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# NAAN MUDHALVAN UPSKILLING PLATFORM

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நான் முதல்வன்

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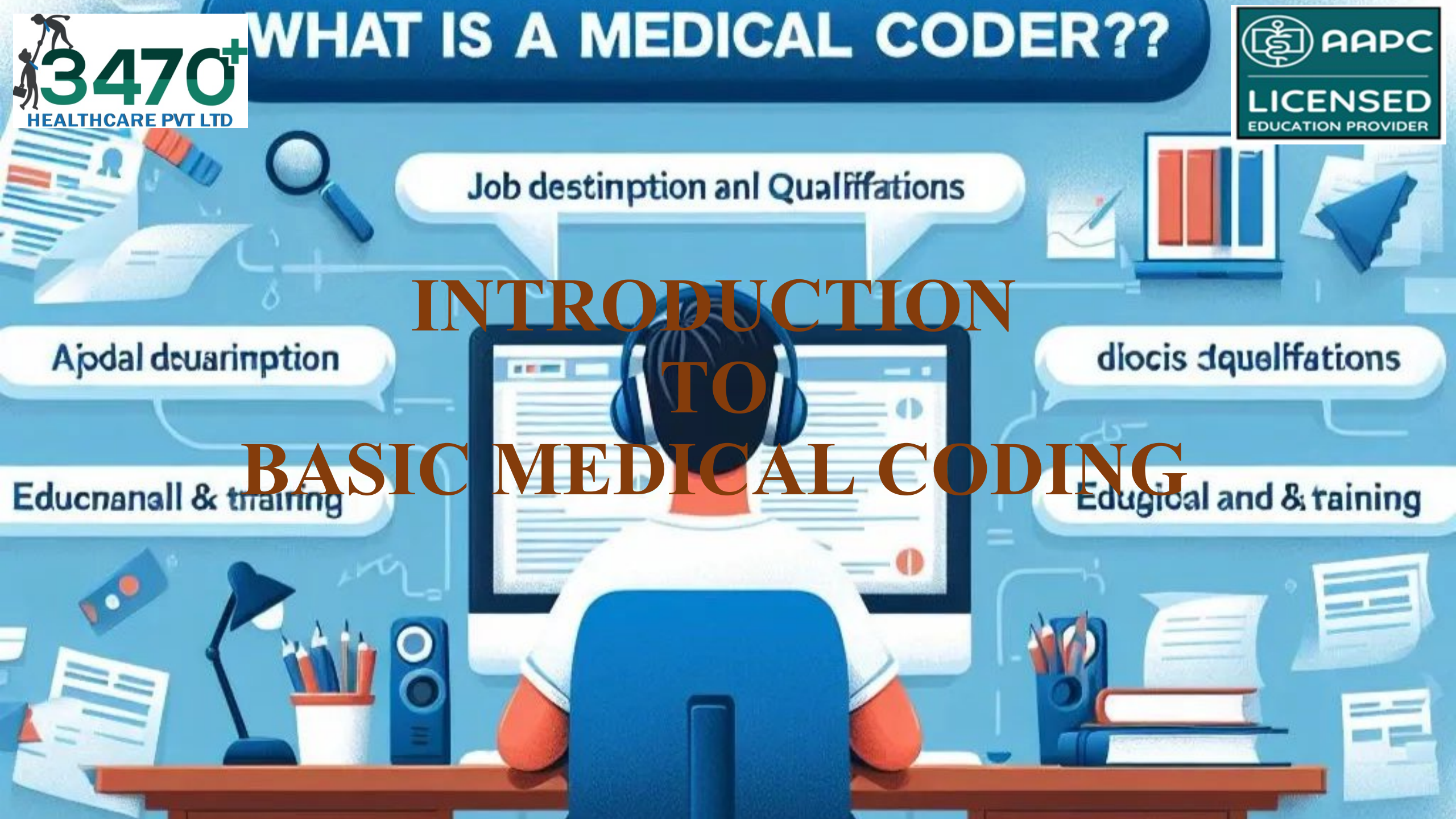


# INTRODUCTION TO BASIC MEDICAL CODING

# INTRODUCTION TO MEDICAL CODING

- **WHAT IS MEDICAL CODING ?**

Transformation of

- healthcare diagnosis,
- Procedures,
- Medical services
- Equipment into universal medical alphanumeric codes

