Introduction to Medical Coding

Coding to Reimbursement Cycle

The relationship of coding to the reimbursement cycle ensures that a physician’s office is quickly and appropriately paid by a third party payer, typically an insurance company. The cycle begins when a patient checks in with the receptionist at the doctor’s office.

- **Step 1**: The medical office receptionist verifies insurance information requirements and ensures the medical history is updated. The receptionist also gathers relevant demographic information about the patient, including an employer’s name, address, and telephone number.

- **Step 2**: The patient is examined by the doctor, and the patient’s medical file is updated with physician documentation, lab work and results, and other documentation. The physician completes an encounter sheet, which lists the most common pre-coded diagnoses, tests, and services used by that office. It also includes diagnosis and procedure codes.

- **Step 3**: A professional medical coder verifies the code selections on the encounter sheet and verifies the diagnosis and procedure against the medical record to ensure accuracy.

- **Step 4**: The billing specialist submits the claim to the insurance company for payment, which is typically done electronically. The claim contains the patient’s insurance information, charges for services and procedures, and diagnosis and procedure codes. If the codes are accurate and accepted by the insurance company claims processor, the medical office will receive payment. The time that it takes insurances to pay varies according to the payer and can be in less than a week, 30 days, or longer.
Coding Errors and Inaccuracies

Error reports are generated by the medical office to identify billing and coding issues or insurance claim errors before claims are actually sent to insurances. Errors, inaccuracies, or incomplete information will delay or deny remittance of payment by the insurance company. These must be addressed immediately by the medical office staff and corrected before claims are submitted to insurance company.

Some common errors:

- A test or procedure was completed but not captured on the patient's encounter sheet.
- Diagnostic information did not justify the procedures or treatments as medically necessary.
- A diagnosis was not coded to its highest level of specificity, and the code was not specific enough for the insurance to reimburse the service or procedure.

A medical office typically will submit a bill for payment directly to the patient if a claim is not paid by the insurance company within 30 – 45 days. Insurances may not pay claims because they never received the claims, they may need more information about the claim, or the claim has errors, and the claim will eventually be denied. This means that the patient is now responsible for payment. The patient must contact the insurance company to determine why the claim was not paid and request a resolution. The patient may need to request that the doctor’s office resubmit the claim with any necessary corrections. This requires additional work for the medical office staff and delays in payment to the medical facility. For this reason, medical offices invest in staffers with the skills and necessary attention to detail to submit claims correctly and to code medical visits correctly and accurately according to the requirements of the various third party payers.
Medical Coding Systems

Medical coding is logical but complex. There are three coding systems, or code sets used for coding inpatient and outpatient medical diagnoses, procedures, and services.

These systems include the following:

- **International Classification of Disease 10th Revision, Clinical Modification (ICD-10-CM)**: ICD-10-CM codes are used to identify diagnosis and are the basis for determining medical necessity of a procedure or treatment. ICD-10-PCS (Procedure Coding System) codes are used to identify inpatient procedures for facility reimbursement only.

- **Current Procedural Terminology (CPT) – 4th edition (CPT-4)**: CPT codes describe the treatment or correction performed by physicians and other medical professionals in both outpatient and inpatient settings. Consultations, eye and dental exams, lab tests, and any treatments for diagnosed medical issues that physicians and other medical professionals perform, including surgery and administering drugs, are coded with CPT. CPT codes were created by the American Medical Association. They are also referred to as Level I HCPCS codes.

- **Healthcare Common Procedure Coding System** (HCPCS): HCPCS codes describe equipment, supplies, and drugs used during the course of diagnosis or treatment that are not listed in the CPT-4 coding system, with some exceptions. Some services have both a HCPCS code and a CPT-4 code. Supplies, such as durable medical equipment, orthopedic aids and prosthetics, and drugs, are coded with the HCPCS. CMS created HCPCS codes for healthcare providers to use when billing Medicare. However, many other insurances also recognize HCPCS codes. These codes are also referred to Level II HCPCS codes.

Each coding system is updated annually (sometimes more often), so coders should refer to the current year’s codes before coding diagnoses and procedures.
The Professional Medical Coder

A professional medical coder must have working knowledge of the functionality of each coding system and continue training as systems are modified or updated. Medical coders must have a strong foundation in medical terminology, anatomy and physiology, diseases, and pharmacology in order to understand the connection between diagnoses and treatments and other services related to a medical visit. The medical coder not only generates the information necessary for billing medical visits to third party payers but also serves to support the medical office staff who need to enter information into the medical records or retrieve medical data to generate reports.