Tools of the Trade

by Cindy C. Parman, CPC, CPC-H, RCC

Automobile mechanics have specialized tools to repair cars; pastry chefs have unique tools to create culinary masterpieces; and professional medical coders employ an assortment of tools to ensure that they correctly code and bill for the services performed.

A wealth of books, online programs, and other tools are available to assist and support coding efforts, and trying to decide what should be purchased for an office, facility, or program can be overwhelming. The following is a list of key coding and billing resources no medical coder should be without. Many of the resources listed are available both in hardcopy and electronic format and from multiple publishers or re-sellers.

No discussion about medical coding is complete without a definition of authoritative coding guidance. While opinions on code assignment can be obtained from a number of sources, authoritative coding guidance is only provided by:

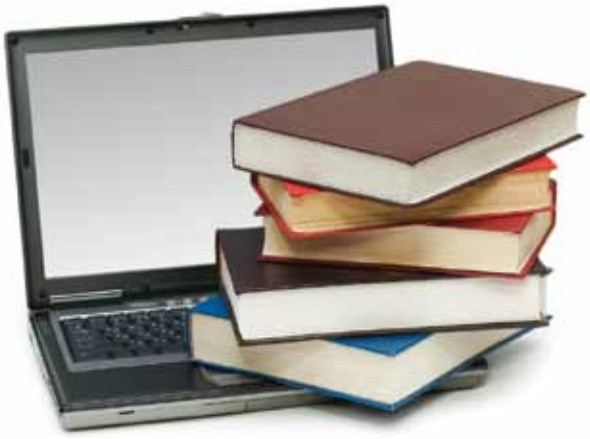
- **The American Medical Association**: The AMA copyrights CPT® codes, and all AMA guidance regarding use of its codes is considered to be authoritative.
- **American Hospital Association**: The AHA publishes official guidance for reporting ICD-9-CM diagnosis codes and will provide data relating to the assignment of ICD-10-CM codes during transition to this new classification.
- **Insurance payers**: These entities are paying benefits for their insured population, and their guidance on coding and billing is considered to be authoritative.

When making a determination regarding coding compliance, consider *all* information and evaluate the *source* of the information. Keep in mind, during an insurance audit or review, it is possible that only authoritative coding guidance will be considered acceptable.

Essential Resources

Resources that every medical coder must have to ensure accurate code assignment include the following.

Medical dictionary and/or anatomy reference. Depending on the medical coder's background and skill level or the complexity of the diagnoses and procedures that require code assignment, having both a medical dictionary and anatomy reference available may be beneficial.



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AMA References. The American Medical Association publishes several different coding references that are essential to code assignment, including:

1. *CPT® Manual*—This reference includes the official procedure code listing for the current year and information on two-digit procedure code modifiers affecting claims payment. Many medical coders prefer the "Professional Edition" because it includes cross-references to other essential publications.
2. *CPT® Assistant*—This monthly newsletter provides valuable information from the AMA regarding the rationale behind procedure code creation and proper utilization. It also includes coding scenarios and questions posed to the AMA for education and communication. Oncology codes are not always referenced in each issue, but over the course of the year, you will find valuable coding information.
3. *CPT® Changes: An Insider's View*—Each year, codes are added, deleted, and/or redefined in the *CPT® Manual.* This resource provides all of the changes, including coding scenarios and the intent of these new codes. Although purchasing this reference on an annual basis may not be necessary, any time oncology codes are added or altered, this book will be invaluable.

Healthcare Common Procedural Coding System (HCPCS) Manual

The Centers for Medicare & Medicaid Services (CMS) developed the HCPCS coding system to standardize coding systems used to process Medicare claims. Healthcare delivery organizations, including physicians, hospitals, and cancer programs must employ these codes when documenting Medicare-related supplies and/or services. An increasing number of private payers also accept or require these Level II codes to provide payment for expenses related to the primary service.

When procedure codes are included in software programs such as hospital encoders or charge description masters, there is often a "short descriptor" comprised of a total of 28 characters. This short definition may not provide complete coding information, requiring the medical coding professional to have sources that provide comprehensive code details.

AHA References

The American Hospital Association publishes the *Official ICD-9-CM Guidelines* and other references for diagnosis coding. In addition, the AHA also offers coding guidance for procedure code assignment in the hospital outpatient department.

