Professional Certificate in Medical Coding and Billing

# Introduction to Medical Coding

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Medical coding is the process of translating healthcare services and procedures into universal alphanumeric codes. These codes are used for billing purposes, insurance claims, data analysis, and reimbursement. Medical coders play a crucial role in ensuring accurate documentation and coding to support healthcare providers and facilities. This glossary will provide an in-depth look at key terms and concepts related to medical coding in the context of the Professional Certificate in Medical Coding and Billing.

Alphabetical Glossary of Terms

1. ABN (Advanced Beneficiary Notice)
- Related Terms: Medicare, Non-covered services
- Explanation: An ABN is a form given to Medicare patients in advance to notify them that a specific service may not be covered by Medicare. By signing the ABN, the patient agrees to pay for the service out of pocket if Medicare denies coverage.

2. AMA (American Medical Association)
- Related Terms: CPT codes, Medical coding guidelines
- Explanation: The AMA is a professional organization that publishes the Current Procedural Terminology (CPT) code set, which is used for reporting medical procedures and services. The AMA also provides guidance on coding practices and updates to ensure accurate coding.

3. Audit
- Related Terms: Compliance, Coding accuracy
- Explanation: An audit is a review process conducted to assess the accuracy and compliance of medical coding practices. Audits can be internal (conducted within the organization) or external (conducted by a third party).

4. Bundling
- Related Terms: NCCI edits, Global package
- Explanation: Bundling refers to the practice of combining multiple services or procedures into a single code for billing purposes. Bundling rules are established by payers to prevent overbilling and ensure appropriate reimbursement.

5. CMS (Centers for Medicare & Medicaid Services)
- Related Terms: Medicare, Medicaid, Healthcare regulations
- Explanation: CMS is a federal agency that administers the Medicare and Medicaid programs. It sets regulations and guidelines for healthcare providers, including coding and billing requirements.

6. CPT (Current Procedural Terminology)

- Related Terms: E/M codes, Modifier
- Explanation: CPT is a standardized code set published by the AMA for reporting medical procedures and services. It is used by healthcare providers, coders, and payers to communicate information about the services provided.

7. Denial
- Related Terms: Claim rejection, Appeal
- Explanation: A denial occurs when a claim for reimbursement is not accepted by a payer, typically due to errors or lack of documentation. Providers can appeal denials to request reconsideration and payment.

8. E/M (Evaluation and Management)
- Related Terms: History, Exam, Medical decision-making
- Explanation: E/M codes are used to report patient encounters for evaluation and management services. These codes reflect the complexity of the visit based on factors such as history, exam, and medical decision-making.

9. ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification)
- Related Terms: Diagnosis codes, Tabular list, Alphabetic index
- Explanation: ICD-10-CM is a diagnostic code set used to report patient diagnoses in healthcare settings. It provides a standardized system for classifying diseases, injuries, and other health conditions.

10. Modifier
- Related Terms: -25, -59, -LT, -RT
- Explanation: A modifier is a two-digit code used to provide additional information or clarify a service or procedure. Modifiers may indicate a specific circumstance, such as a bilateral procedure or a separate service performed on the same day.

11. NCCI (National Correct Coding Initiative)
- Related Terms: Edits, Modifier indicator
- Explanation: NCCI is a set of coding edits developed by CMS to promote correct coding practices and prevent improper payment. NCCI edits identify code pairs that should not be reported together in most circumstances.

12. Payer
- Related Terms: Insurance company, Reimbursement
- Explanation: A payer is an entity that pays for healthcare services on behalf of patients, such as insurance companies, Medicare, and Medicaid. Payers establish reimbursement rates and guidelines for coding and billing.

13. Revenue Cycle
- Related Terms: Registration, Coding, Billing
- Explanation: The revenue cycle encompasses the entire process of generating revenue for healthcare services, from patient registration to coding and billing. Effective revenue cycle management is essential for financial sustainability.

14. Superbill
- Related Terms: Encounter form, Charge ticket
- Explanation: A superbill is a document used by healthcare providers to capture information about services rendered during a patient visit. It typically includes codes for procedures, diagnoses, and other billable items.

15. Unbundling
- Related Terms: Fraud, Upcoding
- Explanation: Unbundling refers to the practice of billing separately for services that should be included in a bundled code. Unbundling can result in overpayment and is considered fraudulent coding.

16. V Code
- Related Terms: External cause code, Z code
- Explanation: V codes are used in ICD-10-CM to report factors influencing health status and contact with health services. These codes are typically used when a patient's condition or encounter does not fit into a specific disease category.

17. Z Code
- Related Terms: Preventive services, Encounter for screening
- Explanation: Z codes are used in ICD-10-CM to report encounters for issues other than diseases or injuries. These codes capture information about preventive services, screenings, and follow-up care.

