Acknowledgments

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Special thanks to the Minister of Health and Population Dr. Hala Zayed and Former Minister of Health Prof. Ahmed Emad Edin Rady for their decision to recognize and professionalize health education by issuing a decree to develop and strengthen the technical health education curriculum for pre-service training within the technical health institutes.
This course is prepared for the undergraduate students at Health Technical Institute aiming at introducing the student to different techniques of medical coding, indexing and ICD-10 coding and reporting guidelines. It should also support the students who master this material to be able to work as a medical coder which is a rapidly growing and interesting career by mastering the required skills and avoiding errors in coding and reporting.

On successful completion of this course, the student will be able to:
1. Define medical coding and indexing.
2. Identify the secrets behind disease classification.
3. Recognize the commonly used terms medical coding.
4. Select the appropriate method of medical coding.
6. Determine the proper use of medical coding.

On successful completion of this course, the student will be able to:
1. Solve exercises on the commonly used classifications of disease.
2. Apply the proper coding to a given disease, symptom, or procedure.
3. Interpret medical coding.
4. Report medical coding according to guidelines.
5. Compare the different systems of medical coding.
6. Hypothesize in a correct way what to be coded and how to be coded.

On successful completion of this course, the student will be able to:
1. Collect required data for proper coding.
2. Examine the patient’s file for finding what to be coded.
3. Label codes correctly.
4. Summarize coding techniques.
5. Solve coding errors.
6. Criticize a coding technique.

| 1. Able to search for a computer software or website to help perform medical coding in a proper and professional way. |
| 2. Work hard to improve the skills required for medical coding as a career. |
| 3. Demonstrate caution and proficiency in applying medical coding. |

| 1. Preface. |
| 2. Introduction. |
| 5. Chapter (3): Economics of healthcare. |
| 7. Chapter (5): Medical coding as a career. |
| 9. Chapter (7): Diagnosis coding. |
| 11. Chapter (9): Coding errors and problems. |

| 1- Lectures using power point presentations. |
| 2- Positive interaction with the lecturer by asking questions or answering them. |
| 3- Practical sessions to solve coding exercises. |
| 4- Hand-outs to simplify the scientific material. |
| 5- External readings of specialized books. |
| 6- Training to answer model question exercises. |

| 1- Practice Test. |
| 2- Midterm Test |
| 3- Final Written Test. |

**Final theoretical written exam:** 3-hours. And 12 Hours Practical per week. Midterm test at the 6th week.

**Quiz at 5 marks**
Midterm 10 marks
Attendance: 5 marks
Clinical skills: 20 marks
Case study: 5 marks
Practical exam at 15 marks
Final written exam: 90 marks
Total: 150 marks

- **Handouts for the lectures and practical sections**
- **Medical coding: What is it? And how it works?** By

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1- المهارات العامة:

4- محتوى المقرر:

5- أساليب التعليم والتعلم

6- أساليب التعليم والتعلم للطلاب ذو الفئات المحددة

7- تقييم الطلاب: 

8- قائمة الكتب الدراسية والمراجع:

- مذكرات
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<tr>
<th>Authors</th>
<th>Title</th>
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<tr>
<td>Patricia Aalseth</td>
<td>Medical billing and coding demystified: A self-teaching guide</td>
<td>Jones and Bartlett Publishers</td>
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<td>Sudbury Massachusetts Boston Toronto London Singapore</td>
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Course Description

This course is prepared for the undergraduate students at Health Technical Institute aiming at introducing the student to different techniques of medical coding, indexing and ICD-10 coding and reporting guidelines. It should also support the students who master this material to be able to work as a medical coder which is a rapidly growing and interesting career by mastering the required skills and avoiding errors in coding and reporting.

Core Knowledge

On successful completion of this course, the student will be able to:

- Define medical coding and indexing.
- Identify the secrets behind disease classification.
- Recognize the commonly used terms medical coding.
- Select the appropriate method of medical coding.
- Determine the proper use of medical coding.

Core Skills

On successful completion of this course, the student will be able to:

- Solve exercises on the commonly used classifications of disease.
- Apply the proper coding to a given disease, symptom, or procedure.
- Interpret medical coding.
- Report medical coding according to guidelines.
- Compare the different systems of medical coding.
- Hypothesize in a correct way what to be coded and how to be coded.
- Collect required data for proper coding.
• Examine the patient’s file for finding what to be coded.
• Label codes correctly.
• Summarize coding techniques.
• Solve coding errors.
• Able to search for a computer software or website to help perform medical coding in a proper and professional way.
• Work hardly to improve the skills required for medical coding as a career.
• Demonstrate caution and proficiency in applying medical coding.

Teaching and Learning Method

• Lectures using power point presentations.
• Positive interaction with the lecturer by asking questions or answering them.
• Practical sessions to solve coding exercises.
• Handouts to simplify the scientific material.
• External readings of specialized books.
• Training to answer model question exercises.

Teaching and Learning Method for students with limited abilities

• N A

The Methods used in student assessment

• Practice Test.
• Midterm Test
• Final Written Test.

Timing

Class work:
Quiz (5th week)
Midterm theoretical (7th week)
Clinical skills through the semester
Final exam
Practical exam (13th week)
Written exam (15th week)

Distribution of grades

Quiz : 5 mark
Midterm: 10 marks
Attendance 5 marks
Clinical: 25 marks
Clinical exam:15 marks
Final written exam 90 marks.
Total percentage 150 mark

**References**

- Handouts for the lectures and practical sections

**Course Overview**

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<td>Introduction: Define and outline importance of studying medical coding, indexing and disease classification.</td>
<td>- Plot a flow chart for medical coding</td>
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<td>2nd</td>
<td>Differences between coding and indexing</td>
<td>- Create explanatory example for each type.</td>
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<td>Coding as a career</td>
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<td>Revision 1</td>
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<td>7th</td>
<td>Disease classification</td>
<td>Explain given disease and symptom terminology</td>
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**TOTAL HOURS (108)**
Introduction

Medical coding affects everyone’s life, whether we realize it or not. Medical coding is best described as translation. The original language is the medical documentation about the diagnoses and procedures related to a patient. This information is converted, through the coding process, into a series of code numbers that describe the diagnoses or procedures in a standard manner. Therefore, medical coding is an ideal example of the statement:

“A place for everything and everything in its place”

This text began as notes for a course in medical coding for second year students at Health Technical Institute. Both authors are interested in medical coding for their practice at some point in the fields of hospital administration and quality management. The authors promise the students to get a palatable introduction to the career of medical coder.

To do this task, the book is divided into 9 chapters.

- In chapter 1, you’ll read a note on the history of medical coding from its earliest form that started as an attempt to avoid the Black Death to its latest form; ICD-11.

- Chapter 2 explains the difference between coding and indexing.

- Chapter 3 covers the economics of healthcare through discussion of payment mechanisms based on medical coding. In this chapter you’ll get answers for questions like why is the same procedure paid at a different
rate if performed in a doctor’s office as opposed to a hospital based clinic? However, tying coding to reimbursement opened the door to potential healthcare organization attempts to “game the system” with fake coding to get more money from payers.

- Chapter 4 explains the steps taken to prevent this issue and the current ethical dilemmas of coders today.

- Chapter 5 discusses the reality of a coding career which does not always involve huge financial return, but is guaranteed to be challenging and intriguing. The chapter explains what skills are needed for success.

- Chapter 6 explains the essential terminology behind disease classification

- Chapter 7 covers diagnosis coding to help you understand the structure and format of international classification of diseases (ICD) and the process of assigning code numbers to any medical condition.

- In Chapter 8 that covers procedure coding, you’ll know that every service the patient receives must be enumerated for statistical and billing purposes. The type of procedure, who performs it, and where it is performed determine which coding system is used. This chapter provides information about ICD, CPT and HCPCS procedure coding.

- Finally, chapter 9 discusses the possible coding errors and how to avoid them as well as Coding problems and how to solve them.
Flow chart of medical coding:

- **ICD** = International Classification of Diseases.
- **HCPCS** = Healthcare Common Procedure Coding System
Chapter 1

History of Medical Coding

1.1- The Black Death

Medical coding in its earliest form started as an attempt to avoid the Black Death. Bubonic plague, caused by the bacteria Yersinia pestis, arrived in Sicily via ship rats in 1347. It spread rapidly, reaching England in 1348. Almost half the city of London’s population of 70,000 died of the disease over the next two years. Given that life expectancy at the time was about 26 years and about 35% of children died before the age of 6, the Black Death contributed to the increased death of the already death-ridden population. Italian author Giovanni Bocaccio lived through the plague in Florence in 1348.

In his book, The Decameron, he describes how the Black Death got its name: “In men and women alike it first betrayed itself by the emergency of certain tumors in the groin or the armpits, some of which grew as large as a common apple.

The form of the malady began to change, black spots or livid making their appearance in many cases on the arm or the thigh or elsewhere, now few and large, then minute and numerous. These spots were an infallible token of approaching death.”

The plague was highly contagious. As soon as people realized that contact with the sick could mean death, they isolated themselves and as Bocaccio describe: “Citizen avoided citizen” and “Fathers and mothers were found to abandon their own children, untended, unvisited, to their fate, as if
they had been strangers”.

Once the initial plague was over, isolated outbreaks continued in Europe throughout the next three centuries. It became an increasingly urban disease, due to poor sanitation and crowded living conditions. The Great Plague of 1665 in London killed 25% of the population (Fig. 1-1). It was at this point that the science of epidemiology, the study of epidemics, was born.

*Figure (1.1): Plague Doctor. The beak was filled with herbs, thought to protect against the Black Death.*
The London Bills of Mortality (Fig. 1-2) were published weekly, and as of 1629 included the cause of death. Information was collected by district administrators in various geographical areas. In order to determine which areas had the most cases of plague, Londoners purchased copies of the Bills and tracked the spread of the disease from one district to another in order to avoid it. During one week in 1665, when the total number of London deaths was 8,297, bubonic plague accounted for 7,165 of those deaths.

Causes of death found in the Bills include diseases recognized today, such as jaundice, smallpox, rickets, spotted fever, and plague. Other conditions have creative descriptions like “gripping in the guts,” “rising of the lights” (croup), “teeth,” “king’s evil” (tubercular infection), “bit with a mad dog,” and “fall from the belfry.”
John Graunt, a London merchant, published Reflections on the Weekly Bills of Mortality in 1665. Its central theme was that deaths from plague needed to be examined in the context of all the other causes of mortality in order to understand the effects of all diseases.

The sixty disease categories in the Bills constituted the first systematic attempt to analyze the incidence of disease.

During the eighteenth century, additional classifications were authored by Linnaeus in Sweden (Genera Morborum, 1763), Bossier de Lacroix in France (Nosologia Methodica, 1785), and Cullen in Scotland (Synopsis...
Nosologic Methodicae, 1785). Nosology is the branch of medicine that deals with classification of diseases.

1.2- **Cholera:**

As the first medical statistician for the General Register Office of England, Dr. William Farr restored the Cullen disease classification to standardize the terminology and utilize primary diseases instead of complications. Farr incorporated additional data into his classification, enabling reporting and analysis of factors such as occupation and its effect on cause of death.

Farr’s dedication to what he called “Hygology” derived from hygiene was evident in his analysis of the London cholera outbreak of 1849. More than 200 pages of tables, maps, and charts reviewed the possible influence of almost every conceivable death-related factor such as age, sex, rainfall, temperature, and geography. Even day of the week and property value were examined.

The single association consistently present was the inverse relationship between cholera mortality and the elevation of the decedent’s residence above the Thames River. Unfortunately, this led Farr to the conclusion that the air was more polluted lower by the river, causing the transmission of cholera. He later converted to the water-borne germ theory of disease after studying a second epidemic in 1866, including data about the source of drinking water for those who died.

1.3- **International List of Causes of Death:**

The need for a uniform classification of causes of death was recognized at the International Statistical Congress organized in Brussels in 1853. The Congress requested that William Farr prepare a classification for consideration at its next meeting in Paris in 1855. His classification was based primarily on anatomical site and consisted of 138 headings.
The list was adopted in 1864 and revised at four subsequent Congresses. Farr died in 1883 and Jacques Bertillon, the chief statistician of the city of Paris, prepared a revised list that was adopted by the International Statistical Institute in 1893. Known as the Bertillon Classification, it was the first standard system actually implemented internationally. The American Public Health Association recommended its use in the United States, Canada, and Mexico by 1898. Delegates from 26 countries adopted the Bertillon Classification in 1900 and subsequent revisions occurred through 1920.

1.4 - Beyond Death:

After Bertillon’s death in 1922, interest grew in using the classification to categorize not only causes of mortality, but also causes of morbidity. Morbidity is a diseased state or the incidence of disease in a population. As early as 1928, the Health Organization of the League of Nations published a study defining how the death classification scheme would need to be expanded to accommodate disease tabulation.