1. ***ICD-9-CM Manual***—This resource, which is updated October 1 each year, includes a comprehensive diagnosis code listing. As with other medical coding references, this classification is published in a relatively standard manner and available from various distributors.
2. ***Coding Clinic for ICD-9-CM***—In addition to the *ICD-9-CM Manual*, the AHA also publishes a quarterly reference that answers questions relating to the reporting and sequencing of diagnosis codes and provides in-depth coding information relating to specific clinical scenarios. Most hospitals and large healthcare organizations have *Coding Clinic* information incorporated into the encoder. If it is necessary to purchase this reference separately, it is available both in print and on a searchable disk.
3. ***Coding Clinic for HCPCS***—This publication addresses procedure codes, primarily as they are reported in the hospital outpatient department. Regular features of *AHA Coding Clinic for HCPCS* include coding examples, correct code assignment for new technologies, articles and topics that offer practical information to improve data quality, and a bulletin of coding changes and/or corrections.
4. **Official ICD-9-CM Coding Guidelines**—These guidelines, which are also updated October 1 each year, are available without charge on the Centers for Disease Control and Prevention (CDC) website at: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines*. This 119-page document includes basic guidelines for code assignment, sequencing of multiple diagnosis codes, reporting of signs and symptoms, neoplasm coding, and more.

Medicare References

Both CMS and local Medicare contractors (fiscal intermediaries, carriers, or Medicare Administrative Contractors) publish authoritative coding and regulatory guidance for physicians, freestanding centers, hospitals, and cancer programs, including:

1. **Local Coverage Determinations (LCDs)**—The coder must obtain copies of all LCDs that apply to billed services. LCDs are available on the CMS website as well as directly from the Medicare contractor's website. In addition, many local Medicare contractors provide email notification of changes or updates to existing policies. Coding professionals can ensure that they receive and implement payer updates in a timely fashion by signing up for these free update services.
2. **CMS Internet-Only Manuals (IOMs)**—These electronic manuals include program issuances, policies, and procedures that are based on statutes, regulations, guidelines, and directives. CMS IOMs are a good source of Medicare and Medicaid information for all providers of service. The Internet-only manuals are located at: *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.
3. **National Correct Coding Initiative (NCCI or CCI)**—In addition to regulatory and coding information, CMS also provides information on bundling edits on its website. The NCCI contains two tables of edits: The Column One/Column Two Table and the Mutually Exclusive Table. These include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. CMS also provides information on the correct application of modifier 59, both in the Policy Manual and in separate documents on the NCCI website. The CMS NCCI information is located at: *http://www.cms.hhs.gov/NationalCorrectCodInitEd/*.
4. ***Federal Register***—Most medical coding references address codes and code definitions, but the medical coder may benefit from having access to regulatory documents such as the *Federal Register.* Published by the Office of the Federal Register, National Archives and Records Administration (NARA), the *Federal Register* is the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents. When CMS issues a final rule for hospital or physician services, it may include specific coding information, new HCPCS Level II codes, or guidelines on the use of existing codes. *Federal*

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"...correct filing leads to more complete and timely reimbursement."

Register information is located at: *http://www.gpoaccess.gov/fr/index.html*.

Insurance References

In addition to information published by CMS, commercial and managed care insurers publish policy guidelines, coverage information, and medical necessity for various services.

Commercial Insurance Policies—In the not-too-distant past, each insurance agreement or contract included a manual that defined covered services, patient financial responsibility, medical necessity, and other requirements for payment. With today's focus on electronic communication, much of this information is also published on the insurer's website. Each oncology practice, program, or facility is responsible for locating the policy relevant to its patients' treatments and reviewing it to determine whether services will be covered.

Additional Resources

Billers and coders may also want to consider resources developed by specialty societies, professional association, and commercial publishers.

Specialty Societies. Most specialty societies have published coding guidance and documentation recommendations, either in a manual format, Q&A on websites, or through periodic announcements. Although this information may not be considered authoritative coding guidance, it does represent standard-of-practice information for the particular specialty.

Professional Associations. Some specialties have professional organizations for business management and other nonphysician personnel, and many times these organizations have publications, listserves, or other resources.

Private Publications. Many commercial entities publish coding resources; however, careful research should be done before a coding publication is purchased. Is the company reputable? How long has it been in business? Where does it get its information? Just because it is a "specialty" product does not mean that it is accurate and complete—in some cases it may be a compilation of opinions expressed by peers in the same specialty instead of authoritative coding information.

Whatever resources you use, remember that medical code assignment is a complex task that involves an understanding of the clinical service performed and determination of the appropriate procedure and diagnosis codes. The medical coding professional must also take into account regulatory guidance, bundling edits, correct modifier application, and a variety of references and publications to ensure that the insurance claim is complete and accurate. The initial submission of a clean claim serves to expedite payment and eliminates the work associated with researching, refiling, and appealing rejected claims. In a time of economic challenges, correct filing leads to more complete and timely reimbursement.

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