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# PURPOSE OF MEDICAL CODING

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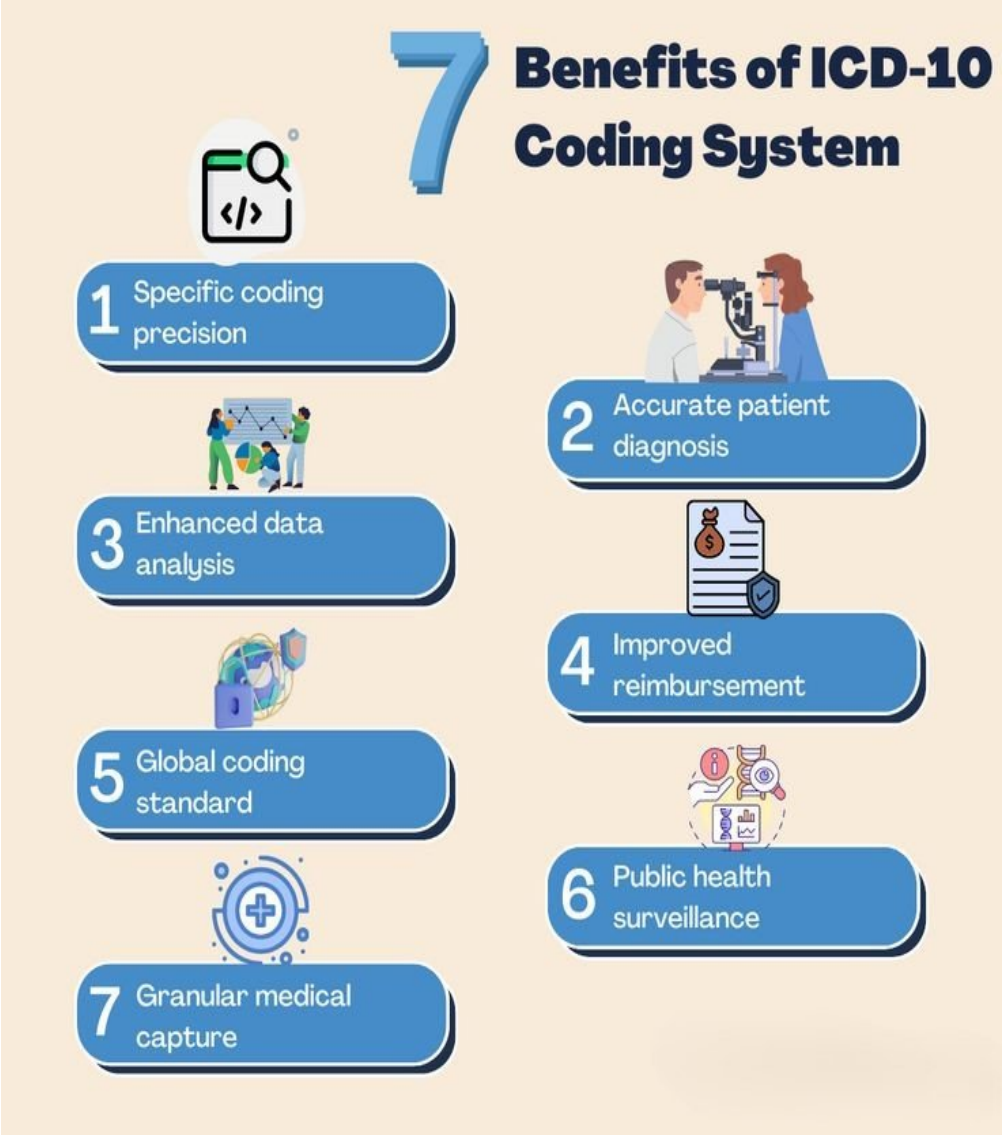
- Medical coding and medical billing are the backbone of healthcare revenue cycle
- Used by health insurance companies to pay health insurance claims
- Helps in billing process at hospitals
- Ensuring payers and patients reimburse providers for services delivered



# TASK OF A MEDICAL CODER

- To review clinical statements and assign standard Codes using CPT, ICD – 10 CM, HCPCS LEVEL II Classification systems.
- Medical coders translate the provider's Documentation into standardized codes that tell Payers the following:
- PT'S diagnosis
- Medical necessity for treatments, services or Supplies the PT received
- Treatments,services and supplies provided to the PT
- Any unusual circumstances or medical condition That affected those treatments and services

- PATIENT-ONE WHO SEEKS MEDICAL SERVICE / TREATMENT.

- PROVIDER-ONE WHO RENDERS (PROVIDES) SERVICES TO THE PATIENT.
- Physician (doctors) and Other qualified health professionals ( registered nurse, physicisn assistants, nurse practitioners, certified registered nurse anesthetists, and physical, speech, occupational, and massage therapists.

- PAYERS-ONE WHO PAYS FOR MEDICAL TREATMENTS
- Health insurance , Self insured employer , Pays by self if uninsured

