. You'll also find procedure related to the adrenal glands, located superior to the kidneys.

As with all Surgery subsections, you should be familiar with the vocabulary of surgery itself and the prefixes and suffixes related to the body. If you see a question with a "thyroid lobectomy, unilateral," you should know this is the removal of one half of the thyroid. You should be able to read that from the '-ectomy' (cutting away) and 'unilateral' (one side of the "butterfly").

Other endocrine glands, like the ovaries and testes, are covered in different sections of the CPT manual. The ovaries, for example, would be found in the male or female genital system subsections, while the pancreas would be found in the digestive system.

For this reason, you can think of the endocrine system subsection of Surgery as a sort of basin that catches procedures on the endocrine system that aren't easily classifiable elsewhere.

CPC EXAM: DIGESTIVE SYSTEM

The digestive system is one of the more straightforward fields of anatomy and surgery that you'll have to know for the CPC exam. In this course, we'll look at the general structure of the digestive system and the types of surgery codes you'll need to know for the exam.

Unfortunately we don't have a number for how many questions focus on the digestive system. You will probably see at least a few (as always, the AAPC does not release how many questions on the exam focus on a particular subject).

Surgical procedures on the digestive system are found in the 40490 – 49999 numerical range, right in the middle of the Surgery section.

The digestive system extends from where food enters to where it leaves the body. That is, from the mouth to the rectum. This is called the alimentary canal, and the digestive system subsection of Surgery is more or less arranged to follow the path from ingestion to excretion.

Generally, food enters the mouth and travels down the esophagus. From there it enters the stomach (look for “gastro” if you're looking for key terms in an exam question). The stomach is divided into two sections: the cardia (upper, not to be confused with ‘cardio’) and fundus (lower).

Upon leaving the stomach, digested food moves into the duodenum. The duodenum is the end of the upper gastrointestinal tract (GI). This will be important in coding procedures, as certain ones start in the mouth and move all the way down to the duodenum, while others pass through the rectum into the lower GI.

From the duodenum, food travels to the small intestine and then to the large intestine, also known as the colon. Food moves through the large intestine to the rectum (look for “procto-,” as in proctology), and then is excreted through the anus.

There are, as you might imagine, countless surgical procedures that affect this long, complicated system.

When coding a procedure on the digestive system, it's important to note where the procedure starts. Some procedures start at the mouth and go all the way to the duodenum. Others, like colonoscopies, start via the rectum and travel through the colon. If given a choice between two procedures, we always code the furthest-in one. That is, if we were removing polyps in the esophagus and the duodenum, we would use the code for the polyp excision in the duodenum, because it's the furthest-in.

Not all exploratory surgical procedures on the digestive system go through one of the openings of the alimentary canal. Several are performed via laparoscopy. A laparoscopy uses a thin tube, inserted via a small incision into the belly, to look at the abdominal organs. You'll find laparoscopy codes in the digestive system subsection, along with codes for laparotomy (mostly exploratory procedures with approaches made through large incisions in the belly) and other surgical procedures.

Note that the digestive system subsection extends beyond the alimentary canal, and includes procedures performed on the pancreas and appendix, both of which are attached to the digestive system.

The digestive system subsection of Surgery closes with various codes for treating and repairing hernias and other malformations or injuries to the GI. Codes for hernia repair procedures are separated by where on the body the hernia occurs and by what type of hernia it is (for example, is the hernia recurring?). Hernia codes also take into account how old the patient is, with different codes for hernia repairs in infants, children, and adults.

As with all Surgery section, you'll need to be familiar with both the human anatomy, and the terminology used in surgical procedures. Know the terms for excision and incision, the -otomies and -ectomies. You should also know to look for several "scope" procedures. These would include anything using an endoscope, which is a long, flexible tube with a camera that helps doctors look directly inside the GI tract.

CPC EXAM: THE URINARY SYSTEM

The urinary system is found in the 50010 – 53899 range in the Surgery section of the CPT manual. These codes are related to procedures directly affecting the urinary system, which is made up of the kidneys, bladder, ureters, and urethra.

The urinary system starts in the kidneys. The kidneys produce urine, which then travels down the first of two ureters to the bladder. You can identify kidneys by the word “renal” or the prefix “nephro-” and the bladder by the prefixes “cysto” and “vesico.” (Think of it this way: a cyst is a sac filled with fluid, much like the bladder).

After sitting in the bladder, urine travels through the urethra and leaves the body from the penis or in front of the vagina. It’s a pretty simple system, sort of like a condensed digestive tract.

Procedure codes for the urinary system include a few systems that are not directly related to the production or disposal of urine, including the prostate. Sometimes, the prostate is accessed via the urethra, meaning the urinary system section is the best place for Surgery codes related to the prostate. For the most part, however, codes in the urinary system subsection are related directly to the urinary process.

In the urinary system section of Surgery, you’ll find codes for renal biopsies, and the introduction of various medical equipment (like catheters or stents) into the urinary tract. You’ll also find codes for the removal of kidney stones (look for the prefix “litho-”, which means ‘stone’).

The urinary system contains codes for kidney transplants, both for the donor and the recipient. For the donor, you’d see a code for a nephrectomy, and for the recipient you’d see a code for the graft. A graft a tissue or organ donation, while an -ectomy you should recognize as an excision—the cutting out of something. You will want to add a bracket to kidney donation codes that specify the person receiving the code as the recipient.

Finally, you’ll also find a number of codes, as you did in the digestive system, for “scopes,” meaning endoscopy and laparoscopy. Laparoscopy, if you’ll recall from the Course on the digestive system, is an exploratory procedure performed through an incision in the skin. That is, they’re not threaded through the urinary tract, but introduced through the abdomen.

Included in the urinary system subsection are a number of procedures that are performed by specialized medical or healthcare professionals. These, like radiology codes, are places where the -26 CPT modifier pops up. Remember, if the medical professional only interpreted the results of the procedure (or exam), but did not perform it themselves, that's a -26 modifier for a professional component.

In general, you shouldn't expect any highly specific questions on the urinary system on the CPC exam. As with all Surgery codes, you should know your medical terminology and anatomy. Look for keywords within questions. If you see anything related to the nephrectomy or the renal system, then the urinary system is the place to look.

CPC EXAM: THE MUSCULOSKELETAL SYSTEM

WHAT IT IS

The musculoskeletal system is one of the densest subsections of Surgery, spanning the 20000 – 29999 numerical range, toward the front of the CPT Manual. What makes it so dense is that there are listed procedures for every muscle and bone on the body. On the CPC exam, there are about 10 questions on the musculoskeletal system, though that's just an approximation.

Covering the entire musculoskeletal system would take hours, so we'll break it down very simply: The musculoskeletal system is divided the sections of the body. Each section of the body, like the arm, has a set of joints (look for "arthro," which means joint), muscles and tendons. There are a number of anatomical diagrams in the CPT manual for you to reference, and you should have a thorough knowledge of the anatomical terms for the body before taking the CPC exam. This knowledge will help you not only in questions related to the musculoskeletal system, but also throughout the test.

Since breaking down the entire musculoskeletal system would take up a whole other eBook, let's look at some specific things to watch out for on the CPC exam.

Within the musculoskeletal subsection, there are a variety of different injuries that may occur in a patient. It's important to be able to differentiate between similar but different injuries that take place on the same part of the body. A fractured finger, for example, is not the same as a dislocated finger, despite the fact that they may produce a similar visible diagnosis and, most likely, a similar amount of pain in the patient. A fracture is a broken bone, while a dislocation is a bone moving out of joint. In a dislocation, the bone is still intact, just in the wrong place.

BASIC VOCABULARY

A few basic, important vocabulary tips. 'Osteo' means 'bone,' while 'arthro' means 'joint.' As with all Surgery codes, you need to know the difference between -ostomies, -otomies, and ectomies, among other surgical vocab terms. You should know the positional terms that tell you where something is, like posterior, superior, inferior, and anterior. You can refer to *Human Anatomy and Medical Terminology* in Section 2 for a more thorough breakdown of anatomy and physiology terms.

One of the most complicated parts of the musculoskeletal system is the spine. Bear in mind that procedures on the spine found in the musculoskeletal subsection of Surgery do not refer to the spinal cord itself, but rather to the vertebrae supporting the spinal cord. That's an important distinction to make.