18. 72-Hour Rule
- Related Terms: Inpatient coding, Hospital services
- Explanation: The 72-hour rule requires that certain outpatient services provided within 72 hours of an inpatient admission be considered part of the inpatient stay for billing purposes. This rule impacts coding and reimbursement for hospital services.

19. 95 Guidelines
- Related Terms: Telehealth, Virtual visits
- Explanation: The 95 guidelines refer to the guidelines for reporting E/M services provided via telecommunication technologies. These guidelines outline the documentation requirements and coding considerations for virtual encounters.

20. 99214
- Related Terms: E/M coding, Level of service
- Explanation: 99214 is a specific E/M CPT code used to report an established patient office visit of moderate complexity. This code corresponds to a specific level of service based on documentation criteria.

21. 99291
- Related Terms: Critical care, Time-based coding
- Explanation: 99291 is a CPT code used to report the first 30-74 minutes of critical care provided to a critically ill or injured patient. This code is time-based and may be reported in addition to other E/M services.

22. 99490
- Related Terms: Chronic care management, Remote patient monitoring
- Explanation: 99490 is a CPT code used to report chronic care management services provided to patients with multiple chronic conditions. This code covers non-face-to-face services such as care coordination and remote monitoring.

23. 3M Encoder
- Related Terms: Code lookup tool, Code assignment
- Explanation: The 3M Encoder is a software tool used by medical coders to look up and assign accurate diagnosis and procedure codes. It provides coding guidance based on official coding guidelines and regulations.

24. 7th Character Extension
- Related Terms: Fracture coding, Injury codes
- Explanation: The 7th character extension is used in ICD-10-CM to provide additional information about the timing and encounter of certain conditions, such as fractures. This extension helps specify the stage of treatment or recovery.

25. 80/20 Rule
- Related Terms: Pareto principle, Coding efficiency
- Explanation: The 80/20 rule, also known as the Pareto principle, states that roughly 80% of results come from 20% of efforts. In medical coding, this principle can be applied to focus on the most common diagnoses and procedures for efficient coding.

26. 835 File
- Related Terms: Electronic remittance advice, EOB
- Explanation: An 835 file is an electronic remittance advice file that provides detailed information about payments and adjustments made by payers for healthcare claims. This file is used by providers to reconcile payments and denials.

27. AHA (American Hospital Association)
- Related Terms: Inpatient coding, Facility coding
- Explanation: The AHA is a professional organization that provides guidance and resources for hospital coding and billing practices. It publishes coding clinics and updates to help facilities stay compliant with regulations.

28. AHIMA (American Health Information Management Association)
- Related Terms: Medical coding certification, Health information management
- Explanation: AHIMA is a professional association for health information management professionals, including medical coders. It offers certifications, educational programs, and resources to support coding and data integrity.

29. ANSI (American National Standards Institute)
- Related Terms: EDI, Code set standards

- Explanation: ANSI is a nonprofit organization that oversees the development of voluntary consensus standards for various industries, including healthcare. ANSI standards ensure interoperability and consistency in code sets and data exchange.

30. ARRA (American Recovery and Reinvestment Act)
- Related Terms: HITECH Act, Meaningful use
- Explanation: ARRA is a federal legislation enacted in 2009 to stimulate economic recovery and promote healthcare technology adoption. The HITECH Act, a component of ARRA, incentivizes the meaningful use of electronic health records.

31. Audit Trail
- Related Terms: Documentation history, Compliance monitoring
- Explanation: An audit trail is a chronological record of system activities that allows for the reconstruction and examination of events. In medical coding, audit trails are used to track changes and ensure data integrity.

32. Charge Description Master (CDM)
- Related Terms: Charge capture, Pricing transparency
- Explanation: The CDM is a database that contains information about billable services and items provided by a healthcare facility. It serves as a reference for coding, billing, and pricing of services to ensure accurate reimbursement.

33. Claim Scrubber
- Related Terms: Claims processing, Error checking
- Explanation: A claim scrubber is a software tool that automatically reviews healthcare claims for errors and inconsistencies before submission to payers. This helps improve claim acceptance rates and reduce denials.

34. Clinical Documentation Improvement (CDI)
- Related Terms: Query process, Documentation integrity
- Explanation: CDI is a process focused on improving the quality and accuracy of clinical documentation to support appropriate coding and billing. CDI specialists work with providers to ensure thorough and specific documentation.

35. Compliance Plan
- Related Terms: HIPAA, Fraud and abuse
- Explanation: A compliance plan is a set of policies and procedures designed to ensure adherence to legal and ethical standards in healthcare operations. The plan addresses areas such as coding, billing, privacy, and fraud prevention.

