MEDICAL CODING
STUDY GUIDE

What is Medical Coding?

Medical coding is a specialized profession within the wider field of healthcare administration. Professional medical coders review the documentation contained in patients' medical records, then they translate the written documentation into universally accepted, industry-standard medical code. These codes are used to submit claims to third party payers, and to gather statistical information, both by tracking incidents of specific diseases, and by discerning developing trends in treatment protocols. Accurate medical coding is essential to the healthcare industry. It is how claims for payment are reported for appropriate reimbursement of provided medically necessary services. Above and beyond that, the granulated, specific data contained in medical codes provides a picture of a given patient's health history. When collected in aggregate, this information is used by actuaries to determine how to allocate capital for future healthcare needs. It is also used to steer incentives to specific programs that encourage quality of care that focus the healthcare industry on providing services that are considered to be of benefit to the general population.

In practice, medical coding is primarily used to file healthcare claims, but the data contained in these claims has further uses for accurate diagnosis and procedure codes, long after individual claims are paid.

Medical Coding is not Medical Billing

In some settings, a medical biller also serves as a medical coder and, in fact, medical billers are familiar with the basic precepts of accurate medical coding. Professional medical coders are aware of the reimbursement implications of the codes they assign, but their primary concern is not with money, but with the accuracy of the information communicated by their work.

Professional certified medical coders essentially act as translators. They review a patient's medical record as written by physicians, therapists, nurses, technicians, and other healthcare providers. After comparing the documentation to the standards established by the American Medical Association, the Centers for Medicare and Medicaid Services, and contractual agreements with commercial health insurance plans, certified medical coders abstract the pages of written information, and they distill it into standardized codes. Procedures are translated into codes contained in the indices of Current Procedural Terminology (CPT codes), the Healthcare Common Procedural Coding System (HCPCS Level II codes), and the codes contained in Volume 3 of the International Classification of Diseases, 9th

Edition, Clinical Modification (ICD-9-CM). Diagnosis codes that describe a patient's condition at the time services were rendered are rendered into codes found in Volume 2 of ICD-9-CM.

Medical billers use these codes to submit claims to describe medically necessary services that should be reimbursed at agreed-upon rates by third-party payers. Statisticians, researchers, public health officials, and internal auditors use these codes to determine what services were provided, and why, to a patient population. Accurate medical coding has many ramifications that affect not only the fiscal health of a healthcare institution, but they also affect public policy on a grander scale.

Is Medical Coding a Viable Career?

According to the American Academy of Professional Coders (AAPC), there are over 110,000 certified medical coders who carry credentials from this professional organization. The basic credential offered by AAPC is the title of Certified Professional Coder (CPC). Specialty certifications are also offered by AAPC, such as Certified Professional Coder-Hospital Outpatient (CPC-H), or Certified Interventional Radiology Cardiovascular Coder (CIRCC).

The American Health Information Management Association (AHIMA) also offers credentials to trained coding professionals. AHIMA offers the designation of Certified Coding Specialist (CCS), and Certified Coding Specialist-Physician-Based (CCS-P).

AAPC credentials tend to focus on the mastery of coding issues in the outpatient professional setting, while AHIMA, which has a broader mandate that covers aspects of health information management beyond only coding, focuses on issues that occur in the inpatient hospital setting. AHIMA offers other credentials that do not center on medical coding, though accurate medical coding is always a component of the required core competencies. Likewise, AAPC offers credentials, such as Certified Professional Medical Auditor (CPMA), or Certified Compliance Officer (CCPO), that have coding as their basis, but also have wider applications.

There are other professional bodies that offer certification to professional medical coders. The reason there are so many specialized credentials available is because there is a demand for them. Employers expect professional medical coders to be certified in the roles they fulfill within an organization. This can be by assigning codes for reimbursement, reviewing healthcare claims for accuracy before or after payment has been received, educating

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Judd E. Hollander

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