Finally, in 1949 at the Sixth Decennial Revision Conference in Paris, the World Health Organization (WHO) approved a comprehensive list for both mortality and morbidity and agreed on international rules for selecting the underlying cause of death.

Known as the “Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death” it is generally referred to as ICD.

From this point forward, the use of ICD was expanded, for indexing and retrieval of records and for data concerning the planning and evaluation of health services.

The purpose of the ICD and of WHO sponsorship is to promote international comparability in the collection, classification, processing, and presentation of morbidity and mortality statistics. The United States
implemented ICD-1 in 1900 and participated in every revision through ICD 7 until 1968. ICD was used for death classification until the sixth revision, when disease indexing began and ICD was used for both purposes.

With the eighth revision, the US developed its own version, known as ICDA-8 or ICD Adapted, due to disagreements over the circulatory section of the international version.

The International Conference for the Ninth Revision was attended by delegations from 46 countries. The classification was being pushed in the direction of more detail by those who wanted to use it for evaluation of medical care or for payment purposes. On the other hand, users in less sophisticated areas did not need the detail in order to evaluate their health care activities. Steps were taken to assure the usefulness of the new revision for all users, and the World Health Assembly adopted ICD 9th revision in May 1976 for implementation effective January 1, 1979. As it did with ICD 8, the US adopted a clinical modification to the international version, and ICD-9-CM (clinical modification) is still in use in this country today.

Changes to ICD-9-CM over the years mirror events in American society. The ICD-9-CM Coordination and Maintenance Committee, a joint effort of the National Center for Health Statistics and the Center for Medicare and Medicaid Services, considers code changes yearly. Although it is possible to code any disease using ICD-9-CM, newly identified or newly concerning conditions often fall into an “other” category, and the assignment of new specific codes is necessary to identify and count those disease entities.

ICD-10 represents a radical departure from the previous 100 years of disease classification. Although it is still organized along body systems, it contains about 8,000 causes of death, almost double the 4,000 in ICD-9. It uses 4 to 6-digit alphanumeric codes instead of the 4-digit numeric codes from ICD-9. In the United States, ICD-10 has been used to classify mortality data since 1999, while we continue to use ICD-9-CM for all other purposes,
such as billing and morbidity statistics.

The impact of changes in coding systems can be analyzed through a comparability study. This means coding the same deaths twice: once using the old coding system and once using the new coding system. The ratio of new system to old in terms of categories of deaths demonstrates the effect of the coding system change on death rates.

In 1979, for example, the data for nephritis, the 11th leading cause of death, had a comparability ratio of 1.74, which means that 74% more deaths occurred from this cause solely due to the change in coding systems.

In 2001, the Journal of the American Medical Association published a research letter describing the effect of coding on AIDS mortality statistics in Florida. For 1999, AIDS mortality rose by 6.7% using ICD-10 coding, while it decreased by 6.6% when the same cases were coded using ICD-9.

If health services analysts are not aware of these effects, data can be misinterpreted. Government agencies, health care insurers, and providers are studying the implications of switching to ICD-10-CM. A study by the Robert E. Nolan Company, commissioned by the Blue Cross and Blue Shield Association, estimated a $6 billion to $14 billion price tag on such a change. Other implications cited by the study are:

- A short-term “data fog” due to a lack of data continuity.
- Delays and backlogs in payment of claims.
2.1- Coding:

Document coding is frequently used in the legal, records, financial and medical communities to quickly organize and classify records for later use.

Medical coding is best described as translation. The original language is the medical documentation about the diagnoses and procedures related to a patient. This information is converted, through the coding process, into a series of code numbers that describe the diagnoses or procedures in a standard manner.

Variations in medical language usage can be found in different geographic locales. The sophistication of terms used also varies among different types of medical personnel. Coding the language is a method of grouping medical statements with the same meaning.

2.2- Indexing:

Indexing is a similar activity, but more like simple data entry in nature and typically used to tag documents for storage and retrieval, rather than active use.

The original ICD-9 was created for collecting statistical data on morbidity and mortality rates. The system was later used by The Veterans Administration and The United States Public Health Service in 1950 for hospital indexing.
Chapter 3
Economics of healthcare

Our method of paying for healthcare has evolved over the last century and continues to evolve today where attractive marketing techniques normally reserved for selling soap and automobiles are used to sell prescription medication, medical tests, and hospital services to prospective patients. It becomes common to see radio and television commercials advertising the benefits of one hospital over another or how a $3,000 body scan can identify the infancy of a disease so that you can be treated before the disease has a chance to spread. Pharmaceutical companies advertise their latest drugs directly to patients although the drug can only be purchased with a prescription from a healthcare provider.

Economics is the driving force that pushes the healthcare industry to aggressively go after the patient as the consumer of its products and services. It is a branch of social science that deals with the production, distribution, and consumption of goods and services. Many of us don’t consider health a consumer product or service like buying an automobile. Yet, healthcare is a business whose sole purpose is to provide products and services in exchange for money.

3.1- FOR-PROFIT AND NOT-FOR-PROFIT

Healthcare providers are divided into two economic categories. These are for-profit and not-for-profit.

A for-profit healthcare provider charges fees that cover expenses and
return a profit. Profit is money collected by the healthcare provider that exceeds expenses and is distributed to its owners as a reward for investing money in the business. An owner can be a physician, a group of physicians, or anyone who gave money to start the healthcare business.

A not-for-profit healthcare provider charges fees that cover expenses only. Theoretically, no money is left over. There isn’t a profit and there aren’t any investors. Not-for-profit healthcare providers strive to bring in enough money to cover expenses and to have enough money left over to handle unexpected expenses—a kind of emergency fund.

3.2- SUPPLY AND DEMAND

The healthcare industry is governed by the economic rule of supply and demand. This rule states simply that “a demand by consumers for products and services will cause someone to provide those products and services”. If there is no demand, then no one will invest time and money making the product or providing the service.

For example, a town of 100 people has a demand for services of a physician. However, the demand is too small to attract a physician because there aren’t enough sick people to make it profitable for a physician to set up a practice in the town. As the town grows to 5,000 people, the demand for healthcare services increases to a level that makes it profitable for one physician to open a practice in town. Still there aren’t sufficient sick people to support a hospital. A town of 50,000 or more might be needed to attract a hospital. A for-profit healthcare provider enters a market when demand is enough to return a profit and withdraws from the market when demand becomes unprofitable. However, not-for-profit healthcare providers usually remain in unprofitable markets because they receive funding from government agencies or charities.
3.3- **SHOW ME THE MONEY**

You have probably heard the story about the hospital that charged a patient a dollar for an aspirin when the local pharmacy sells a bottle of aspirin for 69 cents. This is true. The hospital probably paid a penny for the aspirin but charged a dollar to bring in additional revenue.

**Revenue** is money that is paid to a healthcare provider. Healthcare providers seek to have as many revenue streams as possible. A **revenue stream** is a product or service that is sold to bring in revenue. For example, the parking lot fee at the hospital is a revenue stream and so is the rental fee for telephones and televisions.

Providing the patient with aspirin and other medications is another revenue stream. The amount of revenue that can be generated by a revenue stream depends on the amount of money the healthcare provider charges for a product or service, e.g., charging two dollars for an aspirin brings in more money (greater revenue stream) than changing one dollar for the aspirin. Healthcare providers try to maximize the money generated by each revenue stream in order to provide the cash needed to run their operation. This is true regardless of whether the healthcare provider is for-profit or not-for-profit.

3.4- **HEALTHCARE CHARGES**

A **fee** is the price a healthcare provider charges for a product or service. This is similar to the sticker price on a car. Each healthcare provider sets the fee based on supply and demand although some healthcare providers adjust the fee based on the patient’s ability to pay. When a lot of healthcare providers supply the same product or service, fees are competitive in order to attract new patients and keep current patients. Competitive means that fees for the same product or service are relatively around the same amount. This is like all Ford dealers in the area selling the
same model car at about the same price. Fees are less competitive when there is a high demand for a product or service and there are few healthcare providers supplying it. Typically, the high demand encourages other healthcare providers to supply the product or service resulting in a competitive price. Remember that fees are equivalent to prices. We see pricing adjusted according to supply and demand in grocery stores or at the gas pump, but rarely do we see this happening in healthcare because our medical insurer pays our medical bills. The fee a medical insurer pays is not necessarily the fee seen on our medical bill. This is like the sticker price on a car. You probably pay less than the sticker price. Medical insurers typically pay the allowed charge or the usual, customary, and reasonable fee for a product or service within the specific section of the country. Let’s say that your hospital charges a dollar for an aspirin even though other hospitals in the area normally charge 40 cents. Your medical insurer pays the hospital 40 cents—not the dollar. The hospital has the option to accept the 40 cents as full payment or send you a bill for 60 cents.

Healthcare providers sometimes find themselves in a dilemma. In some cases, the amount that the medical insurer pays doesn’t provide a sufficient financial incentive for the healthcare provider to supply the product or provide the service. The healthcare provider can send the patient a bill for the difference between the original bill and the amount the medical insurer pay back; however, the patient may complain and find another healthcare provider. Furthermore, the patient may be unable to pay the difference. This leaves the healthcare provider to seek legal recourse against the patient, which is expensive and may become public resulting in a loss of other patients who could feel that the healthcare provider is overcharging them. In these situations, the healthcare provider might appeal the partial repayment to the medical insurer. An appeal is a request for the medical insurer to take a second look at the claim. Alternatively, the healthcare provider might simply accept the partial repayment as payment in full.
3.5- PAYING BILLS

Healthcare providers need to receive repayment for medical insurance claims in a timely manner; otherwise they won’t be able to pay their bills. This is like you receiving your paycheck each pay period. If you miss a pay period, you may not be able to pay your bills. Remember the last visit you made to your healthcare provider? You were greeted by a receptionist and then shown into the examination room by a healthcare professional such as a nurse or a medical assistant. The office was well stocked with various medical equipment and supplies. The healthcare provider might have given you an injection of medication following the exam. Once complete, the office staff prepared and submitted your medical claim to the insurance company. Your healthcare provider is responsible for paying the medical and administrative staff, rent, utilities, and vendors who provided medical supplies and pharmaceuticals used to treat you. These expenses are paid before your medical insurer repays the healthcare provider for your visit.

The healthcare provider must supply funds to cover expenses until payment is received from your medical insurer. These funds come from various sources:

1. Payments from previous medical insurance claims
2. Short-term bank loans
3. Profit from payment received from previous visits
4. Investors, who are people who provide funds for a chance to share in the profits
5. Personal funds of the healthcare providers
3.6- THE MONEY GAME

Medical insurers make money by investing premiums. A premium is what you pay for medical coverage. The medical insurer take the risks that it will earn more money from investments than it will pay in medical insurance claims. Let’s say that you pay a $100-per-month premium for medical insurance or $1,200 per year. You’re in pretty good health and didn’t have to visit your physician during the year. This means that your medical insurer has $1,200 since it didn’t need to repay a healthcare provider for medical expenses. Over the course of the year, the insurer invested the $1,200 and earned 10%—that’s $12 per month or $820 for the year. The medical insurer gambles that you and its other policyholders as a group won’t incur an average of $1,200 each worth of medical expenses in a year. The gamble pays off if the medical insurer properly sets the premium based on the probability that a particular group of people will require a specific level of healthcare during the year. This simply means that, for example, as a group, racecar drivers will pay more for healthcare coverage than office workers because racecar drivers have a higher probability than office workers of requiring medical care.

Don’t be concerned about premiums and probability because you won’t use it. However, you should be familiar with the concept of time value of money, which is the principle used by medical insurers when investing premiums. Time value of money means that the medical insurer (or anyone who invests) makes more money from its investments the longer the money is invested. In our example, the medical insurer makes $12 per month for each month that it invests your $1,200 premium. Suppose a healthcare provider submits a $8,200 claim to a medical insurer for a patient’s visit. The medical insurer takes a month to process the claim (and earns $12 from the investment). The medical insurer asks the healthcare provider to submit additional supporting documents, which takes another month (and earns $12 from the investment). Once the claim is approved, another month passes until the healthcare provider receives cash (and the medical insurer earns another $12 from the investment).
Notice that the medical insurer in this example earned $36 by not paying the claim within 30 days of receiving the paperwork from the healthcare provider. In practice, the longer the medical insurer delays payment, the more money the medical insurer earns from its investments. However, the longer payment is delayed, the more the patient’s visit costs the healthcare provider. In a negative cash flow, the healthcare provider is paying interest and bank fees on loans. In a positive cash flow, the healthcare provider is forgoing earning money on investments to pay expenses.

Conflicts arise between medical insurers and healthcare providers over the timeliness of payment. Some healthcare providers feel some medical insurers are needlessly delaying payment in order to earn more money from investments. Some medical insurers feel some healthcare providers are performing needless procedures to increase their claims and that therefore claims must be carefully documented and reviewed, which is time consuming.

