Professional Certificate in Health Information Technology

Medical Coding and Billing

Medical Coding and Billing Key Terms and Vocabulary

Medical coding and billing play a crucial role in the healthcare industry by translating medical procedures, diagnoses, and services into universally recognized alphanumeric codes. These codes are used for various purposes such as insurance claims, medical records, and statistical analysis. To navigate the world of medical coding and billing effectively, it is essential to understand key terms and vocabulary associated with this field. Below is a comprehensive list of important terms to help you grasp the fundamentals of medical coding and billing.

1. Medical Coding: Medical coding is the process of assigning specific codes to medical procedures, diagnoses, and services. These codes are used to ensure accurate billing and reimbursement for healthcare services.

2. International Classification of Diseases (ICD): The ICD is a system used to classify and code diagnoses, symptoms, and procedures. It is maintained by the World Health Organization (WHO) and is widely used for billing and statistical purposes.

3. Current Procedural Terminology (CPT): CPT codes are used to describe medical procedures and services provided by healthcare professionals. These codes are maintained by the American Medical Association (AMA).

4. Healthcare Common Procedure Coding System (HCPCS): HCPCS is a coding system used for Medicare and Medicaid claims. It includes CPT codes along with additional codes for supplies, equipment, and services not covered by CPT.

5. Electronic Health Record (EHR): An EHR is a digital version of a patient's paper chart. It contains all the patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory test results.

6. Protected Health Information (PHI): PHI is any information in a medical record or other health information that can be used to identify an individual and that was created, used, or disclosed in the course of providing a healthcare service.

7. Health Insurance Portability and Accountability Act (HIPAA): HIPAA is a federal law that protects the privacy and security of patients' health information. It sets standards for the electronic exchange of healthcare information.

8. Revenue Cycle Management: Revenue cycle management is the process of managing the financial transactions of healthcare organizations, from patient registration to final payment of a balance.

9. Explanation of Benefits (EOB): An EOB is a statement from a health insurance company that provides

details about what was covered by insurance, what was not covered, and how much the patient may owe.

10. Health Information Management (HIM): HIM is the practice of acquiring, analyzing, and protecting digital and traditional medical information vital to providing quality patient care.

11. Compliance: Compliance refers to adhering to laws, regulations, guidelines, and specifications relevant to medical coding and billing to ensure accuracy and integrity in healthcare practices.

12. Denial Management: Denial management is the process of identifying, appealing, and resolving claim denials to ensure proper reimbursement for healthcare services.

13. Clean Claim: A clean claim is a claim that is accurately completed with all required information and documentation, resulting in prompt payment from insurance providers.

14. Superbill: A superbill is a form used by healthcare providers to document services provided to a patient during a visit. It includes codes for procedures, diagnoses, and services rendered.

15. Remittance Advice (RA): An RA is a document from a payer that provides details about payment, adjustments, and denials for claims submitted by healthcare providers.

16. Health Information Technology (HIT): HIT refers to the use of technology to manage healthcare information, improve healthcare delivery, increase patient safety, and enhance the overall quality of care.

17. National Provider Identifier (NPI): An NPI is a unique 10-digit identification number assigned to healthcare providers by the Centers for Medicare and Medicaid Services (CMS).

18. Fraud: Fraud in medical coding and billing occurs when false information is intentionally submitted for reimbursement. It is illegal and can result in severe penalties.

19. Upcoding: Upcoding is a fraudulent practice where a healthcare provider assigns a higher-level code to a service or procedure than what was actually performed to receive higher reimbursement.

20. Downcoding: Downcoding is the practice of assigning a lower-level code to a service or procedure than what was actually provided, resulting in reduced reimbursement.

21. Medical Necessity: Medical necessity refers to services or procedures that are reasonable and necessary for the diagnosis or treatment of an illness or injury based on accepted standards of medical practice.

