Coding for the Rest of Us: Why Everyone in Your Practice Needs a Basic Knowledge of Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact that we are privileged to care for patients, but as the saying goes “No money, no mission.”
- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the

appropriate service and diagnosis codes.

- The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff **enters the payments and/or charges** if the service codes have not already been posted via the EMR.
- The biller "scrubs" the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

"Coding" means two things: s**ervice codes** and **diagnosis codes**. Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced "hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an

electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.

- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**
- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard accompanying services.
- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

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