36. Concurrent Review
- Related Terms: Utilization management, Inpatient coding
- Explanation: Concurrent review is a process of assessing the medical necessity and appropriateness of care while a patient is still receiving treatment. This review helps ensure that services are provided efficiently and meet quality standards.

37. CPT Assistant
- Related Terms: Coding guidance, Newsletter
- Explanation: CPT Assistant is a publication by the AMA that provides official guidance and interpretations for reporting CPT codes. It offers explanations, examples, and case studies to assist coders in accurate code assignment.

38. Credentialing
- Related Terms: Provider enrollment, Verification
- Explanation: Credentialing is the process of verifying a healthcare provider's qualifications, training, and licensure to ensure they meet the standards for practice. Credentialing is required for providers to participate in insurance networks.

39. Data Analytics
- Related Terms: Business intelligence, Predictive modeling
- Explanation: Data analytics involves the use of statistical analysis and algorithms to interpret large datasets and extract valuable insights. In healthcare, data analytics can be used to identify trends, improve outcomes, and optimize operations.

40. DRG (Diagnosis-Related Group)
- Related Terms: Inpatient coding, Reimbursement methodology
- Explanation: DRGs are a classification system used to group inpatient stays into categories based on similar clinical characteristics and resource use. DRGs determine reimbursement rates for hospitals under the prospective payment system.

41. EHR (Electronic Health Record)
- Related Terms: EMR, Interoperability
- Explanation: An EHR is a digital record of a patient's health information, including medical history, diagnoses, medications, and test results. EHRs allow for real-time access to patient data and enhance communication among providers.

42. Encoder
- Related Terms: Code lookup tool, Code assignment
- Explanation: An encoder is a software tool used by medical coders to search for and assign accurate diagnosis and procedure codes. Encoders provide coding suggestions, guidelines, and references to support code selection.

43. EOB (Explanation of Benefits)
- Related Terms: Remittance advice, Patient responsibility
- Explanation: An EOB is a document sent to patients by insurance companies that explains the payments and adjustments made for healthcare services. The EOB details what the insurance covered, denied, and what the patient owes.

44. Fraud and Abuse
- Related Terms: False claims, Whistleblower

- Explanation: Fraud and abuse in healthcare involve intentional deception or improper practices that result in financial loss or harm. Examples include upcoding, unbundling, kickbacks, and billing for services not provided.

45. HCC (Hierarchical Condition Category)
- Related Terms: Risk adjustment, Medicare Advantage
- Explanation: HCCs are a risk adjustment model used by Medicare to predict healthcare costs and adjust payments based on the health status of beneficiaries. HCCs are derived from ICD-10-CM diagnosis codes reported by providers.

46. HHS (Department of Health and Human Services)
- Related Terms: OCR, Healthcare regulations
- Explanation: HHS is a federal agency responsible for protecting the health and well-being of Americans. HHS oversees healthcare programs, enforces HIPAA regulations, and provides guidance on healthcare policy.

47. HIPAA (Health Insurance Portability and Accountability Act)
- Related Terms: Privacy, Security, Breach notification
- Explanation: HIPAA is a federal law that establishes standards for the privacy and security of protected health information (PHI). HIPAA regulations govern the use, disclosure, and protection of PHI by healthcare providers and entities.

48. ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System)
- Related Terms: Inpatient coding, Medical procedures
- Explanation: ICD-10-PCS is a procedure code set used to report inpatient hospital procedures in the United States. It provides a detailed system for classifying and reporting medical interventions and treatments.

49. LCD (Local Coverage Determination)
- Related Terms: Medicare Administrative Contractor, Coverage policy
- Explanation: LCDs are coverage policies developed by Medicare Administrative Contractors (MACs) to specify the conditions under which Medicare will reimburse for services. LCDs outline medical necessity, coding guidelines, and documentation requirements.

50. MAC (Medicare Administrative Contractor)
- Related Terms: Claims processing, Fee schedule
- Explanation: MACs are private organizations contracted by CMS to process Medicare claims, educate providers, and establish coverage policies. MACs play a key role in administering Medicare benefits and ensuring compliance with regulations.

51. Meaningful Use
- Related Terms: EHR incentive program, Quality reporting
- Explanation: Meaningful use refers to the utilization of certified electronic health record technology to improve patient care, outcomes, and population health. The EHR incentive program incentivizes providers

to demonstrate meaningful use of EHRs.

52. Medical Necessity
- Related Terms: LCD, Coverage determination
- Explanation: Medical necessity refers to the requirement that healthcare services provided to patients are reasonable and necessary for the diagnosis or treatment of a medical condition. Payers use medical necessity criteria to determine coverage.

53. Medicare Fraud Waste and Abuse (FWA