3.7 - THE PRICING GAME

A healthcare provider can charge any fee for a procedure. However, that doesn’t mean the healthcare provider will be paid that fee. In theory the fee for a product or service reflects that which the consumer of the product or service is willing to pay. For example, a car dealer may charge $100,000 for an automobile, but few—if any—consumers will be willing to pay that amount for the car.

Healthcare providers set their fees based on how medical insurers repay the healthcare provider. The medical insurer is a sophisticated buyer—someone who does homework to determine a fair market price for a product or service. This is like you researching car prices before negotiating a price with a car dealer. Medical insurers study the market carefully and calculate the cost for performing every medical procedure and survey healthcare providers throughout the country to determine the normal fee for each procedure. This information is used by medical insurers to set the reimbursement (repayment) to healthcare providers.
3.8- **SQUEEZING OUT WASTE**

Medical costs increase rapidly. There are numerous reasons given by the medical industry for this rise in fees. Some reasons are true and others are half-truths. Regardless, medical insurers develop ways to reduce reimbursements paid to healthcare providers.

A widely used method is to negotiate with healthcare providers a fixed reimbursement for commonly performed procedures. Healthcare providers who reach terms with a medical insurer become a member of the medical insurer’s network of healthcare providers. Since reimbursement is fixed, medical insurers lower their risk of high reimbursement and therefore can offer better terms if patients receive a procedure from a healthcare provider who is within the medical insurer’s network rather than from a healthcare provider who is out-of-network.

The terms of the agreement with healthcare providers reflect fees that the healthcare provider will be reimbursed by the medical insurer. For example, between 90% and 100% of the fee is reimbursed if the healthcare provider is in-network as compared with 80% if it is out-of-network. The patient pays the difference.

The patient has a financial incentive for using only in-network healthcare providers. Healthcare providers expect to see an appreciable increase in their business if they join the network. However, the healthcare provider might have to lower fees. The medical insurer can reduce the increase in medical cost by negotiating fixed fees, which enables the insurer to offer better terms to employers.

In turn, this attracts more business, generating additional premiums that can be invested. Some medical insurers run health maintenance organizations (HMOs). In many cases, these are healthcare facilities run and operated by the insurer and provide the insurer the opportunity to reduce the expenses of
operating the facility (called operating expenses) by negotiating better prices with suppliers. Patients who use HMOs don’t pay anything for medical procedures other than their premium.

3.9- THE MARKETING GAME

The business of healthcare has undergone a dramatic change in recent years. Healthcare providers can no longer set fees freely because medical insurers may not pay those fees. A healthcare provider can refuse to accept terms set forth by medical insurers; however, there is a high probability that their patients will find a healthcare provider who accepts the medical insurer’s terms rather than pay more than is required for a medical procedure. Many healthcare providers are feeling the squeeze and seeing their incomes drop compared with the time before medical insurers negotiated special terms with healthcare providers. As a result, some healthcare providers have turned to marketing techniques traditionally used by consumer product companies to increase their business—and their income.

No doubt you’ve heard commercials for hospitals that advertise how well they rank among other local hospitals. They go straight to the patient for new business rather than rely on physicians. Traditionally hospitals pitched their services only to physicians who then sent their patients to the hospital for medical procedures. The patients had little choice because their physician was usually associated with one or maybe two local hospitals. Practically all hospitals have negotiated terms with most medical insurers making them an in-network healthcare provider. This means that patients receive the best possible fee according to their medical coverage regardless of the hospital. Likewise, many physicians who are in-network are associated with in-network hospitals. The patient now has the capability to choose which hospital will perform the medical procedure. Hospitals use the airwaves and print media to convince patients that their medical facility is better than other local hospitals. Furthermore, hospitals
and other medical facilities create new or enhanced services and then try to encourage patients to buy those services.

For example in some areas of the country, medical facilities tell patients to undergo a full body scan to find tumors and other abnormalities long before symptoms appear. The full body scan is priced at the cost of a three-week family vacation. The scan is probably not covered by medical insurance because it isn’t medically justified. That is, a physician didn’t recognize symptoms first before ordering the diagnostic test. Consumer marketing techniques overcome this problem by convincing patients to directly pay the cost of the procedure—your life might depend on it. They even offer financing plans. Physicians point out that in rare cases this might be true, but for most people the full body scan is an unnecessary medical procedure unless the patient shows symptoms of a disease. In fact, physicians have said that the body scan is likely to find abnormalities such as growths that normally occur in most people but have no negative effect. However, the patient is likely to incur additional medical procedures if these abnormalities are revealed by the full body scan. And this means more business—and more income—for the facility that performed the full body scan and for physicians who are associated with that facility. Medical insurers likely cover those additional procedures because the discovery of the abnormalities provided the medical reason for further procedures. Healthcare providers are starting to use consumer marketing to increase the number of procedures they perform since a price increase no longer guarantees them a higher income.

3.10-THE EFFECT OF PAYMENT METHODS ON CODING

Long ago and far away, coding began as a systematic method of tracking disease incidence. Its entanglement with reimbursement systems has greatly increased its importance within health care organizations.

For years, the hospital medical record departments where coding occurred were dusty file rooms that existed primarily because of documentation-related
regulatory requirements.

With the implementation of inpatient prospective payment via **Diagnosis Related Groups (DRGs)** in 1983, coding made a difference in reimbursement for the first time. Coders were elevated out of the dark basements into the financial limelight.

Medical record departments were transformed into “**Health Information Management Departments**”.

With the newly focused attention on coding, and the potential dollars to be made from using the “right” codes, came the threats of ethical dilemmas and pressure for coders to contribute to the financial success of their employers.
Questions:

1. A revenue stream is:

   a. A product or service that is bought to bring in revenue.
   b. A product or service that is sold to bring in revenue.
   c. A product or service that is sold to pay premiums.
   d. None of the above

2. Payment by an insurer to a healthcare provider for a claim is called a:

   a. Premium.
   b. Reimbursement.
   c. Differential.
   d. Fee.

3. What you pay to medical insurers for medical coverage is called a:

   a. Premium.
   b. Reimbursement.
   c. Differential.
   d. Fee.

4. The price a healthcare provider charges for a product or service is called a

   a. Premium.
   b. Reimbursement.
   c. Differential.
   d. Fee.
3.1- INTRODUCTION: DIAGNOSIS RELATED GROUPS (DRGs)

Using a system developed by Yale University in the 1970s, reimbursement to hospitals was based on Diagnosis Related Groups (DRGs). Data already appearing on the claim form is used to assign each patient discharge into a DRG:

1. Principal diagnosis.
2. Complications and Comorbidities (CCs).
3. Surgical procedures.
4. Age.
5. Gender.
6. Discharge disposition (died, transferred, went home).

The principal diagnosis, the reason the patient was admitted to the hospital, determines to which Major Diagnostic Category (MDC) the case will be assigned. There are 25 MDCs, based on body organ system or disease:

- MDC 1 Diseases and disorders of the nervous system
- MDC 2 Diseases and disorders of the eye
- MDC 3 Diseases and disorders of the ear, nose, mouth, and throat
- MDC 4 Diseases and disorders of the respiratory system
- MDC 5 Diseases and disorders of the circulatory system
- MDC 6 Diseases and disorders of the digestive system
- MDC 7 Diseases and disorders of the hepatobiliary system and pancreas
- MDC 8 Diseases and disorders of the musculoskeletal system and connective tissue
- MDC 9 Diseases and disorders of the skin, subcutaneous tissue, and breast
- MDC 10 Endocrine, nutritional, and metabolic diseases and disorders
- MDC 11 Diseases and disorders of the kidney and urinary tract
- MDC 12 Diseases and disorders of the male reproductive system
- MDC 13 Diseases and disorders of the female reproductive system
- MDC 14 Pregnancy, childbirth, and the puerperium
- MDC 15 Newborns and other neonates with conditions originating in the perinatal period
- MDC 16 Diseases and disorders of blood, blood-forming organs, immunologic disorders
- MDC 17 Myeloproliferative diseases and disorders, poorly differentiated neoplasms
- MDC 18 Infectious and parasitic diseases, systemic or unspecified sites
- MDC 19 Mental diseases and disorders
- MDC 20 Alcohol / drug use and alcohol / drug induced organic mental disorders
- MDC 21 Injuries, poisonings, and toxic effects of drugs
• MDC 22 Burns

• MDC 23 Factors influencing health status and other contacts with health services

• MDC 24 Multiple significant trauma

• MDC 25 Human immunodeficiency virus infections

Within each MDC, the next partition is based on whether or not a significant procedure was performed, and whether or not the patient had complications or comorbidities. Patient age and length of stay in the hospital may also affect DRG assignment. There are over 500 DRGs. Those without significant procedures are known as “medical” DRGs while those with significant procedures are “surgical” DRGs.

Once a DRG has been assigned, the determination of the reimbursement amount can start. Each DRG has a relative weight assigned to it. Patients in a given DRG are assumed to have similar conditions, receive similar services, and use similar amounts of hospital resources. The prospective payment system is based on paying the average cost to treat patients in that DRG. The DRG weights are adjusted annually. As might be expected, the more complex the DRG the higher the weight.

The DRG for a heart transplant has a weight of more than 19.0, while the DRG for an uncomplicated appendectomy is less than 1.0. In order to calculate the reimbursement rate, the weight for the DRG is multiplied times a base payment amount, which has geographical wage and cost of living factors built in. In addition, if the hospital is a teaching facility it will receive additional Indirect Medical Education funds. If it treats a disproportionate (high) percentage of Medicare patients, it will receive extra funding as a result.
Some patients are known as “outliers”:

This means that the charges for their care greatly exceed the average amount considered normal for a particular DRG. Complications, additional unplanned surgery, or other reasons can cause an outlier. Let’s assume that a patient was admitted for a cholecystectomy (removal of the gallbladder) with exploration of the common bile duct. This case would fall under DRG 196 and the reimbursement amount would be around $9,115 depending on the geographic location of the hospital. In order to get extra payment over and above the $9,115, the patient’s charges would have to total at least $44,200. Until the charges reached that point, the hospital would not get one extra dime. If a patient is admitted because of a heart attack and falls out of bed, breaking his leg, the hospital will not get any additional money for the extra days that patient will spend, unless he eventually becomes an outlier.

Like many other aspects of healthcare reimbursement, the ability to code completely to reach the correct DRG depends largely on physician documentation. Coders are not allowed to make assumptions about what might have been. The presence of laboratory results in a chart indicating the culture of bacteria, or a chest x-ray consistent with pneumonia, cannot be used for coding purposes unless the physician documents their existence. Since documentation under prospective payment systems equals better coding equals higher reimbursement, physicians have been “urged” to improve by including additional complications and comorbidities.

3.2- HEALTHCARE FRAUD AND ABUSE

As funding and reimbursement for healthcare cover less and less of the cost of providing care, the temptation to find “gaps” in the reimbursement systems grows. The United States Department of Health and Human Services (HHS) established a Fraud and Abuse Control Program, effective January 1, 1997. The Office of Inspector General (OIG) carries out nationwide audits, investigations, and inspections, in order to protect the integrity of HHS
programs. OIG has the authority to investigate hospitals, pharmaceutical manufacturers, third-party medical billing companies, ambulance companies, physician practices, nursing facilities, home health agencies, clinical laboratories, hospices, and companies that supply durable medical equipment, prosthetics and orthotics. In other words, almost anybody and everybody associated with healthcare. The OIG can also involve the Federal Bureau of Investigation (FBI) or other federal agencies as needed to assist with investigations.

The HHS OIG is primarily concerned with compliance, which means establishing a business environment that complies with principles of business practice, as identified by the OIG, that are intended to increase the stability of the Medical Trust Fund by reducing fraud and abuse in the claims process.

Fraud can occur due to:

1. Deliberately unethical behavior, or

Civil monetary penalties may be obligatory on corporations or individuals found to have violated federal regulations related to healthcare financial transactions. The maximum civil monetary penalty is currently $10,000 per item or service, with the possibility of triple penalties in some instances. Some of the actions for which civil monetary penalties may be imposed are:

1. Submitting a claim or claims that the person knows (or should know) is for an item or service that is not medically necessary.

2. Failing to provide an itemized statement when requested by a Medicare receiver.

3. Billing for an assistant at cataract surgery.

4. Charging a beneficiary for completing and submitting claim forms.
5. Charging a Medicare beneficiary more than the limiting charge (nonparticipating physicians or suppliers).

6. Hiring an individual who has been excluded from participation in federal healthcare programs. Exclusion from federal healthcare programs can occur as a result of convictions for program-related fraud and patient abuse, licensing board actions, and default on health educational assistance loans. Some of the reasons for exclusion were:

   a. Unproven opiate detox program. The procedure is not medically established; six patients died and others were hospitalized after undergoing the procedure.

   b. False blood tests. The provider used blood drawn from his employees to submit false claims.

   c. Illegal prescription of controlled substances.