If you've located a key term that tells you a question is related to the spine, double-check to figure out whether you should be looking at the bones of the spine or the spinal cord and its relation to the nervous system. Procedures that affect the nervous system, such as a decompression of pressure on the spine, will be found in the Nervous System subsection of Surgery. You'll navigate the spine using the numbers of the vertebrae. There are seven cervical vertebrae, twelve thoracic vertebrae, and five lumbar vertebrae. Each of these is noted with an alpha and a number, so the C6 would be the sixth cervical vertebrae.

Essentially, anything that relates to the bones and muscles of the body can be found in the musculoskeletal subsection of Surgery. If a patient needs a bunion removed, that's in the musculoskeletal section. Bone grafts, bone aspirations, tendon repair, joint reconstruction—they're all in the musculoskeletal subsection. By learning the proper terms for the area of the body, you can navigate right to the correct part of the subsection, so it's very important to get some flash cards and get to work.

Like many subsections of Surgery, there are a number of exploratory procedure codes included at the end of musculoskeletal. You'll find the usual suspects of "scopes," including endoscopes and arthroscopes, which is a camera inserted into the joint. You may have heard of athletes receiving arthroscopic surgery. That would be coded in the musculoskeletal subsection.

CPC EXAM: EVALUATION & MANAGEMENT

Evaluation and Management, also called E&M, is the first section of the CPT manual. It contains procedure codes for the assessment of patient's statuses and the recommendation and prescription of treatments.

On the CPC exam, you should expect to see around ten questions about E&M. (Bear in mind that this is an approximate figure, as the AAPC does not release the number of questions that focus on each subject).

Unlike most of the codes in the rest of the CPT manual, E&M codes have some gray areas. The fact that they're open to interpretation can make them difficult to use, but they're flexible for a reason. An E&M procedure is the first step in treating a patient (the doctor has to figure out what's wrong with the patient, after all), and so the E&M code set has to be adaptable enough to deal with a wide variety of patients and an even wider variety of injuries or illnesses.

SUBSECTIONS OF E&M

FIELD	RANGE	FIELD	RANGE
Office or other outpatient services	99201 – 99213	Hospital observation services	99201 – 99213
Hospital inpatient services	99221 – 99239	Consultations	99221 – 99239
Emergency department services	99281 – 99288	Critical care services	99281 – 99288
Nursing facility services	99304 – 99318	Domiciliary, rest home/ custodial care service	99304 – 99318
Domiciliary, rest home (assisted living), or home care plan oversight service	99339 – 99340	Inpatient neonatal intensive, and pediatric/ neonatal critical, care services	99460 – 99465
Prolonged services	99354 – 99360	Case management services	99354 – 99360
Care plan oversight services	99441 – 99444	Special evaluation and management services	99441 – 99444
Newborn care services	99460 – 99465	Home services	99341 – 99350

As we said, E&M is the first section of the CPT manual. It's placed there, out of numerical order, because it's referenced so frequently. E&M codes are found in the 99201 – 99499 numerical range.

Within each of these fields of E&M, there are various codes that correspond to evaluations of varying intensity. One of the main difficulties in coding E&M is evaluating the intensity of the procedure performed.

Many E&M codes, like the ones in critical care and emergency department services, are measured by time. That is, if a physician performs an exam and evaluation for 30 minutes, that will be one code. If they do the same procedure for 45 minutes or an hour, those will be two different codes.

Let's rewind for a second and talk about the most basic and important part of using E&M codes: the history, exam, and medical decision making portion, which is often abbreviated as HEM. Generally speaking, there can be no E&M code without a HEM. The 'history' refers to the patient's medical history and their history with the provider performing the E&M procedure.

The exam refers to the examination of symptoms. This refers not only to the physical examination, but to the verbal assessment as well. When a doctor evaluates a patient, they ask what's bothering them, where something hurts, how long has the patient been experiencing the symptoms, etc. These are all parts of the exam. Obviously, in cases where the patient is unconscious or unable to voice their symptoms (like in the emergency department), the exam won't be verbal.

The medical decision making process entails the doctor deciding on and in some cases recommending treatment. This may be as simple as a doctor prescribing some medication, or it may involve the doctor passing the patient onto a different specialist.

(One important caveat: some preventive medical services do not use HEM, because the patient does not have any symptoms to examine as yet).

When a patient goes to a specialist, this is often called a consult. However, in E&M there are certain rules for consults. A consult must include three Rs: the request for an opinion (from the initial physician), the rendering of the opinion (from the second physician), and the reporting of the opinion (back to the initial physician).

E&M is a difficult section to master, and it's worth taking extra time to study it before the CPC exam. Unlike Surgery, the section is not arranged intuitively by parts of the body. Coders should look to the guidelines for various code-specific rules. For example, E&M has a general rule that there is one E&M code per doctor, per patient, per day. That is, if a doctor sees a patient twice in one day, the entire day's E&M procedures would be bundled into one large code.

Coders should also know the difference between emergency department services and urgent care services, which may be similar in practice, but completely separate in the coding and billing world. Likewise, coders will need to know when to use an outpatient code versus an emergency code.

The best way to handle E&M codes is to constantly narrow your focus. Start by finding the right category of code. Where does the procedure take place? Does the question say anything about critical care or the emergency department? Is it a routine check-up? Then move to the category of E&M. From there you can look for the HEM. A heads up: The CPC exam will sometimes forgo the H (history) of HEM and focus instead on the the E (exam) and M (medical decision making). Don't be thrown off if there's no mention of the H in HEM.

If you need a quick reference, in Appendix C of the CPT manual, you'll find a list of commonly confused E&M codes and some examples of what types of evaluations they represent. Mark this page for future reference.

CPC EXAM: ANATOMY & PHYSIOLOGY

WHAT IT IS

Anatomy is the study of the human body, while physiology is the study of how that body works. It's a huge subject, and one that gets its proper due on the CPC exam.

There will be approximately 10 questions on the CPC exam on anatomy and physiology. (This, again, is not an exact number, as the AAPC does not release the number of questions on each subject). That's a relatively high number, about as many as there will be on Medicine, Radiology, and the other major CPT sections.

On the CPC exam, you'll use your knowledge of anatomy and physiology to navigate through the CPT manual. Remember, you'll use your CPT manual far more often than you will the ICD-9-CM manual or HCPCS manual. If you know the terminology for the human body, you'll recognize "fracture of the distal phalanx," as a broken toe or finger, and move to the musculoskeletal subsection of Surgery.

Below you'll find a list of anatomical terms. If you'll recall, these terms appear in Course 2-10 on human anatomy. You can refer to that course for more information on human anatomy.

ANATOMY TERMS

WORD

BODY PART

Abdominal	Abdomen
Acromial	Point of shoulder
Antebrachial	Forearm
Antecubital	Front of elbow
Axillary	Armpit
Brachial	Arm
Buccal	Cheek
Calcaneal	Heel of foot
Carpal	Wrist
Caudal	Tail
Cephalic	Head
Cervical	Neck
Clavicular	Collar bone
Costal	Rib
Coxal	Hip
Cranial	Skull
Crural	Leg
Cubital	Elbow
Deltoid	Curve of shoulder

Digital	Fingers and toes
Dorsal	Upper back
Femoral	Thigh
Fibular	Outer side of the lower leg between the knee and ankle
Frontal	Forehead
Genital	Pertaining to the reproductive organs
Gluteal	Buttock
Hallux	Great toe
Inguinal	Groin
Lumbar	Loin (lowest part of the spine below the false ribs and between the hips)
Mammary	Breast
Manual	Hand
Mental	Chin
Nasal	Nose
Nuchal	Back of neck
Occipital	Back of head
Olecranal	Point of Elbow
Oral	Mouth
Orbital	Eye
Otic	Ear
Palmar	Palm
Patellar	Kneecap
Pectoral	Chest
Pedal	Foot
Pelvic	Pelvis
Perineal	Between the groin and the anus
Peroneal	Outer side of the calf
Plantar	Sole of foot
Pollex	Thumb
Popliteal	Back of knee
Pubic	Groin
Sacral	Between the hips
Scapular	Shoulder bone
Sternal	Breastbone
Sural	Calf
Tarsal	Ankle
Thoracic	Chest
Umbilical	Navel
Ventral	Belly
Vertebral	Spinal Column

Unfortunately, it'd be impossible to review the anatomy and physiology of the human body in this short course. Clearly, the above table has no information on the physiology of the human body. Documenting the organ systems, and how they function, would take up hundreds of pages.