22. Audit: An audit in medical coding and billing involves a review of documentation, coding, and billing practices to ensure compliance with regulations and guidelines.

23. Compliance Officer: A compliance officer is responsible for overseeing and enforcing policies and procedures related to regulatory compliance in medical coding and billing.

24. ICD-10-CM: ICD-10-CM is the coding system used for classifying and coding diagnoses in the United States. It replaced the ICD-9-CM coding system in 2015.

25. ICD-10-PCS: ICD-10-PCS is the coding system used for classifying and coding inpatient procedures in

the United States. It is based on the ICD-10 system and is used in hospital settings.

26. Modifier: A modifier is a two-digit code appended to a CPT or HCPCS code to provide additional information about the service or procedure performed.

27. Claim: A claim is a request for payment submitted by a healthcare provider to an insurance company for services rendered to a patient.

28. Diagnosis-Related Group (DRG): DRGs are a classification system used to group patients with similar diagnoses and treatments for reimbursement purposes in inpatient settings.

29. National Correct Coding Initiative (NCCI): The NCCI is a coding initiative developed by CMS to promote correct coding methodologies and prevent improper coding practices.

30. Compliance Plan: A compliance plan is a set of policies and procedures designed to ensure adherence to regulations and guidelines in medical coding and billing practices.

31. Coordination of Benefits (COB): COB is the process by which insurance companies determine the order of payment when a patient is covered by more than one insurance plan.

32. Advance Beneficiary Notice (ABN): An ABN is a notice given to a Medicare beneficiary when a healthcare provider believes that Medicare may not cover a particular service or procedure.

33. Charge Description Master (CDM): A CDM is a comprehensive list of charges for all services, procedures, and supplies provided by a healthcare facility.

34. Medical Record Documentation: Medical record documentation is the written or electronic record of a patient's healthcare information, including history, physical examinations, test results, diagnoses, treatments, and outcomes.

35. Medical Necessity Denial: A medical necessity denial occurs when an insurance company determines that a service or procedure was not medically necessary and refuses to reimburse the provider.

36. Fee-for-Service: Fee-for-service is a payment model where healthcare providers are reimbursed based on the services they provide, rather than a fixed amount per patient.

37. Capitation: Capitation is a payment model where healthcare providers receive a fixed amount per patient per month, regardless of the services provided.

38. Health Information Exchange (HIE): HIE is the electronic sharing of healthcare information between different healthcare organizations to improve patient care and coordination.

39. Durable Medical Equipment (DME): DME is medical equipment that is prescribed by a healthcare provider for use at home, such as wheelchairs, oxygen equipment, and hospital beds.

40. Assignment of Benefits: Assignment of benefits is when a patient authorizes their insurance company to pay the healthcare provider directly for covered services.

41. Explanation of Medicare Benefits (EOMB): An EOMB is a statement sent by Medicare to beneficiaries explaining what services were covered, the amount paid, and any patient responsibilities.

42. Workers' Compensation: Workers' compensation is a form of insurance that provides wage replacement and medical benefits to employees who are injured or become ill as a result of their job.

43. Medicaid: Medicaid is a joint federal and state program that provides healthcare coverage to low-income individuals and families.

44. Medicare: Medicare is a federal health insurance program for individuals aged 65 and older, as well as certain younger people with disabilities.

45. Relative Value Unit (RVU): An RVU is a measure used in the Medicare physician fee schedule to determine the relative value of medical services based on physician work, practice expense, and malpractice insurance.

46. Clean Claims Ratio: The clean claims ratio is the percentage of claims submitted by a healthcare provider that are processed without errors or rejections.

47. Healthcare Fraud and Abuse: Healthcare fraud and abuse refer to intentional deception or misrepresentation in the healthcare system for financial gain.

48. Compliance Hotline: A compliance hotline is a confidential reporting mechanism for employees to report suspected violations of laws, regulations, or company policies.

