

# **WORKING IN MEDICAL BILLING AND CODING**

# A GOOD TIME TO START

- According to the Bureau of Labor Statistics:
  - Billing and coding field will expand by 21% between now and 2020
  - 40,000 new jobs
  - Entry level coders make \$34K/yr
  - Top 10% of coders in US make \$27/hr

# WHY THE FIELD IS GROWING

- An aging population:
  - Baby Boomers over 65 years old
  - Older people require more medical attention than younger people
  - More patients means more data to process

# WHY THE FIELD IS GROWING

- Increased focus on health informatics
  - The science of tracking and processing data
- Increased reliance on Electronic Medical Records (EMR) and Electronic Claims
  - The effect of HIPPA

# DAILY DUTIES: CODING

- Coders review medical reports
- Take notes on reports
- Use these notes to find the correct code for the procedure, diagnosis and equipment used
- Check their work to ensure that the codes are compatible with one another
  - And that the codes are compatible with the type of insurance

# EXAMPLE: CODING

- *Situation:*
  - A patient presents with a sore throat. The doctor suspects strep throat and orders a **rapid strep test**. The test comes back positive for **strep**. The doctor prescribes **antibiotics** for the patient.

# EXAMPLE: CODING

- Increased focus on health informatics
- The coder would code for:
  - Strep throat
    - Since the diagnosis (strep throat) has been confirmed, the coder does not need to code for the symptoms
  - Coders only code for symptoms when a positive diagnosis is not attainable
  - The prescription of antibiotics (amoxicillin)

# EXAMPLE: CODING

- For the diagnosis, the coder would use the **ICD code set**
  - ICD-9-CM code for streptococcal sore throat: **680.0**
- For the procedures, the coder would use the **CPT code set**
  - CPT code for rapid strep test: **87880**
  - CPT code for antibiotics: **00781**



# CODING WORKFLOW

- The coder enters this information into the appropriate form or software and moves on to the next report
- This process of reading reports and coding them continues throughout the day
- We'll cover ICD, CPT, HCPCS coding more thoroughly in Section 2

# DAILY DUTIES: BILLING

- Creating medical claims
- Reviewing returned claims that may be
  - Rejected
  - Denied
  - Accepted
- Billing patients
- Collecting payments from patients

# IN-DEPTH: BILLING

- Takes codes from coder, along with itemized information about the patient
  - This is called the “**Superbill**”  
(See *The Medical Billing Process* in section 3)
- Determines **patient’s insurance coverage**
  - May be: (see Section 3 for in depth descriptions of these)
    - Medicare
    - HMO
    - PPO
- Finds the **appropriate claim form**

# IN-DEPTH: BILLING

- The biller also checks that the codes used are accurate and that they demonstrate “**medical necessity**”
  - Medical necessity: when a procedure is justified as reasonable, appropriate, or necessary
    - Usually demonstrated by diagnosis codes
      - “Because the patient has strep, it makes sense for him to be prescribed antibiotics”
- Medical facilities have different rates for different procedures

# IN-DEPTH: BILLING

- Biller takes all this information and **makes a claim**
- Sends that claim either:
  - Directly to the insurance payer
  - To a clearinghouse
    - Third party organization that ensures claim is accurate and formatted correctly

# IN-DEPTH: BILLING

- Payer reviews, or “**adjudicates**” the claim
- Returns it to biller as a **transaction report**
  - This will include how much of the cost the payer will reimburse
- Biller analyzes transaction report and creates balance
- Sends this to patient

# IN-DEPTH: BILLING

- The biller receives payments from patients
- Final phase (if necessary):  
**Collections from patients**
  - Billers may coordinate with collections agencies to ensure that the healthcare provider is paid for the services they perform