One of the ways the OIG gets information on questionable practices is through “whistleblower” suits. Anyone who has information about the practices of a provider can be a whistleblower. In some cases, that individual turns out to be a current or former employee of the organization being investigated. The whistleblower may receive up to 25% of the money the government recovers.

In addition to auditing and investigating providers of services, the OIG also serves as the internal auditor for HHS programs and identifies existing or potential problems with agency financial matters.

3.3- OIG COMPLIANCE GUIDANCE

In response to the large number of identified compliance issues, the OIG began issuing Compliance Program Guidance papers for different types of healthcare entities. They contain seven critical components of an effective compliance program:
1. Implementing written policies, procedures, and standards of conduct.

2. Designating a compliance officer and compliance committee.

3. Conducting effective training and education.

4. Developing effective lines of communication.

5. Enforcing standards through well-publicized disciplinary guidelines.

6. Conducting internal monitoring and auditing.

7. Responding promptly to detected offenses and developing corrective action.

If the healthcare entity implements a compliance program that meets the criteria listed previously, it will be looked upon favorably should a future problem be identified by the OIG, as at least having made the effort.

3.4- WHAT DOES THIS HAVE TO DO WITH CODING?

Think about the implications of a diagnosis or procedure code equal to a certain number of dollars. Is there a huge potential for increasing reimbursement through fraudulent coding? The answer is a most definite “yes.”

A survey of American doctors conducted in 2001 indicated that 39% admitted to having used tactics such as exaggerating symptoms, changing billing diagnoses, or reporting signs or symptoms the patients did not have in order to secure additional services felt to be clinically necessary.

One of the first signs of inappropriate or fraudulent coding is known as “DRG creep”. It can be identified when a hospital’s case mix index, or average of the total of the values assigned to all DRGs for that hospital’s patients, increases from year to year, or when the incidence of high-severity codes is found at a higher level than the incidence of that severity of disease is found in the population. Although it would be nice to think that the increase in higher
weighted DRGs is due to improved physician documentation in the medical record, it can also be due to increased use of specialized expert software systems that identify potential diagnoses that could be used to maximize reimbursement. Once the needed diagnosis is identified, a “query form” can be sent to the physician to see if perhaps he “forgot” to document that condition in the chart. Rules for the use of query forms indicate they cannot lead the physician to document specifically to increase reimbursement.

An analysis of 2002 Medicare inpatient data showed that use of complications and comorbidities had generated an additional $100 million in additional prospective payment system revenue for hospitals in that year. Between 2001 and 2002, the rate of coding a complication or comorbidity
increased in 16 of 99 code pairs studied the first year to increases in 64 of the same 99 pairs reviewed the second year. From 1998 to 1999, none of the 99 pairs showed an increase in the use of complications and comorbidities.

Other abuses are specificity-related. Coders are not supposed to make assumptions about diagnoses based on lab work or other diagnostic results in the chart. Coding is supposed to be based on physician documentation. However, in some facilities a positive culture report was a signal to coders that a bacterial diagnosis could be assigned, even without physician documentation. In January, 2003, a whistleblower suit brought by a coder at a Tennessee hospital alleged a number of DRG coding violations, including specific instructions to coders to up-code or use complications, even without complete chart documentation. The hospital settled for $2 million and the coder whistleblower received $350,000.

Coding is extremely complex. The rules are different, depending on the site of service, and who is submitting a bill. Because there are areas of coding that are open to interpretation, it is often the case that coding errors are mistakes, not intentional. This can be taken into account by investigators if they see "mistakes" but not a "pattern of mistakes".

An example would be investigation by the OIG into the correct assignment of principal diagnosis codes. According to official diagnosis coding guidelines, when a patient has a urinary tract infection, that code is sequenced first, before the code for the organism. If the order of the codes is switched, a higher weight DRG is assigned. If all the cases of this type in a hospital were sequenced improperly, that facility might be charged with intentional fraud.

In another facility, if only a few cases were improperly sequenced, no pattern would be identified and the facility would have to refund money, but it is unlikely that facility would be accused of fraud.

Coders, even in settings such as physician offices, confront ethical
dilemmas on a daily basis. As employees, they want to see their organizations succeed financially. As professionals, they want to adhere to the standards of conduct and ethical principles defined by their professional organizations. Appendix A contains the Code of Ethics of the American Health Information Management Association.

**Unethical coding practices include:**

1. Allowing patterns of retrospective documentation to avoid suspension or increase reimbursement.
2. Assigning codes without physician documentation.
3. Coding when documentation does not justify the procedures that have been billed.
4. Coding an inappropriate level of service.
5. Miscoding to avoid conflict with others.

**3.5- PREVENTIVE MEASURES**

Coding managers and others involved in the process of coding for reimbursement purposes should be pro-active in identifying potential risk areas.

Comparative data is available for all types of facilities to compare their DRG, APC, or other payment category results to national or regional norms.

Using outside auditors to review coding practices and patterns is advisable to increase objectivity.

Billing system edits and payer rejection data are good sources of information to prompt educational efforts for coders.

In June 2004, the OIG published Draft Supplemental Compliance Program
Guidance for Hospitals. It focuses on activities that are most likely to represent a potential source of liability. It includes the following onerous statements:

- “Perhaps the single biggest risk area for hospitals is the preparation and submission of claims or other requests for payment”.

- “Common and longstanding risks associated with claims preparation and submission include inaccurate or incorrect coding, up-coding, unbundling of services, billing for medically unnecessary services or other services not covered by the relevant health care program, billing for services not provided, duplicate billing, insufficient documentation, and false or fraudulent cost reports”.

The need to monitor and improve coding and documentation practices is ongoing and necessary to assure payment accuracy.
Questions:

1. Data appearing on the claim form used to assign patient discharge into a DRG include:
   a. Principal diagnosis.
   b. Gender.
   c. Discharge disposition.
   d. All of the above.

2. DRGs without significant procedures are known as:
   a. Medical DRGs.
   b. Surgical DRGs.
   c. Uncomplicated DRGs.
   d. Complicated DRGs.

3. If the charges for a patient care greatly exceed the average amount considered normal for a particular DRG, such a patient is called:
   a. Outlier.
   b. Claim.
   c. Fraud.
   d. Abused.

4. Reasons for exclusion from federal healthcare programs include:
   a. Unproven program
   b. False blood tests.
   c. Illegal prescription of controlled substances.
   d. All of the above.

5. Unethical coding practices include:
   a. Assigning codes without physician documentation.
   b. Coding an inappropriate level of service.
   c. Miscoding to avoid conflict with others.
   d. All of the above.
Chapter 5
Coding career

INTRODUCTION:

According to the United States Department of Labor, Bureau of Labor Statistics (BLS), job prospects for medical records and health information technicians will grow much faster.

This is one of the few health occupations in which there is little or no patient contact. Average salaries for coders vary by geographic region, size of facility, and type of employer. Entry-level positions are in the $25,000 to $30,000 range.

Individuals, who are experienced, specialized, or supervisors can make as much as $45,000 to $50,000 or more. Working conditions are generally good, in standard office settings.

5.1- REQUIRED ATTRIBUTES:

If you enjoy solving puzzles or reading mysteries, coding is just the thing. Every record you review will be different. Every doctor has different methods of documenting care. New vocabulary appears in response to changing technology. Codes change annually and the rules change periodically as well. Coding is never the “same old same old”. Therefore, coding as a career requires the following attributes:

1. Excellent problem-solving skills.
2. Detail oriented.

3. Excellent reading comprehension.

4. Ability to work independently.

5. Good written / verbal communication skills.


7. Computer literate.

8. Ability to multi-task.

9. Team player.

5.2- CERTIFICATION:

Employers who are hiring coders will be looking for either experience or certification. Although it is possible to start out in a clerical position and work your way up to being a coder, those opportunities are not plentiful. It is not necessary to have a college degree to get a job as a coder, but certification helps.

Two US organizations grant credentials to coders:

1. The American Health Information Management Association (AHIMA):
   
   This association grants the following credentials:
   
   - Certified Coding Associate (CCA).
   
   - Certified Coding Specialist (CCS), and
   
   - Certified Coding Specialist—Physician (CCS-P).
   
   All are based on successful completion of a national exam. All exams require a high school diploma or equivalent and although not required, substantial coding experience is recommended.
Additional information from AHIMA is available at: [http://www.ahima.org](http://www.ahima.org).

2. The American Academy of Professional Coders (AAPC):

This academy grants the following credentials:

- Certified Professional Coder (CPC) and
- Certified Professional Coder—Hospital (CPC-H).

These are also based on a national exam. Candidates must have two years fulltime coding experience. Those without experience may complete the exam but will be designated as apprentices until the required time period is fulfilled.

Additional information from AAPC is available at: [http://aapc.com](http://aapc.com).

A prerequisite for any type of coding certification or study is a thorough knowledge of medical terminology, disease processes, and anatomy and physiology. Courses in these subjects are available at community colleges and trade schools in every state. Many colleges also offer distance learning programs in which classes can be completed at home.
Questions:

1. Coding as a career requires the following attributes:
   a. Excellent problem-solving skills.
   b. Detail oriented.
   c. Excellent reading comprehension.
   d. All of the above.

2. Coding as a career requires the following attributes:
   a. Ability to work independently.
   b. Good communication skills.
   c. Enthusiasm for learning.
   d. All of the above.

3. Coding as a career requires the following attributes:
   a. Computer literate.
   b. Ability to multi-task.
   c. Team player.
   d. All of the above.

4. Which of the following certificates require a two-year coding experience:
   a. Certified Coding Associate (CCA).
   b. Certified Coding Specialist (CCS), and
   c. Certified Coding Specialist—Physician (CCS-P).
d. Certified Professional Coder (CPC).

5. Which of the following certificates do not require a two-year coding experience:

   a. Certified Professional Coder (CPC) and

   b. Certified Professional Coder—Hospital (CPC-H).

   c. Certified Coding Associate (CCA).
Establishing a standard medical language is essential for ensuring continuity of patient care.

6.1- **Medical vocabulary**

It is a system of disease names with explanations of their meanings.

6.2- **Medical classification system**

It is an organization of medical terms into categories.

6.3- **Uses of classification systems**

Classification systems group or categorize healthcare terminology for various uses, which include:

1. Establishing a uniform and standard system for healthcare reimbursement.
2. Providing treatment outcome data for indexing.
3. Determining, collecting, and reporting statistical data.
4. Maintaining a database for clinical, administrative, demographic, and statistical data.
5. Monitoring of fraud, abuse, and other compliance and regulatory issues.
6.4- Classification systems description

Several classification systems (Table 6-1) are commonly used in various healthcare settings.

<table>
<thead>
<tr>
<th>Classification System</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Procedural Terminology (CPT)</td>
<td>Coding system established by the American Medical Association for coding of procedures and services</td>
</tr>
<tr>
<td>Healthcare common procedure coding system (HCPCS)</td>
<td>Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT manual</td>
</tr>
<tr>
<td>International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM)</td>
<td>Coding system used to code and classify diagnoses for inpatient and outpatient encounters and procedures for inpatient encounters</td>
</tr>
<tr>
<td>International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)</td>
<td>Classification system used to permit the systematic recording, analysis, interpretation, and comparison of mortality and morbidity data from different countries and to translate diagnoses, diseases, and other conditions into codes</td>
</tr>
<tr>
<td>International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td>
<td>Coding system used to report diseases and conditions of U.S. healthcare patients</td>
</tr>
<tr>
<td>International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)</td>
<td>Coding system developed to replace Volume 3 of the ICD-9-CM manual</td>
</tr>
<tr>
<td>International Classification of Diseases for Oncology (ICD-O)</td>
<td>Coding system primarily used in tumor or cancer registries for coding the site (topography) and the histology (morphology) of neoplasms</td>
</tr>
<tr>
<td>National drug codes (NDC)</td>
<td>Universal product identifier for human drugs used to identify and report drug products (FDA, 2007)</td>
</tr>
<tr>
<td>Current dental terminology (CDT)</td>
<td>Standardized coding system used to document and communicate data about dental treatment procedures and services to agencies involved in adjudicating insurance claims</td>
</tr>
<tr>
<td>Diagnostic and Statistical Manual of Mental Disorders (DSM)</td>
<td>Standard classification of mental disorders used by mental health professionals in the United States</td>
</tr>
</tbody>
</table>

Table 6.1: Classification systems and their description
6.5- **The Healthcare Common Procedure Coding System (HCPCS):**

The HCPCS is the standardized coding system used to process Medicare and health insurance claims for payment. It consists of two subsystems referred to as Level I and Level II.

**Level ‘I’** is referred to as the **Current Procedural Terminology (CPT)** and associates the descriptions of procedures and services performed by physicians and other healthcare providers with a unique five-digit numeric code. CPT is maintained by the American Medical Association (AMA).