As such, it's a very good idea to take an anatomy and physiology (or medical terminology) course before you take the CPC exam. On the plus side, you'll probably learn plenty about medical terminology in an anatomy and physiology course, and vice versa, so you won't need to double-up.

You've also already got some study materials, whether you know it or not. As we've mentioned in previous courses, your CPT manual is full of helpful illustrations and diagrams. In the introduction to the manual, you'll find a list of illustrations and their page numbers. Ideally, by the time you take the exam you'll be familiar enough with anatomical terminology that you won't need to rely on these illustrations, but they're there for your perusal before the test and for any last minute double-checks in the middle of the exam.

CPC EXAM: MEDIASTINUM & DIAPHRAGM

Codes for the mediastinum and diaphragm are found in the 39000 – 39599 range in the Surgery section of the CPT manual.

The mediastinum is also known as the thoracic cavity. It is a collection of organs and structures held together by loose connective tissue, which includes the heart and its attendant vessels, lungs, esophagus, trachea, thymus, thoracic duct and other anatomical structures. The diaphragm is a sheet of skeletal muscle that separates the thoracic cavity from the abdominal cavity.

You should note, however, that none of the procedures in the mediastinum and diaphragm subsection pertain directly to these organs or structures. Each of the organs contained in the mediastinum is important enough to have its own specific section. Procedures of the heart, for example, would be found in cardiovascular, while procedures of the lungs would be found in respiratory.

Instead, the mediastinum and diaphragm subsection of Surgery consists of procedures operating on the thoracic cavity and diaphragm themselves. These include incision codes, excision codes, and various exploratory procedures (e.g. those using endoscopes). The diaphragm has a few codes for repair procedures, but procedures other than will be found elsewhere in the CPT manual.

Since the mediastinum and diaphragm subsection of Surgery is so brief, you should not worry too much about it. If a question does come up on the CPC exam, you'll be able to recognize it fairly quickly by its use of 'mediastinal' or 'diaphragmatic.'

CPC EXAM: PRACTICE MANAGEMENT

The CPC exam does not limit its coverage explicitly to coding. On the exam, you should expect to see at least a few general practice management questions.

You won't find practice management in your ICD-9-CM or CPT manuals, because it's actually more closely related to the billing side of medical coding. Since coding is such an important part of the reimbursement cycle, however, it makes sense for the AAPC to test you on the basics of practice management.

When preparing for the test, you'll need to know about the basic types of payer, including Medicare, Medicaid, and other third party payers. You should be familiar with the different types of managed care and the basic building blocks of the payer-patient relationship, including deductibles, co-pays, and co-insurances. You'll find more detailed information about all of this in Section 3's Courses on medical billing.

As part of the patient management portion of the CPC, you'll also need to know about medical necessity. This is a relatively basic concept for coders, as you should be familiar with using ICD codes to demonstrate medical necessity on the superbill.

Test-takers should also be familiar with Relative Value Units, or RVUs. RVUs help determine the cost of physician services for Medicare. Each CPT (or, in the case of Medicare, HCPCS) code has an RVU attached to it, which helps determine the value or cost of the procedure. Each RVU is composed of three aspects: the physician work, the practice expense, and the malpractice premium. In order to determine the cost of a procedure, each of these values is multiplied by a unique geographic price index and added up. That number is then multiplied by the Medicare conversion factor (CV), which is the dollar amount Medicare will pay for one RVU. This sum is the cost of the procedure.

You should be aware of HIPAA and how it affects privacy, security, and the coding standards in use today. You can find more information about HIPAA and its affects on medical billing and practice management in Course 3-8.

It's a safe bet that you will not see very many questions on practice management, and those that you do will probably be relatively general. Still, it pays off to have a picture of the entire reimbursement process, as opposed to a confined expertise in coding, so be sure you know at least a little bit about practice management.

CPC EXAM: MALE AND FEMALE REPRODUCTIVE SYSTEM

On the CPC exam, you'll be tested on your knowledge of the male and female genital systems. You'll want to be familiar with both the structure of these systems and the procedures performed on them. The majority of these procedures are surgical in nature, so we'd find them in the Surgery section of the CPT manual.

Procedure codes for the male genital system, reproductive system and intersex, and female genital system are found in the 54000 – 58999 section.

The male genital system has the smaller set of codes, owing to the relative simplicity of the system itself. The male genital system is made up of the prostate, testes, seminal vesicles, vas deferens, and the penis. When looking at procedures performed on the testes, look for the prefix "orchi-."

Coders looking at the male genital system section of Surgery will find codes for penile repairs, especially those involving the urinary opening. You'll also find a number of codes for procedures performed on the prostate, including biopsies and excisions. The male genital system subsection is very small and relatively straightforward. Just know the basic anatomy and you'll be fine.

In very brief set of general "reproductive system" codes, you'll find procedure codes for the placement of needles or catheters into the pelvis. These codes are not limited to male or female patients. Below that you'll also find codes for intersex, or sex change, operations.

The female system is significantly more complicated than the male genital system. The female genital system is made up of the uterus, ovaries, fallopian tubes, cervix and vagina. When looking for procedures performed on the vagina, look for the prefix "colpo-," while procedures on the uterus use the prefix "hystero-," as in hysterectomy.

Surgical procedures on the female genital system may be performed through incisions in the abdomen, via laparoscopy, or transvaginally. It's very important to pay attention to how the procedure is performed. A hysterectomy, for example, may be performed laparoscopically, transvaginally, or via incision. You don't get the question right just for picking out the hysterectomy, in other words, you have to code how they performed it.

Maternity and Delivery, a critical part of the female genital system, follows immediately after this section. We'll cover that in *CPC Exam: Maternity and Delivery* in Section 5.

The key to navigating the male and female genital systems is knowing the anatomy and the proper terminology. Note the method of each procedure (is it performed via laparoscopy, or is it a transurethral prostatectomy, for example) and you should be fine.

CPC EXAM: HEMIC AND LYMPHATIC SYSTEM

As listed on the AAPC's website, you will be tested on your knowledge of the hemic and lymphatic system. Thankfully, these are two simple systems that don't have many procedure codes attached to them, so studying for them shouldn't take too long.

Unfortunately, we do not have an exact figure for how many questions will be devoted to the hemic and lymphatic systems on the CPC exam (The AAPC does not release that information). Due to the brevity of their subsection in the CPT manual, you can assume that there won't be many.

Codes for the hemic and lymphatic systems are found in the numerical range 38100 – 38999.

The word "hemic," means blood, but the hemic system, at least in the CPT manual, does not include the entire cardiovascular system. Codes on the major arteries, heart, and other elements of that system are found in the Cardiovascular subsection (numerical range: 33010 – 37799).

The hemic and lymphatic system, instead, covers procedures of the spleen, bone marrow and stem cells, and the lymph nodes. The spleen is similar in structure to the lymph nodes, and acts as a blood filter (hence 'hemic').

Here you'll find codes for splenectomies, repair on the spleen, and diagnostic laparoscopies on the spleen. Codes for bone marrow include procedures to harvest, preserve, and prepare bone marrow for transplant (as in the case of leukemia sufferers). You can identify stem cells found in bone marrow by the word "hematopoietic," which denotes stem cells that create blood cells.

The lymphatic system is composed of a series of nodes throughout the body. If you've ever had a sore throat, you've probably had swollen lymph nodes. Like the spleen, lymph nodes act as blood filters, and they're also instrumental in the storage of B and T cells, which are the frontline fighters of the immune system.

Despite the lymphatic system's importance in the immune system, there are relatively few procedures listed under its subsection. You'll find codes for excision, drainage (incision), laparoscopy, and radical resection (the complete removal of the lymph nodes).

If there are any major questions on the hemic or lymphatic systems, it should be relatively easy to identify. Simply look for "hematopoietic" (for stem cells) and the prefix "lymph-," and you should be able to navigate the questions easily.

CPC EXAM: MATERNITY AND DELIVERY

In *Male and Female Genital Systems*, we talked about the female genital system. The subsection immediately following female genital is, understandably, maternity and delivery, which we'll cover here.

You will definitely see some questions on maternity and delivery. Unfortunately, we can't give you an exact figure on that, as the AAPC keeps the breakdown of questions private. Still, there's a good chance you'll encounter at least one maternity and delivery question on the CPC exam.

Maternity and delivery codes are found 59000- 59899 numerical range, toward the rear of the Surgery section of the CPT manual. While relatively short, in terms of pages covered, these codes contain large amounts of information.

