

Introduction to Medical Coding

Introduction to Medical Coding

Key concepts, terminology, and workflow basics for beginners

1. What Is Medical Coding?

Aspect	Description
Definition	The process of translating clinical documentation (diagnoses, procedures, services) into standardized alphanumeric codes.
Purpose	• Enables uniform billing and reimbursement • Supports statistical analysis, research, and quality reporting • Facilitates communication among providers, insurers, and regulators
Primary Coding Sets	• ICD-10-CM – diagnoses (International Classification of Diseases, 10th Revision, Clinical Modification) • CPT – procedures/services (Current Procedural Terminology) • HCPCS – ancillary services, supplies, and medications (Healthcare Common Procedure Coding System)

2. Core Coding Classifications

Classification	Scope	Managed By
ICD-10-CM	~70,000 diagnosis codes (disease, injury, symptoms, external causes)	CMS (U.S.) / WHO (global)
ICD-10-PCS	Inpatient procedure codes (for hospitals)	CMS
CPT	~10,000 procedure codes (office, surgery, radiology, pathology, etc.)	American Medical Association (AMA)
HCPCS Level II	Supplies, equipment, ambulance services, drugs, vaccines	CMS

3. The Coding Workflow

1. **Patient Encounter** – Provider documents history, exam, assessment, and plan (H&E&A&P).
2. **Chart Review** – Coder examines the medical record for relevant information.

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3. Code Assignment

- **Diagnosis coding** ? ICD?10?CM (or ICD?10?PCS for inpatient procedures).
 - **Procedure coding** ? CPT (outpatient) or ICD?10?PCS (inpatient).
 - **Supplies/Drugs** ? HCPCS Level II.
4. **Verification** – Ensure codes match documentation, meet payer guidelines, and reflect medical necessity.
5. **Claim Submission** – Codes are entered into the billing system and transmitted to insurers.
6. **Reimbursement & Follow?up** – Claims are adjudicated; coder may handle denials or request additional information.
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4. Basic Coding Principles

Principle	Explanation
Specificity	Choose the most detailed code that accurately reflects the condition or service.
Laterality	Indicate right, left, or bilateral when applicable (e.g., S52.531A – Fracture of right distal radius).
Sequencing	Primary diagnosis = main reason for encounter; secondary diagnoses = comorbidities or complications that affect care.
Code Validity	Use only codes that are active for the claim's service date.
Modifier Use	Add modifiers (e.g., ?25, ?59) to clarify service context or indicate multiple procedures.
Bundling Rules	Follow payer-specific bundling guidelines to avoid unallowable duplicate charges.

5. Common Code Types & Examples

Category	Code Example	Meaning
ICD?10?CM	E11.9	Type 2 diabetes mellitus without complications
ICD?10?CM (External cause)	V89.2XXA	Encounter for follow?up after surgery
CPT	99213	Established patient office visit, moderate complexity

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Category

CodeExample

Meaning

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