**Level ‘II’**, referred to as the **National Codes**, is an alphanumerical coding system that uses a letter followed by four digits to identify products, supplies, and services that are not provided by physicians and other healthcare providers. These include ambulance services, prosthetics, and medical supplies used outside the healthcare provider’s facility. The Center for Medicare & Medicaid Services (CMS), which is the federal agency that administers Medicare, Medicaid, the Health Insurance Portability and Accountability Act (HIPAA), and other healthcare programs, maintains Level II.

6.6- **Current Procedural Terminology (CPT):**

In 1966 the AMA created the CPT manual (www.ama-assn.org/go/cpt) as a tool for reporting procedures and services. Four years later the CPT grew into three editions, referred to as sections and called Categories I, II, and III. In 1983, the CMS incorporated the CPT into the HCPCS to form a uniform system of reporting procedures and services for billing purposes.

**Category I** contains codes approved by the CPT editorial panel of the AMA and includes the majority of codes. This category is further grouped into sections based on medical specialties such as surgery, and within these sections are procedures and services such as a biopsy. Any physician might be able to perform a procedure or service even though her practice might seem outside the specialty. For example, a dermatologist can perform an incision and drainage of
an abscess, which is a procedure listed in the surgery section of Category I.

**Category II** contains optional measures used to treat a patient such as tracking the patient’s blood pressure, weight management, or tobacco intervention. Category II items are not used for payment because they are part of the physician’s normal evaluation and management of the patient, which is a Category I procedure. Category II is divided into sections each with its own numbering system such as:

- Diagnostic and screening processes or results.
- Therapeutic, prevent, or other interventions.
- Follow-up or other outcomes and patient safety.

**Category III** contains temporary codes used to describe emerging technology, services and procedures that have not been approved by the Food and Drug Administration (FDA) or not regularly performed by healthcare providers. Category III is used for collecting information about those procedures and services rather than for billing.

6.7- **INSIDE THE CPT MANUAL**

The CPT manual has six sections, each having a range of codes (Figure 6.2):

<table>
<thead>
<tr>
<th>CPT Section</th>
<th>Range of codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management</td>
<td>99201–99499</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>00100–01999, 99100–99140</td>
</tr>
<tr>
<td>Surgery</td>
<td>10021–69990</td>
</tr>
<tr>
<td>Radiology</td>
<td>70010–79999</td>
</tr>
<tr>
<td>Pathology and laboratory</td>
<td>80048–89356</td>
</tr>
<tr>
<td>Medicine</td>
<td>90281–99199, 99500–99600</td>
</tr>
</tbody>
</table>

*Figure 6.2: Sections and codes of CPT manual*
The first digits indicate the section. For example, anesthesia codes begin with 0 and surgery codes begin with 1 through 6. This means that surgery has six sections. Each section has its own set of billing rules. At the beginning of each section of the CPT manual are guidelines helpful to a medical insurance specialist. It contains such information as definitions, unlisted services, clinical examples, and tips to make it easy to code. Sections are divided into subsection, subheading, categories, and subcategories under which are the related procedures and services. Descriptions of procedures and services are listed alphabetically followed by the CPT code.

There are two types of CPT codes: **stand-alone** and **indented**. A stand-alone code specifies a procedure or service. A semicolon will follow a stand-alone procedure if an indented code is also available. The semicolon will indicate alternative body sites, procedures, or an extent of service. An indented code modifies the procedure or service. For example, 27846 is a stand-alone code for the open treatment of an ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation. 27848 is an indented code that specifies that the open treatment of an ankle dislocation was performed with repair or internal or external fixation. An indented code appears beneath the related stand-alone code in the CPT manual.

**6.8- CPT TWO DIGIT MODIFIER**

A two-digit modifier can be placed at the end of the code to indicate that something unusual occurred. Let’s say that two surgeons performed the surgery that removed the mass from our patient. One was the primary surgeon and the other was the assisting surgeon. Halfway through the operation, the primary surgeon left the operating room and the assisting surgeon become primary. Each surgeon uses the CPT code to bill for the procedure and uses a modifier to indicate the surgeon’s role in the procedure. For example, modifier -62 indicates a primary surgeon and modifier -80 indicates an assisting surgeon.
Appendix A in the CPT manual lists all modifiers and explains how to use them.

6.9- CODING FOR UNLISTED PROCEDURES

Some procedures and services are listed in the CPT manual usually because they are unusual, experimental, or not widely performed by healthcare providers. At the end of each subsection or heading are codes that can be used for unlisted procedures. For example, a new cardiac surgery procedure is assigned 33999. The last two 9s indicate that this is an unlisted procedure of cardiac surgery. The first three digits indicate the subheading that relates to the unlisted procedure.

6.10-Level II National Codes

National codes are used for procedures and services that are not covered by CPT codes. These include procedures and services performed by dentists, orthodontists, and allied healthcare providers such as ambulance services.

All Medicare and Medicaid claims for non-CPT procedures and services must include a Level II code that identifies the procedure or service.

Many third-party payers also require that a national code be used for non-Medicare and non-Medicaid patients to ensure a uniform system for gathering healthcare data and for billing.

A Level II code (Table 6-3) consists of a letter followed by four numbers. Letters K, G, Q, and S indicate temporary assignment of a procedure or service. For example, K is used for durable medical equipment that hasn’t been assigned a permanent letter, and G is the temporary code for procedures and professional services. Temporary procedures and professional services are usually given a permanent letter when the Level II list is updated annually by the CMS.
Table 6-3 Descriptions of first letters of National Codes

Level II codes are used for outpatient services and not for services provided to patients who are cared for in a healthcare facility. Healthcare facilities use the diagnosis from ICD-9-CM and utilize ICD-9-CM, Volume 3 to code claims. Level II codes are in the HCPCS manual.
Questions:

1. A system of disease names with explanations of their meanings is called:
   a. Medical vocabulary.
   b. CPT system.
   c. HCPCS system.
   d. ICD-10 system.

2. An organization of medical terms into categories is termed:
   a. Medical classification system.
   b. Medical vocabulary.
   c. Medical terminology.
   d. Medical dictionary.

3. Uses of medical classification systems include:
   a. Healthcare reimbursement.
   b. Providing treatment outcome data for indexing.
   c. Statistical data.
   d. All of the above.

4. Uses of medical classification systems include:
   a. Maintaining a database.
   b. Monitoring of fraud and abuse.
   c. Quality support.
   d. All of the above.
5. Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT manual is called:

   
   b. Healthcare Common Procedure Coding System level II.
   
   c. ICD-9-CM.
   
   d. ICD-10-CM.

6. Coding system primarily used in tumor or cancer registries for coding the site and the histology of neoplasms is called:

   
   b. Healthcare Common Procedure Coding System.
   
   c. ICD-9-CM.
   
   d. ICD-O.
7.1- **ICD purpose and uses:**

ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes.
ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion that allows for:

1. Easy storage, retrieval and analysis of health information for evidenced-based decision-making;

2. Sharing and comparing health information between hospitals, regions, settings and countries; and

3. Data comparisons in the same location across different time periods.

Uses include monitoring of the incidence and prevalence of diseases, observing reimbursements and resource allocation trends, and keeping track of safety and quality guidelines.

They also include the counting of deaths as well as diseases, injuries, symptoms, reasons for encounter, factors that influence health status, and external causes of disease.

7.2- History of ICD

The first international classification edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893.

WHO was entrusted with the ICD at its creation in 1948 and published the 6th version, ICD-6, that incorporated morbidity for the first time.

The WHO Nomenclature Regulations, adopted in 1967, specified that Member States use the most current ICD revision for mortality and morbidity statistics.

The ICD has been revised and published in a series of editions to reflect advances in health and medical science over time.
Table 7.1 showed the history of ICD versions

<table>
<thead>
<tr>
<th>Revision</th>
<th>Years Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>1900-09</td>
</tr>
<tr>
<td>2&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1910-20</td>
</tr>
<tr>
<td>3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1921-29</td>
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<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1930-38</td>
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<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1939-48</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1949-57</td>
</tr>
<tr>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1958-67</td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1968-78</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1979-98</td>
</tr>
<tr>
<td>10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1999-present</td>
</tr>
</tbody>
</table>

Table 7.1: ICD versions

ICD-10 was endorsed in May 1990 by the Forty-third World Health Assembly. It is cited in more than 20,000 scientific articles and used by more than 100 countries around the world.

The ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. WHO has authorized the development of
an adaptation of ICD-10 for use in the United States for U.S. government purposes. As agreed, all modifications to the ICD-10 must conform to WHO conventions for the ICD. **International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** was developed following a thorough evaluation by a Technical Advisory Panel and extensive additional consultation with physician groups, clinical coders, and others to assure clinical accuracy and utility.

It is important to note that in the United States, ICD-10 consists of two parts: ICD-10-CM for diagnosis coding and the **International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)** for inpatient procedure coding.

A version of ICD-11 was released on 18 June 2018 to allow Member States to prepare for implementation, including translating ICD into their national languages. ICD-11 will be submitted to the 144th Executive Board Meeting in January 2019 and the Seventy-second World Health Assembly in May 2019 and, following endorsement, Member States will start reporting using ICD-11 on 1 January 2022.

For diagnosis coding, you need to open the websites for ICD-9 and ICD-10: In your browser, write these two addresses:

[http://icd9.chrisendres.com](http://icd9.chrisendres.com) (Figure 7.1)

[https://icd.who.int/browse10/2016/en](https://icd.who.int/browse10/2016/en) (Figure 7.2)
Figure 7.1: ICD-9 webpage

Figure 7.2: ICD-10 webpage
Alternatively, you can use the uploaded excel files:

- ICD-9 Diagnosis code.
- ICD-10 Diagnosis code

General Coding Guidelines (ICD-9):

These guidelines tell coding analysts the basic information they need to code correctly, based on physician documentation.

1. Use both the alphabetic index (Figure 7.3) and the tabular list (Figure 7.4) when locating and assigning a code.

**Figure 7.3: Alphabetic index**

**Figure 7.4: Tabular index**
2. Locate each term in the alphabetic index and verify the code selected in the tabular list. Read and be guided by instructional notations.

3. Valid diagnosis codes may have 3, 4, or 5 digits. A 3- or 4-digit code may only be used if it is not further subdivided. Example: “481 Pneumococcal pneumonia” (Figure 7.5) may be used because it is not further subdivided. “482 Other bacterial pneumonia” (Figure 7.6) may not be used because it is further subdivided into 4 and 5 digit codes (Figure 7.7).

![Figure 7.5: Code 481](image1)

![Figure 7.6: Code 482](image2)

![Figure 7.7: Code 482 subdivisions](image3)
4. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable if a definitive diagnosis has not been established by the physician. Example: 780.2 Syncope (fainting) is a symptom code (Figure 7.8). It may be used if the physician does not identify and document a diagnosis responsible for the fainting.

5. Signs and symptoms that are an integral part of a disease process should not be assigned as additional codes. Example: Fluid overload is integral to congestive heart failure and would not be coded separately (Figure 7.9).

6. Signs and symptoms that may not be associated routinely with a disease process should be coded when present.

7. Some single conditions may require more than one code for a full
description. Generally, one code is for the etiology and one for the manifestation of the disease. Instructions, such as “code first”, “use additional code”, “code, if applicable, any causal condition first,” guide the coder. Additional situations requiring more than one code are related to late effects, complications, and obstetrical cases.

8. When a condition is described as both acute and chronic, code both. Example: Acute sinusitis is 461.9 (Figure 7.10). Chronic sinusitis is 473.9 (Figure 7.11). Both codes would be used for “Acute and chronic sinusitis.”

9. Combination codes are single codes used for a combination of two diagnoses, or a diagnosis with an associated manifestation or complication. Do not use multiple codes if a combination code describes all of the elements. Example: Acute cholecystitis is 575.0 (Figure 7.12). Chronic cholecystitis is 575.11 (Figure 7.13). Acute and chronic cholecystitis is 575.12 (Figure 7.13). Only 575.12 would be used to describe both.
10. A late effect is the residual effect after the acute phase of an illness or injury has terminated. There is no time limit as to when a late effect code can be used. The residual condition is coded first. Example: “907.2 Late effect of spinal cord injury”, could be used as an additional code if a patient was being seen for neurogenic bladder.

Abbreviations present in ICD-9-CM:
1. **NEC (Not elsewhere classifiable):** Detail in medical record is specific, but a specific code is not available. Same as “other specified”.

2. **NOS (Not otherwise specified):** Same as unspecified. Information in medical record is not sufficient to assign a more specific code (Figure 7.9).

3. **X:** Used as a placeholder in codes where additional information is needed to assign a specific 4th or 5th digit.