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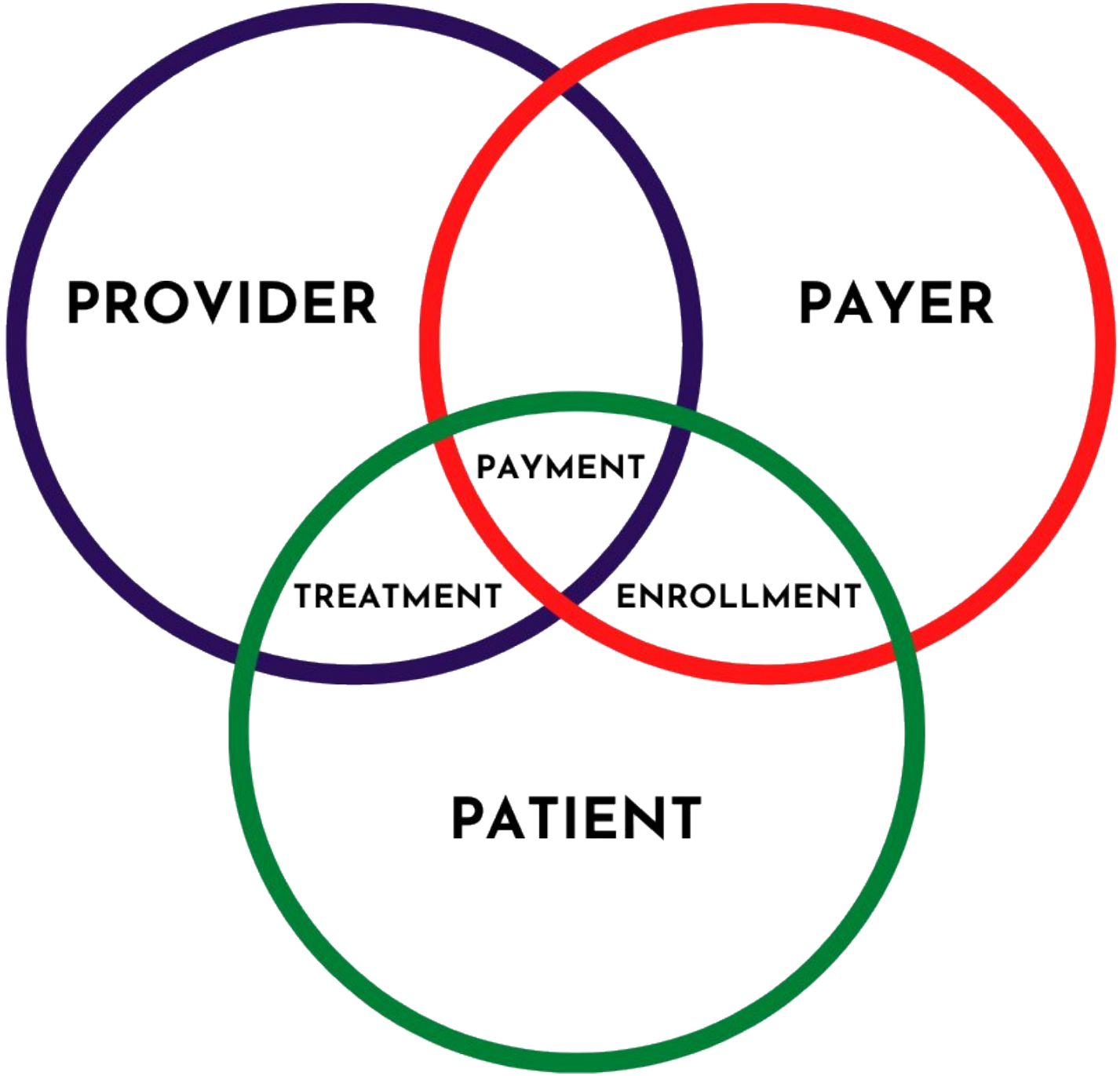

# TYPE OF CODES USED

1. ICD – 10 CM
2. ICD – 10 PCS
3. CPT
4. HCPCS LEVEL II
5. CDT ( CODE ON DENTAL PROCEDURES AND NOMENCLATURE )
6. NDC (NATIONAL DRUG CODES)
7. MODIFIERS
8. MS-DRG ( MEDICAL SEVERITY DIAGNOSIS RELATED GROUPS)
9. APC (AMBULATORY PAYMENT CATEGORIES)
10. AAPC-AMERICAN ACADEMY OF PROFESSIONAL CODERS

# REQUIREMENTS OF A MEDICAL CODER

1. Knowledge of anatomy , physiology and medical terminology.
2. Knowledge of diseases, injuries and clinical procedures.
3. Read and understand medical and surgical reports and patient charts.
4. Knowledge of classification and coding conventions

# RCM – REVENUE CYCLE MANAGEMENT

- **Revenue Cycle Management** Is The Process Used By Healthcare Systems In The United States And All Over The World To Track The Revenue From Patients, From Their Initial Appointment Or Encounter With The Healthcare System To Their Final Payment Of Balance

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# COMMON ABBREVIATIONS

CMS - Centers for medicare and medicaid services

AMA - American medical association

AHIMA - American health information management association

NCHS – National center for health statistics

ICD 1O CM – International classification of diseases, 10th edition , clinical modification.

ICD 10 PCS – International classification of diseases, 10th edition , procedure coding system.

HCPCS – Healthcare common procedure coding system

CPT – current procedural terminology.

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# COMMON ABBREVIATIONS

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HITECH - HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH

HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

PHI - PROTECTED HEALTH INFORMATION

OIG - OFFICE OF INSPECTOR GENERAL

RBRVS – RESOURCE BASED RELATIVE VALUE SCALE

ABN – ADVANCED BENEFICIARY NOTICE

EOB – EXPLANATION OF BENEFIT

# MODIFIERS

- Used by CPT® and HCPCS Level II codes
- Alphanumeric two-character codes to add clarity
- Status of the patient, the part of the body
- On which a service is being performed, a payment instruction, an occurrence that changed the service the code describes, or a quality element.

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# Thank You!