49. Fee Schedule: A fee schedule is a list of charges or fees for medical services and procedures established by healthcare providers or insurance companies.

50. Incident-to Billing: Incident-to billing allows non-physician healthcare providers to bill for services under a physician's supervision at the physician's rate.

51. Medicare Administrative Contractor (MAC): MACs are private companies contracted by CMS to process Medicare claims and provide administrative services.

52. Place of Service (POS): The place of service code indicates where a healthcare service was provided, such as an office, hospital, or nursing home.

53. Clean Claims Rate: The clean claims rate is the percentage of claims processed without errors or rejections on the first submission.

54. Fraud Waste and Abuse (FWA): FWA refers to activities that result in unnecessary costs to healthcare programs, including Medicare and Medicaid.

55. Medical Coder: A medical coder is a healthcare professional who assigns codes to diagnoses and procedures for billing and reimbursement purposes.

56. Medical Biller: A medical biller is a healthcare professional who processes and submits claims to

insurance companies for reimbursement of healthcare services.

57. ICD-10-CM Official Guidelines for Coding and Reporting: The official guidelines provide rules and instructions for correctly assigning ICD-10-CM diagnosis codes.

58. ICD-10-PCS Official Guidelines for Coding and Reporting: The official guidelines provide rules and instructions for correctly assigning ICD-10-PCS procedure codes.

59. Medical Coding Certification: Medical coding certification validates a coder's knowledge and proficiency in assigning accurate codes according to established coding guidelines.

60. Medical Billing Certification: Medical billing certification demonstrates a biller's expertise in processing claims, handling denials, and ensuring proper reimbursement for healthcare services.

61. Claim Scrubber: A claim scrubber is a software tool that checks claims for errors, missing information, and compliance issues before submission to payers.

62. Charge Capture: Charge capture is the process of recording and documenting all billable services provided to a patient for accurate billing and reimbursement.

63. Accounts Receivable (AR): AR is the amount of money owed to a healthcare provider for services rendered but not yet collected from patients or insurance companies.

64. Days Sales Outstanding (DSO): DSO is a measure of how long it takes for a healthcare provider to collect payment for services rendered.

65. Compliance Training: Compliance training educates healthcare staff on laws, regulations, and policies related to medical coding and billing to ensure ethical and legal practices.

66. Health Information Privacy: Health information privacy refers to the protection of patients' personal and medical information from unauthorized access or disclosure.

67. Health Information Security: Health information security involves safeguarding electronic health records and other healthcare information from cyber threats and data breaches.

68. Revenue Cycle Analyst: A revenue cycle analyst monitors and analyzes financial data related to billing, collections, and reimbursement to optimize revenue generation.

69. Charge Description Master Coordinator: A CDM coordinator maintains and updates the CDM to ensure accurate pricing and coding of services provided by a healthcare facility.

70. Health Information Exchange Coordinator: An HIE coordinator facilitates the secure exchange of electronic health information between healthcare organizations to improve care coordination.

71. Medical Coding Auditor: A coding auditor reviews and evaluates coding accuracy, compliance, and documentation to identify errors and ensure proper reimbursement.

72. Claims Processor: A claims processor reviews and processes insurance claims, verifies coverage, and

determines reimbursement amounts for healthcare services.

73. ICD-10 Trainer: An ICD-10 trainer provides education and training on the ICD-10 coding system to healthcare professionals to ensure accurate code assignment.

74. Health Information Manager: A health information manager oversees the collection, storage, and security of patient health records and ensures compliance with regulatory requirements.

75. Revenue Cycle Director: A revenue cycle director is responsible for managing all aspects of the revenue cycle, including billing, collections, and financial reporting.

76. Health Information Technology Specialist: A HIT specialist implements and maintains technology systems for managing health information, including EHRs, billing software, and data analytics tools.

77. ICD-10-CM Coding Guidelines: Coding guidelines provide instructions on how to assign ICD-10-CM diagnosis codes accurately based on documentation and coding conventions.