**Converting ICD-9 code to ICD-10 code:**

This can be done using the following websites:

- For diagnosis (Figure 7.15): [https://icd.codes/convert/icd9-to-icd10-cm](https://icd.codes/convert/icd9-to-icd10-cm)

![Figure 7.15: ICD-9 to ICD-10 code conversion for diagnosis](image)

- For procedures (Figure 7.16):
  [https://icd.codes/convert/icd9-to-icd10-pcs](https://icd.codes/convert/icd9-to-icd10-pcs)

![Figure 8.16: ICD-9 to ICD-10 code conversion for procedure](image)

**Examples from previously used codes:**

Look carefully at the following examples to see the difference between...
the two versions as regards the code itself and the disease terminology.
Figure 7.21: Converting code 482.3

Figure 7.22: Converting code 482.4

Figure 7.23: Converting code 482.8

Figure 7.24: Converting code 482.9

Figure 7.25: Converting code 575.0
Figure 7.26: Converting code 575.11
Chapter 8
Procedure coding

- Medical coding
  - Diagnosis
    - ICD
  - Procedure
    - Hospital Inpatients
    - All others
      - Physician bill
        - ICD
      - CPT/HCPCS
    - Facility bill
      - ICD
      - CPT/HCPCS
8.1- **Procedure coding**

In addition to the patient’s diagnosis, the other pieces of information associated with every healthcare encounter are the procedure codes, the dates the procedures were performed, the location in which they were performed, and the physician or other provider who performed them.

The term “procedure coding” encompasses a wide variety of services to patients:

- Surgery: operative treatment of disease or injury.
- Anesthesia: the process of blocking pain or other perceptions.
- Radiology: the use of imaging modalities for diagnosis, interventional techniques, or radiation therapy for treatment.
- Laboratory: testing performed on biological specimens to get information about the health of a patient.
- Pathology: diagnosis of disease based on the gross and microscopic examination of cells and tissues.
- Diagnostic testing: non-lab, non-radiologic testing to arrive at a diagnosis.
- Evaluation and management: “visits” to evaluate patients and manage their care.
- Psychiatric: treatment of mental or emotional disorders.
- Osteopathic: branch of medicine that uses manipulative techniques to supplement treatment of disease.
- Chiropractic: focuses on spinal function to improve health.
- Rehabilitation: physical, occupational, speech, and other therapies to improve functioning.
- Alternative: diagnostic or treatment methods with theoretical bases that differ from conventional medicine, such as acupuncture.
- Preventive: actions, such as vaccinations, to prevent disease or injury.

All types of providers, whether facilities or individual practitioners, use ICD-9 CM diagnosis codes. This is not true for procedure or supply codes. The
type of billing code used depends on several factors:

- Location or site of service where the procedure was performed.
  - Type of charge being coded:
    - Professional
    - Facility
    - Dental
    - Durable medical equipment, prosthetics, or supplies
    - Drugs and biologics

8.2- Hospital Procedures vs. Doctor’s Procedures

As a case study, let’s assume that you have always been in good health, but that over the past weekend, you started having pain in your stomach region. It started near your navel and then became more and more severe as it moved toward the lower right side of your abdomen. You decided to go to the emergency room. After the exam and some lab work, the doctor decided that you had appendicitis. A surgeon was contacted and you were taken to the operating room for an appendectomy, or removal of your appendix. From the time you entered the emergency room to the time you were discharged home after recuperation from your surgery, the hospital maintained a medical record documenting every occurrence during your stay. In addition to documentation by the emergency room physician and the surgeon, your medical record also includes notes by the nursing staff, orders from physicians, reports of the results of diagnostic testing such as the lab work, administrative paperwork such as consent forms, visits by allied health personnel such as the dietitian, your vital signs, and details such as whether or not you went to the bathroom. The surgeon who removed your appendix will also start a medical record for you at his office, even though you have not yet been there. At this point, it will probably contain a copy of the operative report dictated by the surgeon for the hospital record and a copy of the hospital “face sheet” of demographics with your name, address, and insurance information. When you visit the surgeon for a follow-up visit after your surgery, he will add a progress note to his office chart. After you
are discharged from the hospital, your medical record will be processed by the Health Information Department of that facility. It will be assembled into a standard order, checked for missing documentation and signatures, placed in a folder, and the diagnoses and procedures coded. In an increasing number of hospitals, all of the documentation is maintained electronically, lessening the need for, and reliance on, paper. As a patient, you are issued a unique number under which all of your health information is maintained. These numbers are specific to a facility or chain of facilities only; they are not used across organizational boundaries, with a few exceptions. Known as a patient number, or medical record number, or patient identifier, this unique number follows you throughout your care. Patients who are admitted to the hospital as an inpatient generally receive a wristband with their name and medical record number. This is used to prevent identity errors and resulting incorrect medication administration, wrong surgery, or lab specimen errors. Medical coding analysts will look at your record in order to assign ICD-9-CM diagnosis codes to your diagnosis “acute appendicitis,” and they will also assign ICD-9-CM procedure codes to your procedure “appendectomy.” They may also check the results of the surgical pathology examination of your appendix to determine whether or not you actually had appendicitis. The diagnosis code and procedure code will be routed to the hospital business office where a bill will be generated for the facility charges incurred during your stay. If you have insurance, a claim form with the diagnosis and procedure codes will be sent to that payer for reimbursement. Meanwhile, the surgeon is also interested in getting paid. While the surgeon’s claim form to your insurance company will usually contain the same ICD-9-CM diagnosis codes used by the hospital, the procedure code will be different. Current Procedural Terminology, also known as CPT, will be used by the surgeon.

8.3- **Hospital Procedure Coding**

Remember that coding started as a way to categorize deaths. It evolved into a method of indexing hospital diagnoses and procedures in order to assess
the healthcare status and needs of the living. The first advocate of hospital statistics was Florence Nightingale, the famous nurse. While serving in a battlefront hospital during the Crimean War of the 1850s, she observed that far more soldiers died of disease than of war injuries. Her relentless efforts to improve sanitation reduced the mortality rate in her hospital from 40% to 2% in one year. When she returned to England after the war, she submitted a statistical report to the British government, hoping to convince them that improvement of sanitary conditions in local hospitals would also reduce deaths. The government refused to allow her to publish her data. She persisted, using Army data already available, informing the public of her cause. When she began her campaign, life expectancy in England was 39 years. When she died 50 years later in 1910, it had risen to 55, at least in part due to her efforts. Before 1960, hospitals used various systems to index procedures. With the manual methods in use at that time, “indexing” literally meant using index cards. A card was set up for each procedure code or category, and the medical record numbers of patients who underwent that procedure were written on the card, along with the date of the procedure. At the same time, statistical reports were prepared showing how many of various procedures were performed monthly or annually. If researchers needed information on cases from a particular procedure category, the medical records could be pulled based on the information in the indexes. The first revision of the International Classification of Diseases (ICD) that contained procedure codes was a version of ICDA-7 issued by the United States Public Health Service in 1959. It contained procedure codes up to three digits. ICDA-8, also with three-digit codes, was used from 1970-78 and ICD 9-CM from 1979 to the present. The latter classification was expanded to 4-digit codes for procedures. Concurrent with the development of consistent procedure coding systems was the initiation of the Uniform Hospital Discharge Data Set (UHDDS). Although vital statistics data, such as births, deaths, and marriages, had uniform definitions in the United States, there was no agreement before 1973 on what data should be collected and reported by hospitals. The National Center for Health Statistics collected hospital data, but the emphasis was on the
institutions’ overall activities, not the problems of their patients. The statistics described how busy they were, but not what they were accomplishing in the way of patient care.4 An amendment to the Public Health Act in 1974 made the National Committee on Vital and Health Statistics a statutory body and required that there be an annual report to Congress on the health of the American people. Health United States 19755 was a hit with the press. It reported in one place, for the first time, 603 pages of health-related data, such as the average physician fee for an initial office visit ($12.17 for a pediatrician and $17.62 for a surgeon), and the average net income of physicians ($43,570 for a pediatrician and $62,320 for a surgeon). Hospital discharge data by diagnostic category was skimpy, and there was no information about hospital procedures except for the number of hospitals reporting various types of services, such as burn units, home care, renal dialysis, and blood banks. Currently, the UHDDS Procedure Code Guidelines, developed in 1973 and revised in 1985, govern the types of procedure code data collected on hospital inpatients. Additional rules developed by Medicare with the advent of its Prospective Payment System come into play because of the link between procedure coding and reimbursement.

8.4- Physician Procedure Coding

Prior to 1981, there were a number of different systems used to code physician procedures. There was no requirement that a code number be submitted with a claim for payment, so many physicians merely submitted a verbal description of what they had done. This required the insurance companies to figure out what some of the arcane descriptions meant before they could decide how much to pay. When Medicare was enacted in 1965, physicians looked for a better system to report their services. What better group to design a physician coding system than their own professional organization, the American Medical Association (AMA)? The first edition of Current Procedural Terminology (CPT) was published by the AMA in 1966. Primarily containing surgical procedure codes, with smaller sections on medicine, laboratory, and radiology, it consisted of four-digit code numbers. Expansion of CPT led to.

- The addition of modifiers for further specificity in reporting in CPT-3 (1973).

- The inclusion of additional codes for new technology in CPT-4 (1977).

In 1992, the Evaluation and Management (E&M) codes were added to describe cognitive efforts involved with non-surgical services. CPT is updated annually to reflect changes in medical and surgical services. In 1983, the federal government entered into an agreement with the AMA that CPT would be the mechanism for reporting physician services under Medicare. As is usually the case, other payers follow Medicare procedures and by 1990 CPT had become the single uniform system for reporting of physician services. Today it is estimated that over 95% of services provided by physicians are reported using the CPT coding system. While ICD-9-CM is a system in the public domain, CPT remains a proprietary system owned and operated by the AMA. It is not possible to obtain a copy of CPT without purchase.

There are a number of additional professional services place of service or location codes for places where a facility would not be submitting a bill to a federal payer including School, Homeless shelter, Doctor’s office, Assisted living facility, Group home, Military treatment facility, Nursing facility, Custodial care facility, Residential substance abuse treatment facility, and Psychiatric residential treatment center.

The location or place of service is important in coding because many payers have different reimbursement schedules, co-pay amounts, or coverage limitations depending on where the service is provided.

The Evaluation and Management (E&M) codes in CPT are defined based on location:

- Hospital inpatient
- Office or other outpatient
- Hospital observation
- Emergency department
- Nursing facility (skilled, intermediate, long term care, psychiatric, residential treatment center)
- Boarding home or custodial care
- Home (private residence)

8.5- ICD-9-CM Procedure Coding Guidelines (Hospital Inpatients Only)

UHDSS guideline states that procedure codes and dates of all significant procedures are to be reported. The identity (number) of the person performing the procedure must also be reported.

What is a “significant procedure”?

One or more of the following:

1. Surgical in nature
   - Incision
   - Excision
   - Amputation
   - Introduction
   - Endoscopy
   - Repair
   - Destruction
   - Suture
2. Carries a procedural risk
   a. Professionally recognized risk that a procedure may potentially cause body impairment, injury, disease, or death
   b. Trauma risk—procedures that are invasive, able to produce tissue damage, or introduce toxic or noxious substances
   c. Physiologic risk—procedures that use any drug or physical substance that can affect the body
   d. Any procedure using pre- or post-operative medications
   e. Procedures that use long-life radioisotopes

3. Carries an anesthetic risk
   a. Any procedure using general anesthesia
   b. Any local, regional, or other type of anesthesia causing functional impairment that requires care in usage to protect the patient from harm

4. Requires specialized training
   a. Specialized professionals, qualified technicians, or clinical teams specifically trained for the performance of the procedure

8.6- How to Locate a Procedure

The method for finding a procedure in ICD-9-CM is the same as that for ICD-9-CM diagnosis coding. There is an alphabetical index and a tabular list for verification. Many procedures are eponymic, named after the surgeon who developed the procedure. If no entry in the alphabetical index is found under
the eponymic name for the operation, it is necessary to read the operative report to identify the type of procedure and then search the index for the procedure with the technique or methods most closely approximating the eponymic procedure.

Examples will be illustrated for ICD-9 and ICD-10 using the relevant website as well as the excel sheet:

![Figure 8.1: ICD-9 webpage](image)

You can search for a procedure using the items listed on the left side using either tabular or alphabetic indices or typing a search procedure directly as shown in figure 8.1.

Suppose you need to find the code for laparoscopic cholecystectomy, you can search for the word laparoscopic cholecystectomy directly or by entering another key word like gallbladder.
Searching for the same procedure in ICD-10 is shown in Figure 8.3-8.5

Open website: https://www.icd10data.com/ICD10PCS/Codes

Figure 8.3: Convert the code of laparoscopic cholecystectomy from ICD-9 to ICD-10 by writing the code 51.23 which we know already from the previous example and click convert codes.
Instead of laparoscopic cholecystectomy, you’ll find “Resection of Gallbladder, Percutaneous Endoscopic Approach”. This example illustrates the difficulty you might face as a coder to find a procedure code.

