Coding and Billing Key Terms

Current Procedural Terminology (CPT): A system of procedure codes and descriptions published annually by the American Medical Association (AMA). It has been adopted by the Secretary of Health and Human Services as the standard system of reporting medical services. It is accepted by virtually all commercial health insurance carriers and required by Medicare and Medicaid.

Healthcare Common Procedural Coding System (HCPCS): A two-level coding system that identifies healthcare procedures, equipment, and supplies for claim submission purposes. It has been selected for use in HIPAA transactions. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These codes are important to know so that you can properly bill for such services as medication injections. Medicare also requires use of these codes for selected services even when there is a CPT code, eg, administration of influenza vaccine.

International Classification of Diseases: A diagnostic medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set is to classify causes of death. A US extension, maintained by the National Center for Health Statistics within the Centers for Disease Control (CDC), identifies morbidity factors, or diagnoses. The **ICD-9 CM** codes (International Classification of Diseases, 9th revision, Clinical Modification) have been selected for use in HIPAA transactions. Claims processing requires you to submit a diagnostic code with each procedure using this classification system.

Effective October 1, 2015, CMS will transition from ICD-9 code sets to ICD-10 code sets to report medical diagnoses and inpatient procedures.. This transition is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). CPT coding for outpatient procedures and physician services are not affected by this change.

MAC Carrier: A private company that has a contract with Medicare to pay your Medicare Part B bills. This is the company that pays your claims—they are a valuable resource for billing questions.

Documentation Guidelines: The Center for Medicare and Medicaid Services (CMS) published guidelines in 1995 and 1997 that provide detailed criteria regarding the documentation required to support the selection of evaluation and management codes. These guidelines were created for use by CMS for audit purposes. CMS allows physicians to use either set of guidelines. The guidelines can also be used to improve your understanding of code selection. http://www.cms.hhs.gov/medlearn/emdoc.asp

National Correct Coding Initiative (NCCI): When claims are processed by Medicare or other insurance carriers, they are compared against computerized edits.

Medically Unlikely Edits (MUEs): Additional edits developed by the Center for Medicare and Medicaid Services (CMS).

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Place of Service Codes: Place of service codes specify where the patient received their medical care or supplies. Place of service codes are ascribed to medical facilities such as inpatient hospitals, nursing facilities, and hospices. Place of service codes are typically two digits long.

Need more help? Many more definitions can be found at http://www.cms.hhs.gov/glossary/

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