Unlike many other codes, most maternity and delivery codes bundle a number of procedures that occur over long stretches of time. For healthy, routine deliveries, maternity and delivery procedure codes include antepartum care, delivery, and postpartum care. That is, the monthly (up to 28 weeks gestation), bi-weekly (up to 36 weeks gestation), and weekly (up to delivery) visits are all included in the delivery codes. So too are the evaluations of the mother's blood pressure, amniotic fluid, and urinalysis.

Note however that procedures that fall outside the range of maternity care (say the mother gets a head cold) are not included in maternity and delivery codes, and must be listed separately.

Fetal ultrasounds are used in a number of procedures in the maternity and delivery section. One example: amniocentesis, the draining or sampling of the amniotic fluid via a hollow needle, uses an ultrasound to guide the surgeon and help avoid damaging the fetus. When an ultrasound is used in a maternity procedure, it's listed in the maternity and delivery subsection. If its used in a diagnostic capacity, it's found in the Radiology section.

Other antepartum services that are found in the maternity and delivery subsection include vaginal or cervical repairs and tests on the fetus.

The most important codes in this relatively short section are the delivery codes. There are four different types of delivery: vaginal, caesarean, and vaginal birth after a caesarean, which is abbreviated to VBAC. In a VBAC, there are two outcomes: successful and unsuccessful. To illustrate this, let's say a woman delivered her first child via caesarean section, but is going to deliver her second child vaginally. If the delivery is successful, we would code that as a successful VBAC, not as a vaginal delivery. Likewise, if the delivery was unsuccessful, and the doctor has to step in to perform a caesarean to complete the delivery, we would code that as an unsuccessful VBAC, not as a regular caesarean.

The maternity and delivery subsection is rounded out with a variety of abortion codes. These codes include procedures for treatment following an abortion (for example, if the abortion goes septic, or if it only partially successful), and there are also codes for induced abortions.

As you're studying for the CPC exam, be sure to keep an eye on the maternity and delivery section. You will most likely see at least one question on these codes, and it should be relatively obvious.

CPC EXAM: EYE AND OCULAR ADNEXA

Codes for the eye and ocular adnexa are found in the 65091 – 68899 numerical range of the CPT manual, toward the very end of the Surgery section.

“Adnexa” refers to the parts of the body adjoining the organ, so the subsection on the eye and ocular adnexa includes procedures on the eye itself in addition to the ocular muscles and eyelids. This subsection also includes the conjunctiva and lacrimal system, which line and protect the eye.

The eye is made up of the cornea, anterior chamber, iris, lens, vitreous humor (a colorless mass that makes up the bulk of the eyeball), retina, and the optic nerve. It’s supported by four primary muscles and two oblique muscles. The horizontally oriented muscles are the medial rectus and the lateral rectus, and the vertical muscles are the superior and the inferior rectus. There is also the inferior and superior oblique muscles, which aid in eye rotation and elevation. Exterior to the eye are the eyelids and lacrimal system (tear ducts).

The first portion of the eye and ocular adnexa subsection focuses on procedures of the eyeball itself. Here you’ll find codes for removal and repair of the eye, and also implants. Note that an “ocular implant” occurs inside the muscular cone of the eye (inside the set of muscles listed above, including inside the eye) and an “orbital implant” occurs outside the muscular cone. Recall that the orbit of the skull is the cavity where the eye is situated.

The anterior segment of the eye is next. The anterior section of the eye encompasses the lens, cornea, conjunctiva (the membrane that coats the eye), iris, and ciliary body. In other words the front (‘anterior’) of the eye. The vast majority of procedures live here, including keratoplasties (cornea transplants), repairs for the iris and ciliary body, and various procedures on the lens.

The posterior segment section includes procedures on the retina and vitreous, including repairs for retinal detachment. Finally, the ocular adnexa section features procedures for the repair, adjustment, excision and exploration of the ocular muscles, which we talked about above. In the ocular adnexa section you’ll also find codes for procedures on the eyelid.

Finally, the conjunctiva section includes procedures on the conjunctiva and lacrimal system, which includes the lacrimal sac and ducts. Here you’ll find codes for incisions, drainages, and grafts for the conjunctiva, along with repairs and exploratory procedures of the lacrimal gland.

The eye and ocular adnexa subsection of Surgery is relatively brief, but don’t be surprised if you see a question or two on the exam covering it. Know your vocabulary terms and it should be easy to pick out the right answer.

CPC EXAM: ICD-9-CM

The ICD-9-CM manual is one of the three main coding manuals, and one of the two that you'll use the most in your medical coding job (along with the CPT manual). It makes sense, then, that the CPC exam would feature approximately ten questions on this code set.

If you've taken all the courses up to this point, you should be readily familiar with ICD-9-CM. We'll do a quick review regardless.

ICD-9-CM is our diagnostic code set. We use it to describe the injuries, illnesses, and conditions in patients, as reported on the medical reports. In terms of the reimbursement process, ICD-9-CM codes are used to demonstrate medical necessity for medical procedures (which are described using either CPT or HCPCS).

The ICD-9-CM manual is divided into three volumes. The first volume is the tabular index, which groups the codes numerical by similarity. This volume is loosely divided into "chapters," each of which covers a certain field. The first chapter, for instance, contains codes for infectious and parasitic diseases.

The second volume is the alphabetical index of codes. You can use this volume to look up diagnosis codes by their medical name, or, in certain cases, by their more colloquial term. This is your first point of navigation.

ICD-9-CM codes are three to five characters long and are, with a few exceptions, entirely numeric. The first three numbers of a code is called the category. The category describes the patient's condition, illness, or injury. In cases where the code is more specific than the general condition, the category is followed by a decimal point and another digit, called the subcategory. The subcategory is sometimes followed by yet another digit, called the subclassification. The subclassification further expands on the information provided by the subcategory.

We can find the correct ICD-9-CM code in either the tabular or the alphabetic index, but we always confirm our codes in the tabular index.

The third and final volume of ICD-9-CM contains procedural codes used by hospitals and other inpatient facilities. We won't be covering them here.

We've covered ICD-9-CM codes extensively in *ICD-9 & ICD-9-CM* and *Using ICD-9-CM* in Section 2. Turn there if you'd like a more thorough review. Let's move on to the exam and what to expect.

On the CPC exam, you should expect to see ICD-9-CM codes in test case questions: questions that provide a sample medical report, and then ask you to figure out the correct codes for the diagnosis and procedure provided.

You'll code these questions as you would a normal medical report. You abstract the information, note what needs to be coded, go to the alphabetical index, and then confirm in the tabular.

Once you get to the tabular, you'll need to pay attention to the notes included with many of the ICD-9-CM codes. These notes include See, See Also, Includes, Excludes, and Code First. If, for example, you're coding a retinal problem related to diabetes, there will probably be a Code First note under the retinal diagnosis that tells you to code the underlying condition (diabetes) before the present diagnosis.

See and See Also codes are included to direct coders to better or more appropriate diagnosis codes. Includes and Excludes are relatively self-explanatory: they tell the coder if the diagnosis they're looking for does, in fact, 'live' in that code.

These notes are part of the reason why we never code from the alphabetical index. If you skip confirming your codes in the tabular index, you might miss an important note that informs you of a better, more accurate diagnosis codes. Remember, as medical coders, we always want to code to the highest degree of specificity. Your job on the CPC exam will be to select the best possible answer out of the four, so it's imperative you use the most accurate codes possible.

You should also review the coding guidelines and conventions for ICD-9-CM. These are found in the front of the ICD-9-CM manual, and will inform you of the proper ways of using the code. The notes (See, See Also, Includes, etc) are part of the guidelines and conventions, so you already know a bit about them. Just be sure to read each code carefully and check the notes.

One final note about ICD-9-CM and ICD-10-CM. The American healthcare industry, almost across the board, will upgrade to the newer ICD-10-CM set of diagnostic codes on October 1 of 2014. Up until that point, you'll still be tested on ICD-9-CM. You may even be tested on ICD-9-CM after the changeover date—the AAPC hasn't made that clear. As of this writing, however, only ICD-9-CM will be on the exam, and so you should confine your preparation to that code set.

CPC EXAM: HCPCS LEVEL II

The third code set you'll be tested on is Healthcare Common Procedure Coding System, or HCPCS. HCPCS, if you'll recall from *Human Anatomy and Terminology* and *HCPCS Codes* from Section 2, is a code set developed by the Center for Medicare and Medicaid Studies (CMS) to help code procedures and medical equipment. HCPCS codes are used to report medical procedures to Medicare, Medicaid, and several other third-party payers.

