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Understanding the role of Medical Coding

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Medical coding - a niche segment in Revenue Cycle Management (RCM) - is a prerequisite for medical billing, filing and claiming reimbursement. It is the process in which a patient's history covering his/her condition, diagnosis, prescription and procedures are converted into a set of alphanumeric codes. These are then used in medical billing to process claims.

Coders refer to primarily 3 types of codes namely: Current Procedural Terminology (CPT), International Classification of Diseases (ICD) or the Healthcare Common Procedure Coding System (HCPCS). ICD is a set of codes published by the World Health Organization (WHO), used to identify known diseases and other health problems and are the primary set of codes used by coders. CPT is a U.S. standard for coding medical procedures, developed by the American Medical Association (AMA), to bring clarity to the treatment procedures and medical billing. HCPCS was developed by the Centers for Medicare and Medicaid (CMS) and consists of 3 levels.

While ICD coding standards focus on the diagnosis, CPT identifies the services provided, and are used by insurance companies to determine how much physicians will be paid for their services. Medical coding is the base for medical billing and the rest of the RCM process in the healthcare industry.

Importance of RCM & medical coding

A healthy revenue cycle has become essential for all healthcare providers in the light of increasing operational costs, demand for value based care and providing the best patient experience. Any typical RCM process consists of eligibility, coding, charge capture, claims submission, reimbursement, accounts receivable and patient collections.

Medical coding being the second step in the RCM process, is a very crucial step. Coding, when done accurately, should be able to present the complete medical story of a patient. This valid record forms the basis for medical billing and insurance claims. While coding, the coder captures the codes representing the exact treatment/procedure provided to the patient. Based on these codes, medical billers submit claims to the payers (insurance providers or government programs such as Medicaid/Medicare) to receive reimbursement for the services rendered to the patients. Accurate coding minimizes the chances of claim rejections/denials, enhancing the reimbursement process and thereby the overall financial health of the revenue cycle process.

Challenges in Medical coding

While medical coding is a task of high importance in the RCM process, it is no doubt a challenging and complex task too. It is a task that requires the coder to have an eye for detail, the ability to analyze medical reports and then apply the appropriate codes. Some of the common challenges in coding include:

Over coding and under coding:

These are the most common errors in coding which can result in serious consequences. Over coding results in claiming payment for more than what was serviced. Up coding and unbundling are two forms of over coding. Over coding is considered fraudulent, consequences of which are financial and legal penalties.

Under Coding is when the codes do not fully cover the scope of work provided by the healthcare provider which can leave a substantial amount of money unreimbursed for the provider.

Missed procedures:

There can be instances where a patient visits a healthcare provider with a certain condition but might be diagnosed with a list of health issues and provided treatment for the same. These are generally listed towards the end of the report. Sometimes coders may not read the entire report and end up not coding all the ailments and treatments provided to the patient. There can also be instances where providers may have missed including procedures or treatment that were provided to the patient. All these can lead to the provider being reimbursed for less than the actual set of services provided

Incorrect codes:

A common tendency among coders is to memorize codes over a period of time. Such coders refer to codes from their memory rather than from books or reference materials, and can result in errors. Also coding from memory often stops the coder from reading the entire medical record and missing the actual ailment which the provider may have diagnosed towards the end of the report.

There are also many cases where the coders may fail to link the ICD codes with the correct CPT codes. This in turn is bound to lead to denials and delayed reimbursements.

Medical Coding and billing has evolved tremendously over the years. While on the one hand the number of codes are seen increasing (the move from ICD-9 to ICD-10 saw the number of codes double) making the task more complex for the coders, the pressure to maintain financial health and provide the best patient experience is also mounting. Thus, having a direct impact on claims submission and reimbursement, the importance of medical coding in the RCM process can only be seen to increase.

With healthcare industry maturing and becoming a global playing field, boundaries no longer restrict patients and healthcare providers. Patient-centric, “smart” tech-enabled healthcare is fast gaining center stage. To maintain this dynamic growth and create a win-win situation for both patients and healthcare providers, there will be a need to adopt a set of uniform medical codes across the globe. Medical coding could in a way help connect healthcare providers and patients across disparate systems helping facilitate the best patient experience.

Julius Raj Stephen , SVP – Client Services, Omega Healthcare Management Services Pvt. Ltd.