

MEDICAL BILLING AND CODING DEFINITIONS

MEDICAL BILLING: The process of submitting and following up on claims with health insurance companies in order to receive payment for services rendered by a healthcare provider. Medical billing translates a healthcare service into a billing claim. The responsibility of the medical biller in a healthcare facility is to follow the claim to ensure the practice receives reimbursement for the work the providers perform.



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MEDICAL CODERS: Medical coders review clinical statements and assign standard codes using CPT®, ICD-10-CM, and HCPCS Level II classification systems. The coder must make sure that the diagnosis code supports the treatment rendered. The medical coder and medical biller may be the same person or may work with each other to ensure invoices are paid properly.

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) – standardized code systems necessary for Medicare and other health insurance providers to submit healthcare claims in a consistent and orderly fashion. There are two levels of HCPCS: Level I: CPT – used to submit medical claims to payer for procedures and services performed by physicians, nonphysician practitioners, hospitals, laboratories, and outpatient facilities. Level II: National Procedure Code – set for healthcare equipment suppliers when filing health plan claims for medical devices, supplies, medications, transportation services, and other items or services.

CURRENT PROCEDURAL TERMINOLOGY (CPT) – procedure codes. Published by the American Medical Association (AMA). The primary way provision of medical services is reported. CPT refers to a set of medical codes used by physicians, allied health professionals, nonphysician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform. CPT codes are used to report procedures and services to federal and private payers for reimbursement of rendered healthcare.

EVALUATION AND MANAGEMENT (E&M): E&M is the medical coding process in support of medical billing. Example: examine patient, document findings, determines action for treatment - doctor's visit or consultation. This is translated into a 5-digit Current Procedural Terminology (CPT) code to facilitate billing. CPT codes describe the medical, surgical, and diagnostic services. 7 components: history*, examination*, medical decision making*, counseling, coordination of care, nature of presenting problem, and time (*key components). Based on – place of services, type of service, and patient status.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): HIPAA sets the bar for compliance of medical billing and coding, to prevent fraud, waste, and abuse by healthcare providers.

EXAMPLES OF PAYERS

- **Commercial Insurance:** Private insurance carriers (i.e. Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), Point-of-service Plans (POS))
- **Networks:** Function as a middleman by negotiating contracts with providers and pricing claims (determines fees)
- **Third Party Administrators:** Intermediaries either operate as a network or access networks to prove claim. Often handle claims processing for employers who self-insure their employees
- **Government Payers:** Medicare/Medicaid/Tri-Care
- **Patient Protection and Affordable Care Act (ACA):** Healthcare reform law/State plan – varies by state

REFERENCES: American Academy of Professional Coders, AAPC. Retrieved from aapc.com.

ICD-10-CM/PCS Medical Coding Reference, Retrieved from ICD10Data.com.

ICD-10-CM Official Guidelines for Coding and Reporting, FY20. Retrieved from www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf

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