HCPCS divided into two levels. The first level is identical to CPT Category I. Whether a code is a HCPCS Level I code or a CPT code depends on what payer it's getting sent to. For the CPC exam, you'll have to study HCPCS Level II, which is where the codes for a number of healthcare services not easily classifiable in CPT reside.

You will see approximately five questions on the CPC exam related to HCPCS Level II. Let's take a look at HCPCS Level II now.

HCPCS Level II codes are five characters long, and each starts with a letter. This letter denotes which grouping the code is in. Here's another look at the groupings of the Level II codes.

GROUPINGS OF LEVEL II CODES

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

It helps to think of HCPCS Level II as the things medical professionals use, where CPT/HCPCS Level I are the procedures medical professionals perform using those things. In HCPCS Level II, you'll find codes for injectible medicine, durable medical equipment (DME), chemotherapy drugs, and other crucial, but otherwise unclassifiable, medical equipment.

HCPCS Level II codes are the most specific out of any of the codes you'll see on the CPC exam. There are different codes for each amount of injectible medicine, for instance, and each type of wrist brace, neck brace, wheelchair, and walker gets its own specific code.

As such, it's extremely important that, if you see a HCPCS question on the CPC exam, you look up the code in your HCPCS manual. A question may have codes for four different neck braces, and paying attention to the small details provided in the question will help you select the correct answer.

One final note on HCPCS: You may encounter some HCPCS modifiers on the CPC exam. HCPCS modifiers, remember, are similar but different to CPT modifiers. Like CPT modifiers, HCPCS modifiers are two characters long and are added to the end of a procedure code with a hyphen. Unlike CPT modifiers, which are entirely numeric, HCPCS modifiers can be alphanumeric or entirely alpha.

HCPCS Modifiers provide a range of extra information about medical procedures, including where on the body the procedure was performed (such as what side of the body or which toe) and whether the procedure was performed in an ambulance or other distinct location. These modifiers may be used with CPT codes.

CPC EXAM: CODING GUIDELINES

On the CPC exam, you'll be tested on general medical coding guidelines. This seems like a relatively straightforward topic, but it actually entails a number of different things.

Each code manual (ICD, CPT, and HCPCS) has its own set of guidelines, and each section of those individual manuals (especially CPT) has its own guidelines. These guidelines may change with the situation, severity, or location of the procedure.

As such, it'd be almost impossible to thoroughly review the general coding guidelines in a course as short as this. As you familiarize yourself with the coding manuals, code sets, and general practice of medical coding, you'll automatically familiarize yourself with a number of coding guidelines.

In fact, you've already learned a number of these guidelines just by taking the prior courses. If you know how to use modifiers, for instance, than you've learned an important set of guidelines. Ditto for the notes that are included in many diagnosis and procedure codes.

Coding guidelines can be seen as a sort of general best practices for the coding profession. The best way to study for these is through study, and the best study tool is probably the AAPC study guide, available on the AAPC website. This book, which is available to members at \$70 and non-members at \$100 might seem a bit costly, but it's an incredibly valuable resource for your studies. It will help you learn more about some of the overarching parts of coding, including coding guidelines, practice management, and medical terminology. We strongly recommend you consider purchasing this or a similar study guide before taking the CPC exam.

CPC EXAM: MEDICAL TERMINOLOGY

Much like anatomy and physiology, learning medical terminology is not something you can summarize in one simple video.

You'll need to know your ectomies from your otomies (as you've probably already seen in the prior courses), and it's very helpful to familiarize yourself with the common prefixes and suffixes common to the medical vocabulary.

Below you'll find a few tables from *Human Anatomy and Physiology* from Section 2. Use these to brush up on your prefixes and suffixes.

PREFIXES

PREFIX	MEANING	EXAMPLE
Ambi-	Both	Ambidextrous
Aniso-	Unequal	Anisocytosis
Dys-	Bad, painful, difficult	Dyslexia
Eu-	Good, normal	Eukaryote
Hetero-	Different	Heterogeneous
Homo-	Same	Homogeneous
Hyper-	Excessive, above	Hypertension
Hypo-	Lack, below	Hypoglycemic
Iso-	Equal, same	Isotope
Mal-	Bad, poor	Malnutrition
Megalo-	Large	Megalomania

SUFFIXES

SUFFIX	MEANING	EXAMPLE
Ambi-	Both	Ambidextrous
Aniso-	Unequal	Anisocytosis
Dys-	Bad, painful, difficult	Dyslexia

SUFFIXES CONT.

PREFIX	MEANING	EXAMPLE
Eu-	Good, normal	Eukaryote
Hetero-	Different	Heterogeneous
Homo-	Same	Homogeneous
Hyper-	Excessive, above	Hypertension
Hypo-	Lack, below	Hypoglycemic
Iso-	Equal, same	Isotope
Mal-	Bad, poor	Malnutrition
Megalo-	Large	Megalomania

SUFFIXES COMMON TO
SURGICAL PROCEDURES

PREFIX	MEANING	EXAMPLE
-centesis	Puncture a cavity to remove fluid	Amniocentesis
-ectomy	Surgical removal or excision	Hysterectomy
-ostomy	A new permanent opening	Tracheostomy
-otomy	Cutting into, incision	Gastrotomy
-orrhaphy	Surgical repair or suture	Gastrorrhaphy
-opexy	Surgical fixation	Nephropexy
-oplasty	Surgical repair	Rhinoplasty
-otripsy	Crushing or destroying	Lithotripsy

By knowing your medical prefixes and suffixes, you'll have a much easier time navigating complicated medical terminology. If you know the root word and the suffix, you already know the procedure. For instance, an orchiectomy is the removal of a testicle. "Orchi" is testes, and an "-ectomy" is a surgical removal. Yikes.

Still, this course won't be enough to prepare you for the CPC exams question on medical terminology. We recommend taking either an outside medical terminology and/or anatomy and physiology course before you take the CPC exam. The bonus of this

It's also not a bad idea to look at some online flash cards. There are dozens of different flash card sets out there, and most are entirely free. Don't use these as your primary method of learning medical terminology, but they're a good resource if you're looking for a way to brush up.

CPC EXAM: PATHOLOGY & LABORATORY

One of the two smallest sections of CPT Category I, the Pathology and Laboratory section contains codes for the numerous medical tests specialist perform to determine the cause of a patient's condition. This may include blood tests, drug tests, urinalysis, hematology, and a variety of other assessments.

Despite being a relatively small section (compared to, say, Surgery), around ten of the 150 questions on the CPC exam will focus on Path and Lab. (This figure is approximate, as the AAPC does not publish the makeup of the CPC exam).

Pathology and Laboratory features a variety of clinical tests. Most of these, like the panels found at the front of the section, include taking samples from the patient and analyzing them. (Panels is a set of biological samples, like blood, analyzed in a lab).

TYPES OF TESTS AND THEIR NUMERICAL RANGE

FIELD	RANGE	FIELD	RANGE
Organ or Disease-oriented Panels	80047 – 80076	Drug Testing	80100 – 80104
Therapeutic Drug Assays	80150 – 80299	Evocative/ Suppression testing	80400 – 80440
Consultations (Clinical Pathology)	80500 – 80502	Urinalysis	81000 – 81099
Molecular Pathology	81200 – 81479	Multianalyte Assays with Algorithmic Analyses	81500 – 81599
Chemistry	82000 – 84999	Hematology and Coagulation	85002 – 85999
Immunology	86000 – 86849	Tranfusion Medicine	86850 – 86999
Microbiology	87001 – 87999	Anatomic Pathology	88000 – 88099
Cytopathology	88104 – 88199	Cytogenic Studies	88230 – 88299
Surgical Pathology	88300 – 88399	In Vivo Laboratory Procedures	88720 – 88749
Other Procedures	89049 – 89240	Reproductive Medicine Procedures	89250 – 89398

There are two types of general tests in Path and Lab: qualitative and quantitative. Quantitative tests how much of a certain thing is in the body (say, calcium or alcohol), while qualitative tests for the presence of a substance, period.

Path and Lab codes are measured by the number of tests performed, and not the results of the test. That is, if you tested for Phenobarbital and alcohol, you'd list that as two procedures.

