Addendum

Subsequent to the original printing of this study guide, NHA determined that enough time had elapsed since the transition from ICD-9 to ICD-10 that the CEHRS certification exam and study guide should only cover information on ICD-10. For clients who received a printed copy of the study guide prior to this change, this addendum provides details on the changes. These are:

- All references to ICD-9 have been removed and updated to ICD-10 as appropriate.
- The pages covering ICD-9 and ICD-10 in chapter 2 have been replaced with the pages attached to this document, which provide additional content on ICD-10.
- Quiz questions in chapter 2 that refer to ICD-9 have either been updated or removed.
Learning Objectives
After reading this chapter, you will be able to:

- Enter coding and billing information in the EHR.
- Abstract diagnoses and procedural descriptions from the medical record.
- Enter diagnoses and procedural descriptions from the medical record into the EHR.
- Generate insurance verification reports.
- Generate patient statements.
- Post payments to patient accounts at the time of visit.
- Generate encounter forms/superbills.
- Generate face/admission sheets.
- Find codes in the ICD*, CPT, and HCPCS manuals.

Introduction

Patients who receive care from providers pay fees that support continuing operations of the facility. A patient may pay for medical services directly, called private or self-pay, or by using insurance.

In general, insurance pays for provider visits, laboratory and radiology tests, emergency department visits, hospitalization or inpatient services, outpatient services, and prescription medications. Insurance policies differ in the services they cover, deductible and copayment amounts, treatment options, and insurance limit amounts. An individual can purchase insurance directly from an insurance company or through an employer as part of a group plan. The U.S. government offers an insurance program called Medicare, which is available to individuals 65 and older and to people who have certain disabilities. Each state offers an insurance program called Medicaid, which covers patients who meet certain eligibility criteria and who are otherwise uninsured. Medicaid eligibility and coverage differs in each state so it is best to learn the guidelines for the state in which you work.
EHR software is a vital part of the health care industry. As an EHR specialist, you use insurance information to generate insurance verification reports, and you enter information you receive from the patient to generate the patient face sheet, which is also called an admission report or intake form. Then, you record payments made to the facility into the patient account.

In the electronic records environment, providers enter information directly into the EHR system at the point of care. Traditionally, coders take this information and assign a numeric code set to the encounter for the diagnosis and the procedure. However, in today’s EMR software, many systems map ICD-10-CM/PCS and CPT codes to the menu items providers may choose during treatment that assigns the code when they document patient care. This enables the EHR specialist to verify the accuracy of the code assignment and to process the insurance claim and patient bill quickly and efficiently.

EHR technology allows for more streamlined documentation of patient care. This in turn enables providers to bill accurately, which supports an efficient revenue cycle that maintains financial stability for the facility.

**Enter Coding and Billing Information in the EHR**

In the health care setting, coding and billing provide the means for reimbursement to providers and facilities for their services. Therefore, these are extremely important steps in the health care workflow.

Medical codes come in various forms and evolved from different needs of the medical facility. The International Classification of Disease (ICD) is a classification and coding system that is in place around the world. In the U.S., ICD-10-CM/PCS is an integral part of the revenue cycle for hospitals and health care facilities.

ICD-10-CM captures diagnoses for inpatient and outpatient settings. ICD-10-CM disease and injury codes contain up to seven alphanumeric characters, such as T82.120S (Displacement of cardiac electrode, sequela). Assignment requires the interpretation of coding conventions (e.g., Code also, Excludes 1). The first character of an ICD-10-CM code is always a letter, and codes that contain four or more characters require the use of a decimal. The placeholder "x" is used when a seventh character is required but there is no fifth and/or sixth character, such as T14.8xxA (Other injury of unspecified body region, initial encounter).

ICD-10-CM contains an (1) Index to Diseases and Injuries, which includes a Neoplasm Table, Table of Drugs and Chemicals, and an Index to External Causes; and a (2) Tabular List of Diseases and Injuries. Main terms in the index are boldfaced, and subterms are indented. When using the ICD-10-CM index to locate a code, the tabular list must be reviewed to validate accuracy of code assignment.
In the inpatient setting, you will code procedures using ICD-10-PCS. ICD-10-PCS procedure codes contain seven alphanumeric characters (using letters A-H, J-N, and P-Z), such as 0DTJ0ZZ (Resection of Appendix, Open Approach). No decimal is used in ICD-10-PCS codes, and letters I and O are not used (because they could be confused with numbers 1 and 0). ICD-10-PCS contains an (1) Index and (2) Tables. Main terms in the index are boldfaced, and subterms are indented. When using the ICD-10-PCS index to locate a procedure, the appropriate table must be used to "build a code" (e.g., index main term "Appendectomy" directs the coder to table 0DTJ to locate the fifth through seventh characters, resulting in 0DTJ0ZZ for an open approach or 0DTJ4ZZ for a percutaneous endoscopic approach).