Searching offline using excel sheet

1- ICD-9:

Open the file “ICD-9 Procedure code”

Press on the keyboard on control + F simultaneously

On the screen that will appear write: laparoscopic cholecystectomy

Press “find all” (Figure 8.6)
Figure 8.6: Searching for laparoscopic cholecystectomy in ICD-9 Excel sheet

Click “close” and the code will appear (Figure 8.7).

Figure 8.7: ICD-9 Excel sheet searching result

2- ICD-10

Open the file “ICD-10 Procedure code”. The interface is illustrated in figure 8.8
Figure 8.8.: ICD-10 procedure code interface

Press on the keyboard on control + F simultaneously

On the screen that will appear write: laparoscopic cholecystectomy

Press “find all”

Again, nothing will be found (Figure 8.9)

Figure 8.9: Results for finding nothing in ICD-10 excel sheet

So, again, you’ll write gallbladder, a list will appear (Figure 8.10).
Figure 8.10: Results for gallbladder in ICD-10 excel sheet

Press on “close” and navigate to find what you’re looking for
Most healthcare coding problems affecting patients become evident under two circumstances:

1. Patients are denied for insurance, or

2. Patients are denied by insurance.

Get a Life

When you apply for life insurance, the standard application form includes a space for your signature authorizing the company to check your medical information from various sources. One of those sources may be the Medical Information Bureau (MIB, Inc.) It is an association of more than 500 US and Canadian life insurance companies, organized in 1902. It describes its core fraud protection services as protecting “insurers, policyholders, and applicants from attempts to conceal or omit information material to the sound and equitable underwriting of life, health, disability, and long term care insurance.”

MIB maintains a database of individuals who have applied for insurance. The database includes information on about 230 medical conditions that indicate the applicant’s risk. In addition, other data such as hazardous occupations or adverse driving records are included. When you apply for insurance, the company, with your authorization in hand, can check to see if you have an MIB record, and if so, what your risk factors are. Likewise, if you have an exam in conjunction with your application, information from that exam such as high blood pressure or an abnormal EKG can be added to your MIB record. You may
obtain a copy of your MIB record. There is a small fee for the record, unless you have been turned down for insurance based on MIB as an information source.

For the Record

If you think that medical information about you is incorrect, you probably need to obtain a copy of your medical record. The Federal Health Insurance Portability and Accountability Act (HIPAA) requires health-care providers, health plans, and healthcare clearinghouses to allow you access to your medical records. There is often a fee for copying medical records. It may be more economical to review the record in person at the doctor’s office, hospital, or other facility and then request copies of only the relevant information you need.

Some of the parts of your record that can be helpful in addressing errors or incorrect bills are:

1. Face sheet.

   This form is usually found on inpatient hospital records. It contains your demographic information such as date of birth, address and phone number, insurance policy numbers, and the dates of your admission and discharge. More important, it also contains the principal and other diagnoses, the principal and other procedures, and the diagnosis and procedure codes that were assigned by the hospital. These codes should match up with the codes submitted on claim forms to your insurance company.

2. Doctors’ orders.

   Nothing can be done to you or for you without a doctor’s order. Physicians order tests, treatments, medications, diets, and nursing interventions such as vital signs or dressing changes. If you are disputing charges on a bill, checking what was billed against the orders in the record may disclose errors.
3. Operative report.

If you had surgery, the surgeon is required to document the type of operation, the technique used, operative findings, complications, and estimated blood loss. The description of the procedure in the operative report should match the description of the procedure code for which you were billed. If more than one procedure was performed, payers may invoke bundling rules that define which procedures will be paid and which won’t.

4. History and Physical.

This report, known as the “H&P” is the initial assessment of your physical and emotional status as you enter the hospital. It could be important in issues related to medical necessity. Were you sick enough to require hospitalization and the treatments that were ordered?

5. Discharge Summary.

An account of your hospital course, this report is where the doctor makes his final statement about your diagnoses and procedures and also where plans for your ongoing treatment or follow-up are documented. The diagnoses and procedures here should match up with the face sheet and with any claims submitted to your payer.

How Do Coding Errors Occur?

Medical coding analysts are involved in constant decision-making. Is it this diagnosis or that? Which diagnosis should be principal? Was the procedure bilateral? Did the physician document enough time to code critical care? Even the task of deciphering physician handwriting involves deciding what was actually documented.

There are two types of errors coders make during decision-making:
1- Performance errors:

Misreading words, missing details important to the code assignment, failing to pull together details from various parts of the record, transposing digits in code numbers.

2- Systematic errors:

Lack of sufficient medical knowledge to understand the documentation, lack of knowledge of or misapplication of coding rules. Although coding without physician documentation flies in the face of compliance guidance, offices and facilities in a hurry to keep their cash flow moving will code with only parts of the record complete. For example, a pathology report with the ultimate diagnosis for a surgical specimen may not be available for a week after the surgery. If the patient has been discharged, the hospital will be interested in getting its bill out right away. Coding may be based on the surgeon’s post-operative diagnosis, and if the surgeon is wrong, the diagnosis could be something different once the pathology report is available. In the CPT realm, the coding of excision of skin lesions depends on whether or not the lesion is cancerous, so coding before the pathology report is available could lead to inaccurate codes and inappropriate reimbursement.

Coders rely heavily on reports that are transcribed from the physician’s dictation. If errors are made in transcription, they can also result in incorrect coding.

When EOB = No reimbursement:

Your first inkling that your insurance is denying or rejecting a claim for your treatment is usually when you receive an Explanation of Benefits (EOB) from your payer. It tells you what was billed, what has been approved, what has been paid, and what you have to pay. If a claim or part of a claim was rejected, the EOB will use a reason code to tell you why. The problem with the reason codes is that When EOB = No $, they are not always specific enough to identify
the actual problem. Here is an example “Claim lacks information needed for adjudication.” You are shaking your head and asking “what information?” As you investigate the cause of the rejection and work to obtain payment for the claim, it is essential that you maintain a record of your contacts and correspondence:

1. Set up a file folder for each provider. If you don’t have file folders, even just a folded piece of paper with the provider’s name on the outside can help keep your documents in order.

2. Make sure you keep all of the EOBs, even if it does not indicate a rejection. They can be useful if you are later involved in a dispute about the bill for service. When you receive bills from providers, put them in the appropriate folder, by date. If you pay the bill in person or send a check, keep any receipts or cancelled checks or credit card statements attached to the corresponding bill.

3. When you are involved in discussions with provider business offices or insurance company customer service centers, make a note of the date and time of your call, and the specific name of the individual with whom you speak.

4. Keep copies of letters or other correspondence you send to providers or insurers.

All of these materials may be needed in backing up future appeals if your initial efforts are not successful.

1. Contact the Provider

As a first step after receiving a rejection or denial, it is advisable to contact the healthcare provider who submitted the claim. Sometimes you will receive your EOB before the provider gets their remittance advice, so it is possible they may not be aware of your problem.
The provider’s business office should be able to help you analyze the rejection and let you know whether they plan to appeal. Their staff may be better at figuring out why the claim was rejected than you, so it is worth a phone call.

Inconsistencies and omissions are obvious provider errors in claims submissions. Some of the coding-related rejection reasons the provider should be able to fix and re-submit are:

1. Missing data elements, such as diagnosis code, procedure code, date of service
2. Incorrect data elements, such as diagnosis or procedure codes not valid on the date of service (remember that all coding systems change at least annually)
3. Inconsistent data elements such as diagnosis or procedure codes that do not match with your gender or age. It is also possible for a procedure code to be inconsistent with the place of service, such as an inpatient code used in a doctor’s office
4. Incorrectly used data elements, such as modifiers that do not go with the type of procedure code used
5. Requested documentation not sent; the provider must send copies of your medical record when requested, for review and approval. Ask for an itemized bill for the episode of care containing denied services. Contact the Insurer or other Third-Party Payer if the rejection is for a reason other than a provider error; contact the insurer to discuss the reason for the rejection.

Rejections of this type are:

Procedures can be non-covered for a variety of reasons. It can be due to the specific plan you have, due to the place where the service was provided, or due to the type of provider giving the service. Routine or screening examinations and preventive services are often not covered. The procedure code for the denied service and the diagnosis should be verified.

2. **Medical necessity.**

Insurance companies pay for procedures and tests that are intended to improve your condition. They do not cover cosmetic procedures or experimental procedures and may have defined lists of diagnoses for which various procedures are indicated. If your doctor uses a diagnosis not on the list, the claim will not be paid. This can be a coding problem because the documented diagnosis may not have been coded to the appropriate level of specificity, thus causing the denial.

3. **Frequency limits.**

Some services are only covered up to a limited number of times within a specified time period. Rejections of this type can be coding problems if an error has been made, for example, in coding the number of chest x-rays you had on a given date. In interactions with insurance companies, it is important to use the term “appeal.” If you use the term “complaint,” there may not be an associated time limit within which the company is required to respond. However, with an appeal, a legally-mandated time frame is usually present. Request an Internal Review if you are not satisfied with the results communicated to you by your payer, you may request an internal review. This process varies from payer to payer. You will usually have to complete a formal appeal form and submit it. There may be a time limit for appeals, so make sure you find out how soon you are required to appeal. Employer-sponsored health plans are required to allow you at least 180 days to appeal. At this point, it may also be helpful to involve others in your efforts. The Human Resources department of your employer may be able to assist you in negotiating with the payer. Your employer contracts with
the payer to provide coverage, so your employer has a vested interest in making sure its employees are receiving appropriate coverage and service. If you are a senior citizen, every state has a Senior Health Insurance Assistance Program to help people with insurance problems.

4. Request an External Review

Once you have exhausted the internal review process of your payer, in most states you can request an external review. There are often rules about what type of issue can be appealed. Medical necessity cases are the norm. It may also be a requirement that the amount of money in question meet a certain threshold, such as $100 or $500. A helpful website containing information about insurance appeals and various state regulations is the Kaiser Family Foundation at www.kff.org/consumerguide.

5. Contact Provider Again

If all else fails, contact the provider once again and explain your situation. Ask if they would consider lowering the price of the denied procedure, service, supply, or drug so that you will have to pay less out of pocket.
Appendix
AHIMA code of ethics

Preamble

The ethical obligations of the health information management (HIM) professional include the safeguarding of privacy and security of health information; disclosure of health information; development, use, and maintenance of health information systems and health information; and ensuring the accessibility and integrity of health information.

Healthcare consumers are increasingly concerned about security and the potential loss of privacy and the inability to control how their personal health information is used and disclosed. Core health information issues include what information should be collected; how the information should be handled, who should have access to the information, under what conditions the information should be disclosed, how the information is retained and when it is no longer needed, and how is it disposed of in a confidential manner. All of the core health information issues are performed in compliance with state and federal regulations, and employer policies and procedures.

Ethical obligations are central to the professional’s responsibility, regardless of the employment site or the method of collection, storage, and security of health information. In addition, sensitive information (e.g., genetic, adoption, drug, alcohol, sexual, health, and behavioral information) requires special attention to prevent misuse. In the world of business and interactions
with consumers, expertise in the protection of the information is required.

Purpose of the American Health Information Management Association
Code of Ethics

The HIM professional has an obligation to demonstrate actions that reflect
values, ethical principles, and ethical guidelines. The American Health
Information Management Association (AHIMA) Code of Ethics sets forth these
values and principles to guide conduct. (See also AHIMA Vision, Mission, Values)
The code is relevant to all AHIMA members and CCHIIM credentialed HIM
professionals [hereafter referred to as certificants], regardless of their
professional functions, the settings in which they work, or the populations they
serve. These purposes strengthen the HIM professional’s efforts to improve
overall quality of healthcare.

The AHIMA Code of Ethics serves seven purposes:

- Promotes high standards of HIM practice.
- Identifies core values on which the HIM mission is based.
- Summarizes broad ethical principles that reflect the profession’s core
  values.
- Establishes a set of ethical principles to be used to guide decision-making
  and actions.
- Establishes a framework for professional behavior and responsibilities
  when professional obligations conflict or ethical uncertainties arise.
- Provides ethical principles by which the general public can hold the HIM
  professional accountable.
- Mentors practitioners new to the field to HIM’s mission, values, and ethical
  principles.
The code includes principles and guidelines that are both enforceable and aspirational. The extent to which each principle is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical principles.

**Code of Ethics Principles**

**The Code of Ethics and How to Interpret the Code of Ethics**

**Principles and Guidelines**

The following ethical principles are based on the core values of the American Health Information Management Association and apply to all AHIMA members and certificants. Guidelines included for each ethical principle are a non-inclusive list of behaviors and situations that can help to clarify the principle. They are not meant to be a comprehensive list of all situations that can occur.