Let's look at the first section of panels. Each panel has a set of requirements. A comprehensive metabolic panel, for instance, has to test for albumin, carbon dioxide, potassium, sodium, total protein, and nine other substances. What the panels require determines on the system or pathology the panel is trying to determine.

Up next is drug testing. The first portion of this subsection is made up of qualitative assays. They test whether a drug is present. Then there's the drug assays. There's a specific code for each type of drug. These drug assay codes are all quantitative (how much lidocaine in the system, for instance).

The Path and Lab section also includes a number of pathological tests. Molecular pathology procedures test genes, antigens, and a number of other biological functions to assess the possibility, or confirm the diagnosis of, a condition. A test for the genetic predisposition to a certain type of breast cancer, for example, would be found here.

Following the molecular pathology is the chemistry subsection. In this subsection, there are tests for specific chemical compounds, which can tell the pathologist or physician about the patient's condition. The immunology section is similar. Tests in this section help determine the presence or response of certain important chemicals in the body as they are related to the immune system. Here you'll find tests for certain allergens and quantitative assays for tumor antigens.

Path and Lab also contains a subsection for microbiological tests. These tests determine the presence of organisms like giardia, rubeola, hepatitis, and HIV. There are specific codes for each microbiological organism.

The section closes with anatomic pathology, surgical pathology, and a number of others types of pathological investigation. In anatomic pathology you'll find procedure codes for autopsies.

Surgical pathology involves the assessment of human tissue. Any time tissue is removed for examination, there's a relevant Path and Lab code. If a surgeon is performing a biopsy of the bone marrow, there's a Path and Lab code for it. Ditto for the resection of an adrenal gland, or a mastectomy. These surgical pathology codes are divided by level. Each level is rather large and covers a wide range of things. They're grouped by the difficulty and/or expense of the excision or resection procedure. So, the more difficult or costly a tissue sample is to obtain, the higher the level of surgical pathology code you'll use.

Surgical pathology also includes codes for Path and Lab tests that are performed during surgery. You will probably see a question on this on the CPC exam. In this procedure, a pathologist analyzes a tissue sample during the procedure in order to ensure the surgeon has removed the appropriate amount of tissue.

CPC EXAM: INTEGUMENTARY

The integumentary system is, put simply, the skin. The skin is the largest organ in the human body. It protects, and allows for homeostasis, among a number of other functions.

The skin is made up of three main layers: the epidermis, the dermis, and the hypodermis. Each of these performs its own set of specific functions. The dermis, for example, allows for the skin's flexibility, and also houses nerve endings and blood vessels.

You should expect approximately ten questions on the integumentary system on the CPC exam. Let's review the system itself and its dedicated CPT subsection now.

You'll find codes for procedures on the integumentary system in the 10021 – 19499 numerical range of the CPT manual. It's the first subsection of Surgery.

You'll find codes for incisions, wound debridement, skin tag removal, and the excision of benign and malignant lesions at the front of the integumentary subsection. Debridement and excision codes all include measurements: the depth of the tissue removed via debridement, for example, or the diameter of the lesion removed. Code according to these measurements. There are also specific codes for the number of lesions removed in a single procedure. Keep this in mind as your reading any question related to lesion removal.

Toward the middle you'll find codes for skin grafts, skin repair, and other tissue transfers. In this section, you'll need to know the different sources of grafts (autografts are grafts from the patient, allografts are grafts from a cadaver, and xenografts are grafts from animals or man-made sources). You'll also find a number of codes for different skin replacement surgeries.

The next area of the integumentary section is burns. Here you'll need to know the "rules of 9s." The surface area of the human body is divided into multiples of 9: the legs are each 18%, as is the front and back of the torso. Each arm accounts for 9%, as does the head. The genitals are 1%. So a patient who has burns over the left leg and left arm has burns over 27% of their body.

At the end of the integumentary subsection, you'll find codes for the breasts. The breasts aren't technically part of the integumentary system, but according to the AMA, this is the best place for them. You'll find codes for mastectomies, breast repair and reconstruction, and the excision of cysts, tumors, and lesions.

CPC EXAM: RESPIRATORY SYSTEM

We're going to close out our review of the topics on the CPC exam with the respiratory system and the cardiovascular system. Both of these are found in what's sometimes referred to as the "30,000 series," along with the hemic and lymphatic system and mediastinum and diaphragm. (The musculoskeletal system, for instance, takes up all of the 20,000 series, featuring codes between 20000 and 29999).

We'll focus on the respiratory system here, and the cardiovascular system in *CPC Exam: Cardiovascular*, in Section 5.

You should expect to see around 10 questions on codes in the 30,000 series. Of those ten, only one or two will be on the respiratory system. Still, you can't be too prepared, so let's dive into the respiratory system now.

The respiratory system is, obviously, how we breathe. Air enters into our body through our nose or mouth. When it enters through our nose, it travels through the nasal cavity and into the nasopharynx. When it enters through the mouth, it travels into the oropharynx (think "oral" = oro).

The two pharynxes meet in the oropharynx, and air then travels down the esophagus and the larynx, through the trachea, and into the bronchi (singular: bronchus), which are tree-like sets of tubes that extend into each lung. The trachea meets the bronchi at a point called the carina. Each bronchus divides into a set of smaller tubes, known as the bronchiole. Those tubes terminate in hollow sacs called alveoli. Each lung is made up of lobes. The right lung has three lobes, while the left has two.

The procedure codes are laid out just like the structure of the respiratory system. Toward the front of the subsection you'll find codes for procedures on the nose, including the removal of foreign bodies, and reconstructive surgery like rhinoplasties. You'll also find procedures on the sinuses in this part of the respiratory subsection.

Following the nose and nasal passages, you'll find a procedures on the trachea and bronchi, including exploratory surgery (with endoscopy), excision, and repair (such as "carinal repair").

The final and largest area of the respiratory system subsection is that of the lungs and pleura. The pleura are a set of membranes that cover the lungs. The parietal pleura coats the lungs on the outside, and separates them from the chest cavity. The visceral pleura is situated between the parietal pleura and the lung itself.

Under lung and pleura you'll find codes for incision, excision, resection, removal, and exploration of the lung and pleura. You'll also find codes for video-assisted thoracic surgery (VATS) procedures. You'll also find codes for transplantation. These, like other transplantation or graft codes, have guidelines for coding where the donor lung came from. That is, is the lung coming from a cadaver or a live donor.

CPC EXAM: CARDIOVASCULAR SYSTEM

The other major subsection in the 30,000 series is the cardiovascular system. As we mentioned in the previous course, around ten of the 150 questions on the CPC exam will focus on the 30,000 series of CPT codes. Only two or three of those questions will focus on the respiratory system, meaning the majority will focus on cardiovascular.

Surgical codes for the cardiovascular system are found in the numerical range 33010 – 37799, toward the front of the Surgery section.

The cardiovascular system is what transports blood around the body. It's centered, as you know, in the heart, which is comprised of four chambers: the right atrium, left atrium, right ventricle, and left ventricle. Blood enters the heart through the heart through the atriums, and leaves through the ventricles.

The left atrium and ventricle pump oxygenated blood through the body, while the right atrium and ventricle pump de-oxygenated blood to the lungs, where the blood will receive oxygen. Once oxygenated, blood goes from the lungs back to the heart, where it pumps the newly oxygenated blood through the arteries. Veins, in turn, take de-oxygenated blood back to the heart.

The human body is laced with veins and arteries, which effectively mirror each other. Diagrams for the systems of veins and arteries are available at the front of the cardiovascular subsection, along with guidelines. The most important veins in the body are the two venae cavae (singular: vena cava), which returns blood to the heart (via the right ventricle). The most important artery is the aorta, which along the body's trunk.

The first section of codes in the cardiovascular subsections concerns the heart. There are a variety of procedures related to the heart, but you should pay special attention to the codes on pacemakers or pacing cardioverter-defibrillators.

Note that these two devices are not the same. A pacemaker includes a battery pack that runs current to the heart via electrodes. The placement of these electrodes (such as epicardial, on top of the heart), is important both for the coding and the eventual billing of the procedure.

A pacing cardioverter-defibrillator performs a similar function to a pacemaker, but requires a distinct set of codes. For pacemakers and cardioverters, there are separate codes for which part of the heart the electrodes attach to, in addition to how the pacemaker is inserted, where it's placed, and how the electrodes are placed on to the heart (e.g. transvenously, or via thoracotomy).