ICD-10-PCS procedures are organized into 17 sections, which include: 0 Medical and Surgical, 1 Obstetrics, 2 Placement, 3 Administration, 4 Measurement and Monitoring, 5 Extracorporeal or Systemic Assistance and Performance, 6 Extracorporeal or Systemic Therapies, 7 Osteopathic, 8 Other Procedures, 9 Chiropractic, B Imaging, C Nuclear Medicine, D Radiation Therapy, F Physical Rehabilitation and Diagnostic Audiology, G Mental Health, H Substance Abuse Treatment, X New Technology. The first character of an ICD-10-PCS code always corresponds to the section where the procedure is classified. The second through seventh characters have specific meanings, which are unique to each section.

In the outpatient setting or to capture procedures done by providers for their billing purposes, you should use the CPT code set. CPT codes capture medical, surgical, and diagnostic services providers perform and also are known as Level I HCPCS codes. Healthcare Common Procedural Coding System (HCPCS) consists of two levels. CPT codes make up Level I, while Level II codes capture services, supplies, and equipment for which no Level I or CPT code exists. An example of a HCPCS Level II code is A6412, which is an occlusive eye patch. If a patient receives this at an office visit, you should submit this HCPCS code to the insurance company for the payment of this item, in addition to the codes that represent the provider services and any other treatment or equipment.

Correct coding takes study, practice, and a commitment to staying up-to-date as the technology and profession evolves. As an EHR specialist, your role in coding and billing will vary depending on your place of employment.

Abstract Diagnoses and Procedural Descriptions from the Medical Record

Coding begins with the review of the documentation of patient treatment and course of care in the medical record. In the inpatient setting, coding is built off the principal diagnosis or reasons for admission. In the outpatient setting, the term principal diagnosis is not valid. Instead, you will look for the “first-listed diagnosis” to code outpatient visits.
To find the first-listed diagnosis, review the documentation from the patient visit. For the provider’s office setting, review the provider's notes. This often presents in a format like this:

“25-year-old female, established patient, presenting with painful urination, visible blood in urine. Urinalysis confirms presence of bacteria, nitrites. Urinary tract infection; prescribed Nitrofurantoin 100 mg, BID. Return to clinic in 2 weeks for follow up.”

In this record entry, the diagnosis is clear: a urinary tract infection. The coding process for this patient would include the Evaluation and Management (E&M) code to capture the time spent by the clinician, and the ICD-10-CM diagnosis code. This patient underwent no procedures.

If the patient was in for a less specific issue that could not be identified without further testing, you would code the symptoms. Here is an example:

“25-year-old male, established patient, presenting with pain in lower back. Reports moving heavy furniture previous week. Imaging studies ordered for lower back; patient prescribed rest, ice to affected area, and Flexeril 10 mg, TID. Return to clinic in 1 week for follow up.”

In this record entry, there is no obvious diagnosis other than pain in the patient’s lower back. Therefore, the code assignment would include the E&M code to capture the time spent by the clinician, and the ICD-10-CM diagnosis code for lower back pain only. This patient underwent no procedures.

As the examples above illustrate, knowing the medical record and the location of the various provider documentation sources is critical for accurate coding and appropriate reimbursement. Each EMR system will be set up uniquely to meet the needs of each facility. Understanding how providers document and where the information resides within the EHR system will make your job much easier.

**Enter Diagnoses and Procedural Descriptions from the Medical Record into the EHR**

Today, most coders use what is known as an encoder, which is software that helps assign codes for diagnoses and procedures. Encoders guide you in the assignment of codes, and in many cases, eliminate the need to search through hundreds of pages of books to locate a code.

Most EHR and EMR systems in use today come with an integrated encoding system or the ability to interface with an existing encoder. Some of these may already exist within the separate practice management system. Practice management software helps