78. ICD-10-PCS Coding Guidelines: Coding guidelines provide instructions on how to assign ICD-10-PCS procedure codes accurately based on documentation and coding principles.

79. CPT Coding Guidelines: CPT coding guidelines outline rules and conventions for assigning CPT codes to medical procedures and services based on documentation and coding criteria.

80. HCPCS Level II Coding Guidelines: HCPCS Level II coding guidelines provide instructions on how to assign HCPCS Level II codes for supplies, equipment, and services not covered by CPT.

81. Compliance Risk Assessment: A compliance risk assessment identifies potential areas of non-compliance in coding and billing practices and develops strategies to mitigate risks.

82. Health Information Technology Governance: HIT governance establishes policies and procedures for the strategic management of health information systems and technologies.

83. Revenue Cycle Performance Metrics: Performance metrics measure the efficiency and effectiveness of revenue cycle processes, such as claims processing, denial rates, and collections.

84. Health Information Exchange Standards: HIE standards define the technical requirements for the secure exchange of electronic health information between different healthcare systems.

85. ICD-10 Implementation: ICD-10 implementation refers to the transition from ICD-9 to ICD-10 coding systems in healthcare organizations to improve coding accuracy and specificity.

86. ICD-10 Training: ICD-10 training provides education and resources to healthcare professionals on the use of the ICD-10 coding system for accurate code assignment.

87. ICD-10-CM Official Coding Guidelines: The official coding guidelines for ICD-10-CM provide rules and conventions for assigning diagnosis codes based on clinical documentation.

88. ICD-10-PCS Official Coding Guidelines: The official coding guidelines for ICD-10-PCS provide rules and

conventions for assigning procedure codes based on clinical documentation.

89. Medical Coding Software: Medical coding software automates the coding process, helps assign accurate codes, and improves efficiency in medical coding and billing.

90. Electronic Claims Submission: Electronic claims submission allows healthcare providers to submit claims to insurance companies electronically for faster processing and reimbursement.

91. Compliance Monitoring: Compliance monitoring involves regular audits, reviews, and assessments of coding and billing practices to ensure adherence to regulations and guidelines.

92. Health Information Technology Security: HIT security measures protect electronic health information from unauthorized access, disclosure, or cyber threats.

93. Revenue Cycle Optimization: Revenue cycle optimization aims to streamline billing and collections processes, reduce denials, and maximize revenue for healthcare organizations.

94. Health Information Technology Integration: HIT integration involves connecting different technology systems, such as EHRs, billing software, and data analytics tools, to improve data sharing and workflow efficiency.

95. ICD-10-CM Coding Conventions: Coding conventions for ICD-10-CM provide guidelines on how to interpret and apply diagnosis codes based on documentation and coding rules.

96. ICD-10-PCS Coding Conventions: Coding conventions for ICD-10-PCS provide guidelines on how to interpret and apply procedure codes based on documentation and coding principles.

97. CPT Coding Conventions: Coding conventions for CPT codes outline rules and criteria for assigning procedure codes accurately based on documentation and coding guidelines.

98. HCPCS Level II Coding Conventions: Coding conventions for HCPCS Level II codes provide guidelines on how to assign codes for supplies, equipment, and services not covered by CPT.

99. Compliance Program Development: Compliance program development involves creating policies, procedures, and training programs to ensure adherence to regulations and guidelines in coding and billing.

100. Health Information Technology Implementation: HIT implementation involves deploying and integrating technology systems for managing health information, such as EHRs, billing software, and data analytics tools.

In conclusion, mastering the key terms and vocabulary related to medical coding and billing is essential for professionals working in health information technology. Understanding these terms will help ensure accurate coding, billing, and reimbursement processes, as well as compliance with laws and regulations in the healthcare industry. By familiarizing yourself with these terms and concepts, you will be better equipped to navigate