Let's move on to coronary artery bypass grafts (CABGs). Codes for these procedures are found after codes for the heart. A CABG is essentially a re-routing of blood to avoid a blocked or congested area. It's typically done with venous material. You may have heard of triple- or quadruple-bypasses. In cases of these procedures, the "triple" refers to the number of grafts used in the procedure.

There is, as you might imagine, a wide variety of CABGs. Some are performed with venous material only, while others use arterial grafts, or some combination of the two. Know this section for the exam.

As the cardiovascular codes go up, the procedures move further away from the heart. You'll find codes for arterial grafts, transluminal angioplasties (widening of blockages via balloons), aneurysm repair, and more.

In order to prepare for the cardiovascular section of the CPC exam, it's important to review the anatomy of the heart and know the terms for the major cardiovascular throughways in the body. That means you should know your vena cava from your carotid artery, in other words.

Since the cardiovascular section contains a lot of specific terminology and procedures, and since there are a number of code-specific guidelines for each procedure, it's well worth your time to study the section thoroughly.

CPC EXAM: WHERE TO TAKE AN EXAM

Now that you've got a better idea of what to expect from the CPC exam, you may want to start thinking about sitting for the test. After you complete an anatomy and physiology course (or a medical terminology course), reviewed the AAPC CPC Study Guide, and taken a few practice exams, you should be ready to take the test.

The AAPC administers the CPC exam all over the country. Even Alaska has three test-taking locations. To find the test location nearest to you, simply go to the AAPC's website and use their search engine.

THE CPC APPRENTICE PROGRAM

Getting a CPC exam isn't just a matter of completing the CPC exam with a score of 70 percent or higher. In order to earn certification from the AAPC, you need to have at least two years of professional coding experience.

That would seem to preclude new coders from taking the CPC exam, but that doesn't have to be the case. The AAPC helpfully offers an "apprentice" program attached to their CPC certification. If you complete the CPC exam with less than two years of professional experience, you get a CPC-A certification.

The CPC-A certification allows you to work as a certified coder while working toward a full certification through either on-the-job experience or the completion of continuing education units (CEUs).

In order to earn a full certification through on-the-job experience, you need to send two letters of recommendation, demonstrating two years of experience to the AAPC. One of these must be from your employer, and must be written on your employer's letterhead. The other may be from a co-worker. These letters should confirm your work experience and capability using the ICD-9-CM, CPT, and HCPCS code sets.

In order to earn a full certification through CEUs, you must provide documentation of 80 contact hours of instruction in the CPT, ICD-9-CM, and HCPCS code sets. 'Contact hours' is just a fancy way of saying an hour of scheduled instruction. An hour-long class would be one contact hour. You can take coding classes at many community colleges, and there are also instruction programs that are not affiliated with a school, though you should be at least a little skeptical of these, as some of them are scams.

Confirmation of these 80 hours of instruction must be sent from an instructor on school letterhead. You may also send a diploma or certificate stating the completion of 80 hours of schooling, or a school transcript that describes same.

Once you've submitted the requisite documentation of instruction or work experience, the AAPC should grant you a full certification within two to four weeks. To see the contact information and learn more about the CPC Apprentice program, visit the AAPC website

THE CPB EXAM

For the vast majority of this Section, we've discussed the AAPC's CPC exam, which certifies individuals who are working in medical coding. However, the AAPC offers far more than the simple CPC exam. There are a number of variations on the CPC exam, each of which certifies a person to work in coding for a specific field of medicine. The AAPC also offers a professional billing certification for those individuals who want to work on that side of the reimbursement cycle.

This test is known as the Certified Professional Billing exam, or CPB.

The CPB exam is comprised of 200 multiple-choice questions, and takes five hours and 40 minutes to complete. The test costs \$260 for AAPC members and \$300 for non-members.

Like the CPC, the CPB will test you on the entirety of the billing process.

To pass the CPB, you'll need to be familiar with

- Types of insurance (44 questions)
- Billing regulations (25 questions)
- HIPAA and compliance (10 questions)
- Reimbursement and collections (28 questions)
- Billing (28 questions)
- Coding (15 questions)
- Case analysis (50 questions)

As you can see, coding does pop up on the CPB exam, but the majority of the test is devoted to how billers interact with insurance payers. You'll need to know the ins and outs of managed care, Medicaid and Medicare, how to format and create claims, how to adhere to the various billing regulations established by HIPAA and other bodies, and lots more. The Case analysis questions will present you with source documents that you must analyze to determine the correct answer, not unlike the case studies questions you'd see on the CPC.

To learn more about the CPB exam, visit the AAPC's website

ACCREDITED BILLING AND CODING SCHOOLS

Medical billing and medical coding are two of the fastest growing jobs in the health sector. The Bureau of Labor Statistics (BLS) expects jobs in health information and management (which includes coding and billing) to grow by around 20 percent between now and 2020. That's over 6 percent higher than the average job growth rate.

As such, there are a lot of organizations, schools, and companies that offer instruction and training in medical coding and billing. Some of these are excellent, well-reputed schools. We'll look at how to pick the right coding and billing program in this course. Other programs are less respectable, and there are a number of scams out there you should avoid. We'll talk about how to avoid medical billing and coding scams in the next Course.

THE IMPORTANCE OF ACCREDITATION

Accreditation is the process by which a third party organization or governing body confirms the quality of instruction of an educational institute. Essentially, accreditation is quality control. There are two types of accreditation: institutional and programmatic. Institutional accreditation affirms the quality of a school as a whole, while programmatic accreditation affirms the quality of a particular program within the school.

Colleges and universities are accredited at the institutional level by the accrediting bodies approved by the Council of Higher Education Accreditation (CHEA). These agencies are divided geographically, so schools in Vermont are accredited by the New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE), while schools in California are accredited by the Western Association of Schools and Colleges Accrediting Commission for Community and Junior Colleges (ACCJC-WASC).

Schools receive their programmatic accreditation from agencies devoted to that subject area. Medical billing and coding programs are accredited by the Commission on Accreditation of Health Informatics and Information Management Education (CAHIIM). Note that this program only accredits programs that give out associate and baccalaureate degrees, meaning certificates are not covered.

When you're looking at a school for billing and/or coding, you want to make sure it's accredited regionally and by CAHIIM. Accreditation ensures an employer or another school will recognize the degree you earn at the accredited school. Accreditation also allows students to apply for and receive federal funding to attend that school. You won't be eligible for the Free Application for Federal Student Aid (FAFSA) unless you're enrolled in an accredited school.

DEGREES AND CERTIFICATES

An associate's degree is a two-year degree, often seen as the halfway point to a full bachelor's degree. It's typically completed after 60 or more hours of instruction (the typical bachelor's degree includes 120 credit-hours of schooling). Most associate degree programs take two years to complete.

Certificates, on the other hand, are usually completed in one year. Where associate's degrees demonstrate both general knowledge and a focus in one area, certificate programs are generally confined solely to one area of study. These programs are often more affordable and easier to earn while working another job. The tradeoff is that an associate's degree may look better to a prospective employer or certifying body.

The AAPC, for instance, recommends you have an associate's degree before you take the CPC exam to become a certified coder. That's just a recommendation, though, and many professional coders and billers enter into the field with only a certificate in their respective subject.

Bachelor's degrees in medical billing and coding are not offered frequently. If you're going to earn a bachelor's degree in health informatics (the general field of health information, including collection, analysis, and management), you'll want to look for managerial positions related to coding and billing, rather than coding and billing itself. We won't be covering bachelor's degrees here.

PICKING A SCHOOL

Now that you know a little bit more about the different kinds of medical billing and coding education you can receive, let's look at how to pick the right school for you.

Community colleges and technical schools are the best option for learning medical billing and coding. First, they're less expensive than traditional universities. Second, several of them offer both associate and certificate programs, meaning you can choose the path that works best for you. Third, they're flexible. Most community colleges and technical schools offer night classes, meaning you can earn a certificate or degree while continuing your career.

Community colleges and technical schools also have the benefit of accreditation and association with a larger, more renowned school. Better yet, they'll give you the chance to receive face-to-face instruction from an instructor, which is invaluable in a subject as complex as medical billing and coding.

At this point, you may be thinking about getting a medical billing and coding degree online. Online education is one of the fastest-growing fields of education in the U.S. today, but that doesn't mean it's the right choice for everyone.

You should avoid, whenever possible, private, for-profit online schools like the University of Phoenix and DeVry. While most for-profit online colleges have accreditation, the quality of education there is lower than your average community college, and the cost is often higher. These schools often promise condensed classes and flexible schedules, but the result is diminished quality of instruction. That's something that a future employer will take into account when you're applying for a job.