1. **Advocate, uphold, and defend the individual’s right to privacy and the doctrine of confidentiality in the use and disclosure of information.**

   A health information management professional shall:

   1.1- Safeguard all confidential patient information to include, but not limited to, personal, health, financial, genetic, and outcome information.

   1.2- Engage in social and political action that supports the protection of privacy and confidentiality, and be aware of the impact of the political arena on the health information issues for the healthcare industry.

   1.3- Advocate for changes in policy and legislation to ensure protection of privacy and confidentiality, compliance, and other issues that surface as advocacy issues and facilitate informed participation by the public on these issues.

   1.4- Protect the confidentiality of all information obtained in the course of
professional service. Disclose only information that is directly relevant or necessary to achieve the purpose of disclosure. Release information only with valid authorization from a patient or a person legally authorized to consent on behalf of a patient or as authorized by federal or state regulations. The minimum necessary standard is essential when releasing health information for disclosure activities.

1.5- Promote the obligation to respect privacy by respecting confidential information shared among colleagues, while responding to requests from the legal profession, the media, or other non-healthcare related individuals, during presentations or teaching and in situations that could cause harm to persons.

1.6- Respond promptly and appropriately to patient requests to exercise their privacy rights (e.g., access, amendments, restriction, confidential communication, etc.). Answer truthfully all patients’ questions concerning their rights to review and annotate their personal biomedical data and seek to facilitate patients’ legitimate right to exercise those rights.

II. **Put service and the health and welfare of persons before self-interest and conduct oneself in the practice of the profession so as to bring honor to oneself, peers, and to the health information management profession.**

A health information management professional shall:

2.1- Act with integrity, behave in a trustworthy manner, elevate service to others above self-interest, and promote high standards of practice in every setting.

2.2- Be aware of the profession’s mission, values, and ethical principles, and practice in a manner consistent with them by acting honestly and responsibly.
2.3- Anticipate, clarify, and avoid any conflict of interest, to all parties concerned, when dealing with consumers, consulting with competitors, in providing services requiring potentially conflicting roles (for example, finding out information about one facility that would help a competitor), or serving the Association in a volunteer capacity. The conflicting roles or responsibilities must be clarified and appropriate action taken to minimize any conflict of interest.

2.4- Ensure that the working environment is consistent and encourages compliance with the AHIMA Code of Ethics, taking reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the code.

2.5- Take responsibility and credit, including authorship credit, only for work they actually perform or to which they contribute. Honestly acknowledge the work of and the contributions made by others verbally or written, such as in publication.

A health information management professional shall not:

2.6- Permit one’s private conduct to interfere with the ability to fulfill one’s professional responsibilities.

2.7- Take unfair advantage of any professional relationship or exploit others to further one’s own personal, religious, political, or business interests.

III. Preserve, protect, and secure personal health information in any form or medium and hold in the highest regards health information and other information of a confidential nature obtained in an official capacity, taking into account the applicable statutes and regulations.

A health information management professional shall:

3.1- Safeguard the privacy and security of written and electronic health information and other sensitive information. Take reasonable steps to
ensure that health information is stored securely and that patients’ data is not available to others who are not authorized to have access. Prevent inappropriate disclosure of individually identifiable information.

3.2- Take precautions to ensure and maintain the confidentiality of information transmitted, transferred, or disposed of in the event of termination, incapacitation, or death of a healthcare provider to other parties through the use of any media.

3.3- Inform recipients of the limitations and risks associated with providing services via electronic or social media (e.g., computer, telephone, fax, radio, and television).

IV. **Refuse to participate in or conceal unethical practices or procedures and report such practices.**

A health information management professional shall:

4.1- Act in a professional and ethical manner at all times.

4.2- Take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues. If needed, utilize the Professional Ethics Committee Policies and Procedures for potential ethics complaints.

4.3- Be knowledgeable about established policies and procedures for handling concerns about colleagues’ unethical behavior. These include policies and procedures created by AHIMA, licensing and regulatory bodies, employers, supervisors, agencies, and other professional organizations.

4.4- Seek resolution if there is a belief that a colleague has acted unethically or if there is a belief of incompetence or impairment by discussing one’s concerns with the colleague when feasible and when such discussion is likely to be productive.

4.5- Consult with a colleague when feasible and assist the colleague in taking
remedial action when there is direct knowledge of a health information management colleague's incompetence or impairment.

4.6- Take action through appropriate formal channels, such as contacting an accreditation or regulatory body and/or the AHIMA Professional Ethics Committee if needed.

4.7- Cooperate with lawful authorities as appropriate.

A health information management professional shall not:

4.8- Participate in, condone, or be associated with dishonesty, fraud and abuse, or deception. A non-inclusive list of examples includes:

- Allowing patterns of optimizing or minimizing documentation and/or coding to impact payment
- Assigning codes without physician documentation
- Coding when documentation does not justify the diagnoses or procedures that have been billed
- Coding an inappropriate level of service
- Miscoding to avoid conflict with others
- Engaging in negligent coding practices
- Hiding or ignoring review outcomes, such as performance data
- Failing to report licensure status for a physician through the appropriate channels
- Recording inaccurate data for accreditation purposes
- Allowing inappropriate access to genetic, adoption, health, or behavioral health information
• Misusing sensitive information about a competitor
• Violating the privacy of individuals

Refer to the AHIMA Standards of Ethical Coding for additional guidance.

4.9- Engage in any relationships with a patient where there is a risk of exploitation or potential harm to the patient.

V. Advance health information management knowledge and practice through continuing education, research, publications, and presentations.

A health information management professional shall:

5.1- Develop and enhance continually professional expertise, knowledge, and skills (including appropriate education, research, training, consultation, and supervision). Contribute to the knowledge base of health information management and share one’s knowledge related to practice, research, and ethics.

5.2- Base practice decisions on recognized knowledge, including empirically based knowledge relevant to health information management and health information management ethics.

5.3- Contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the health information management profession. These activities may include teaching, research, consultation, service, legislative testimony, advocacy, presentations in the community, and participation in professional organizations.

5.4- Engage in evaluation and research that ensures the confidentiality of participants and of the data obtained from them by following guidelines developed for the participants in consultation with appropriate institutional review boards.
5.5- Report evaluation and research findings accurately and take steps to correct any errors later found in published data using standard publication methods.

5.6- Design or conduct evaluation or research that is in conformance with applicable federal or state laws.

5.7- Take reasonable steps to provide or arrange for continuing education and staff development, addressing current knowledge and emerging developments related to health information management practice and ethics.

VI. Recruit and mentor students, staff, peers, and colleagues to develop and strengthen professional workforce.

A health information management professional shall:

6.1- Provide directed practice opportunities for students.

6.2- Be a mentor for students, peers, and new health information management professionals to develop and strengthen skills.

6.3- Be responsible for setting clear, appropriate, and culturally sensitive boundaries for students, staff, peers, colleagues, and members within professional organizations.

6.4- Evaluate students' performance in a manner that is fair and respectful when functioning as educators or clinical internship supervisors.

6.5- Evaluate staff's performance in a manner that is fair and respectful when functioning in a supervisory capacity.

6.6- Serve an active role in developing HIM faculty or actively recruiting HIM professionals.

A health information management professional shall not: 
6.7- Engage in any relationships with a person (e.g. students, staff, peers, or colleagues) where there is a risk of exploitation or potential harm to that other person.

VII. *Represent the profession to the public in a positive manner.*

A health information management professional shall:

7.1- Be an advocate for the profession in all settings and participate in activities that promote and explain the mission, values, and principles of the profession to the public.

VIII. *Perform honorably health information management association responsibilities, either appointed or elected, and preserve the confidentiality of any privileged information made known in any official capacity.*

A health information management professional shall:

8.1- Perform responsibly all duties as assigned by the professional association operating within the bylaws and policies and procedures of the association and any pertinent laws.

8.2- Uphold the decisions made by the association.

8.3- Speak on behalf of the health information management profession and association, only while serving in the role, accurately representing the official and authorized positions of the association.

8.4- Disclose any real or perceived conflicts of interest.

8.5- Relinquish association information upon ending appointed or elected responsibilities.

8.6- Resign from an association position if unable to perform the assigned responsibilities with competence.
8.7- Avoid lending the prestige of the association to advance or appear to advance the private interests of others by endorsing any product or service in return for remuneration. Avoid endorsing products or services of a third party, for-profit entity that competes with AHIMA products and services. Care should also be exercised in endorsing any other products and services.

IX. State truthfully and accurately one’s credentials, professional education, and experiences.

A health information management professional shall:

9.1- Make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the health information management profession, a professional health information association, or one’s employer.

9.2- Claim and ensure that representation to patients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, training, certification, consultation received, supervised experience, and other relevant professional experience are accurate.

9.3- Claim only those relevant professional credentials actually possessed and correct any inaccuracies occurring regarding credentials.

9.4- Report only those continuing education units actually earned for the recertification cycle and correct any inaccuracies occurring regarding CEUs.

X. Facilitate interdisciplinary collaboration in situations supporting health information practice.

A health information management professional shall:
10.1- Participate in and contribute to decisions that affect the well-being of patients by drawing on the perspectives, values, and experiences of those involved in decisions related to patients.

10.2- Facilitate interdisciplinary collaboration in situations supporting health information practice.

10.3- Establish clearly professional and ethical obligations of the interdisciplinary team as a whole and of its individual members.

10.4- Foster trust among group members and adjust behavior in order to establish relationships with teams.

XI. Respect the inherent dignity and worth of every person.

A health information management professional shall:

11.1- Treat each person in a respectful fashion, being mindful of individual differences and cultural and ethnic diversity.

11.2- Promote the value of self-determination for each individual.

11.3- Value all kinds and classes of people equitably, deal effectively with all races, cultures, disabilities, ages and genders.

11.4- Ensure all voices are listened to and respected.

The Use of the Code

Violation of principles in this code does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the code would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members although in some situations, violations of the code would constitute unlawful
conduct subject to legal process.

Guidelines for ethical and unethical behavior are provided in this code. The terms "shall and shall not" are used as a basis for setting high standards for behavior. This does not imply that everyone "shall or shall not" do everything that is listed. This concept is true for the entire code. If someone does the stated activities, ethical behavior is the standard. The guidelines are not a comprehensive list. For example, the statement "safeguard all confidential patient information to include, but not limited to, personal, health, financial, genetic and outcome information" can also be interpreted as "shall not fail to safeguard all confidential patient information to include personal, health, financial, genetic, and outcome information."

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values and ethical principles, and offers ethical guidelines to which a HIM professional can aspire and by which actions can be judged. Ethical behaviors result from a personal commitment to engage in ethical practice.

Professional responsibilities often require an individual to move beyond personal values. For example, an individual might demonstrate behaviors that are based on the values of honesty, providing service to others, or demonstrating loyalty. In addition to these, professional values might require promoting confidentiality, facilitating interdisciplinary collaboration, and refusing to participate or conceal unethical practices. Professional values could require a more comprehensive set of values than what an individual needs to be an ethical agent in one’s own personal life.

The AHIMA Code of Ethics is to be used by AHIMA members and certificants, consumers, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies,
and other professional groups) that choose to adopt it or use it as a frame of reference. The AHIMA Code of Ethics reflects the commitment of all to uphold the profession’s values and to act ethically. Individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments, must apply ethical principles.

The code does not provide a set of rules that prescribe how to act in all situations. Specific applications of the code must take into account the context in which it is being considered and the possibility of conflicts among the code’s values, principles, and guidelines. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional. Further, the AHIMA Code of Ethics does not specify which values, principles, and guidelines are the most important and ought to outweigh others in instances when they conflict.

**Code of Ethics 2011 Ethical Principles**

**Ethical Principles:** The following ethical principles are based on the core values of the American Health Information Management Association and apply to all AHIMA members and certificants.

A health information management professional shall:

1. Advocate, uphold, and defend the individual’s right to privacy and the doctrine of confidentiality in the use and disclosure of information.

2. Put service and the health and welfare of persons before self-interest and conduct oneself in the practice of the profession so as to bring honor to oneself, their peers, and to the health information management profession.

3. Preserve, protect, and secure personal health information in any form or medium and hold in the highest regards health information and other information of a confidential nature obtained in an official
capacity, taking into account the applicable statutes and regulations.

4. Refuse to participate in or conceal unethical practices or procedures and report such practices.

5. Advance health information management knowledge and practice through continuing education, research, publications, and presentations.

6. Recruit and mentor students, peers and colleagues to develop and strengthen professional workforce.

7. Represent the profession to the public in a positive manner.

8. Perform honorably health information management association responsibilities, either appointed or elected, and preserve the confidentiality of any privileged information made known in any official capacity.

9. State truthfully and accurately one's credentials, professional education, and experiences.

10. Facilitate interdisciplinary collaboration in situations supporting health information practice.

11. Respect the inherent dignity and worth of every person.


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