You don't want to take a certificate program that takes less than a year to complete, in other words. If you are going to pursue an online degree, try and find a program that's affiliated with not-for-profit public school or university. Many schools now offer courses and even degree programs online. If you've got to get an online coding or billing degree, pick one of these schools before you look into a private, for-profit school.

Note that you may make an exception for professional organizations like the AAPC and the American Health Information Management Association, or AHIMA. Both of these professional organizations offer courses in medical billing and coding. However, since they're not education bodies, they can't be accredited. Taking courses from these organizations can be expensive, though, and it's still better to pursue a degree or certificate at a community college or technical school than take classes solely through the AAPC or AHIMA.

WHAT TO LOOK FOR

When you're looking into getting a degree or certificate in medical billing and coding, there are a few things you should look for from a prospective school. The first is, obviously, accreditation. The second is a dedicated program to health information. You'll want to look for classes in coding and billing software, the healthcare process, anatomy and physiology, and general medical terminology. If you're going to invest in a degree or certificate, make sure you get the full spectrum of the medical billing and coding professions.

HOW TO RECOGNIZE INDUSTRY SCAMS

Medical billing and coding is a boom industry these days, which means plenty of jobs.

Unfortunately, as the number of job opportunities and training programs rise, so too do the number of people trying to take advantage of eager trainees. Scams are abundant in the medical coding and billing world, and they're frequently targeted at people who are just getting started in the field. If you've got no experience in coding and billing, how are you to know what's a reputable program and what's a scam? In this course, we'll help you figure that out.

IF IT'S TOO GOOD TO BE TRUE, IT IS

The majority of scams you'll see online promise you a billing or coding certification in less than a month. You can study from home! You'll get to work from home! Just take these ten classes and you'll have a job within weeks.

THE IMPORTANCE OF ACCREDITATION

Medical billing and coding takes a long time to master. You should expect your training in coding and billing to take at least six months to a year, and most associate's degree programs take two years. The coding and billing professions are too complicated to master in just a month. Even with 36 hours in a day, there's no way you could learn about anatomy and physiology, ICD-9-CM codes, CPT codes, coding regulations, billing guidelines, payer structures, HCPCS compliance—you get the idea.

How long a program in billing and coding takes should be your first tip-off. If you see anything promising a certification or completion of a program in under half a year, just skip the whole thing.

WORKING AT HOME

Another favorite selling point of the billing and coding scam is the chance to work at home. Maybe you're a stay-at-home parent, or maybe you just like the idea of setting up your own home office. Another version of this is the "start your own billing/coding business" scam. Plenty of programs offer software, instructional courses, and a network of professional contacts looking for coding and/or billing help.

Think about it: Billing and coding are incredibly important parts of the health-care reimbursement process, and coders and billers handle loads of delicate private information like social security numbers and the medical histories of patients. Do you think any provider would fork that information over to someone with no experience in the field, and thus no professional references?

The people who do run billing and coding services out of their homes tend to have years of experience, sometimes more than a decade. You have to prove that you know the ins and outs of the whole enterprise, and no one will hire a brand-new coder with no track record of coding or billing employment. If you're going to start out as a medical coder, you'll do it at a provider's office.

**OTHER WAYS TO
SPOT A SCAM**

The short take: Avoid any program that says you'll be able to work at home or start your own business.

If a service offering you coding and/or billing instruction isn't accredited or affiliated with any of the major professional associations like the American Association of Professional Coders (AAPC) or American Health Information Management Association (AHIMA), you should probably steer clear.

Health information professional associations (like AAPC and AHIMA) also have a stake in preventing coding and billing scams. If a program that's offering coding and billing instruction isn't endorsed or recognized by one of these major professional associations, it's not worth your money to take classes from them.

Finally, you should check with the Better Business Bureau about the status of a questionable coding and billing agency. Chances are good that if a billing or coding instruction service is a scam, they'll have complaints filed against them. Do your research and you'll be able to spot a scam in no time.

In conclusion, any coding and billing instruction service that seems too good to be true probably is. You should avoid any instructional program that promises you employment, certification, or expertise in anything less than six months. (And it's always better to err on the side of caution and look only at programs that take a year or longer). A coding and billing instructional program should be accredited or recognized by the major professional organizations in the field.

The best way to avoid a medical billing and coding scam is to skip the shortcuts altogether. Look for certificate or associate degree programs at your local community college or trade school.

GETTING YOUR FIRST MEDICAL BILLING AND CODING JOB

Once you've completed your training in medical billing and coding, it's time to venture out into the job market. A word of warning: because medical billing and coding is expanding so rapidly, many young coders often find the job market saturated. It can be tough to get a coding or billing job right away.

Many new coders and billers start working in related healthcare fields, and then use that experience as leverage to get a billing or coding job. With a lucrative, growing field like coding and billing, it's all about getting your foot in the door.

HOW TO GET YOUR FOOT IN THE DOOR

Health informatics (the fancy term for the study, analysis, and management of health information and data) isn't just coding and billing. There's a huge range of positions that support healthcare providers and help them run their practices.

If you can't get into coding right away, try working the office or front desk of a physician. Make connections with the doctors and provider offices you visit on a regular basis and see if they're hiring or if they know of someone who is. Clerical work might seem like a dead-end, but this type of work demonstrates a commitment to the field and hands-on experience with how the business of healthcare works.

You can also look for work in medical records. Like working at a receptionist or front office position, it's a slightly indirect way of getting into coding, but your familiarity with the provider's office will serve you well. You can also look for work through a temp agency, though your success there may vary.

Don't discount volunteering or job shadowing, either. While you don't want to work for too long for free, volunteering at a provider's office can give you some first-hand experience and demonstrates your interest. Job shadowing is another way of getting a great look at the business from the inside. If you have a relationship with a professional biller or coder, just ask them if you can trail them for a day. You'll learn more in a day of watching how a biller works than you would in a week in the classroom.

One of the best ways to get your foot in the door and get professional experience is through an internship. These, like many coding positions they lead up to, can be scarce.

WHERE TO LOOK FOR A JOB OR INTERNSHIP

There are a variety of good job resources for medical billing and coding. You can find internships on third-party aggregator sites like InternMatch, or you can search for openings via LinkedIn.

Some of the best resources for finding new jobs are the professional organizations that we mentioned in the previous course: the American Association of Professional Coders (AAPC) and the American Health Information Management Association (AHIMA).

We talked at length in the last Section about preparing for the AAPC's CPC exam. If you're looking to take that test at some point in the future, it makes sense to join the AAPC now, especially if you can take advantage of their student rate, which is just \$70 a year. Membership in either of these professional organizations will grant you contacts and connections to coders and billers all over the country. Both of these organizations also have excellent job boards and provide lots of free job resources for new health information professionals.

Another option for those fresh out of school is to take the CPC exam right away, without the two years recommended work experience. It will be a challenge, but if you're confident in your schooling and your skills, you should be able to pass the exam. Once you have passed, you can take part in the CPC Apprentice program. You won't be a fully certified coder, but you'll have a leg up on the rest of the uncertified competition. Plus, once you do find a coding job, you can use that as a means of gathering work experience to put toward your full certification.

HOW TO INTERVIEW FOR A JOB

Let's say you've managed to track down and apply to your first coding job. Next up comes the interview process, which can be unnerving if you've never done it before. Let's look at what to know and how to prepare for this important interview.

Firstly, you'll want to do your research. Learn a little bit about the company you plan on applying to, and bring that to bear in your interview. You'll want to demonstrate how your particular skills can better the company, and how your career goals could align with the goals of the company.

Be prepared to get tested. No one's going to plunk down a stack of multiple-choice problems, but they very well may test you on vocabulary and medical terminology. You may have to work through some hypothetical patient interaction scenarios, in which you explain how you'd communicate with a patient who, let's say, is behind on their payments.

Speak to your experience, especially when it comes to coding or billing software. It's good to ask your interviewer some questions as well—What type of practice management program do you use here? What's your average case volume? Ask practical, serious-minded questions and base your responses to later questions on the answers.

It's also good to state your goals for the future. If you're a non-certified biller or coder, you should explain how you're interested in earning a certification in the near future.

Even with these tips in mind, it won't always be easy to land your first coding or billing job. Just remember to be patient and persistent, and you should do fine.