

2017 HOSPITAL CODING

Reference Guide for Clinical Physicians
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2017 Hospital Coding Guide 5869r18

M Mosston



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Understanding Hospital Billing and Coding Debra P. Ferenc, 2013-02-26 Updated Claim Forms chapter covers the UB 04 claim form Updated information covers diagnosis and procedural coding with guidelines and applications Updated claim forms and names are used throughout *Coding and Reimbursement for Hospital Inpatient Services* Karen S. Scott, 2006 The most comprehensive resource for hospital inpatient coding and reimbursement Provides educators students and healthcare practitioners with the most authoritative guidance available for managing inpatient coding and reimbursement issues This must have resource was developed to give you easier access to the most up to date information you need for inpatient coding and reimbursement You ll save time and make more effective decisions with this one of a kind resource Covers reimbursement methodologies for hospital inpatient services the structure and organization of the Medicare Inpatient Acute Care Prospective Payment System the relationship between coding and DRG assignment and data quality and coding compliance processes related to coding and reimbursement for inpatient services **Step-by-Step Medical Coding, 2017 Edition - E-Book** Carol J. Buck, 2016-11-08 Take your first step toward a successful career in medical coding with guidance from the most trusted name in coding education From Carol J Buck the bestselling Step by Step Medical Coding is a practical easy to use resource that shows you exactly how to code using all current coding sets Practice exercises follow each step of information to reinforce your understanding of important concepts In depth coverage includes reimbursement ICD 10 CM CPT HCPCS and inpatient coding with an Evolve website that includes 30 day access to TruCode Encoder Essentials No other text so thoroughly covers all coding sets in one source 30 day access to TruCode Encoder Essentials in addition to separate encoder practice exercises on the Evolve companion website help you understand how to utilize an encoder A step by step approach makes it easier to build skills and remember the material UNIQUE Real world coding reports cleared of any confidential information simulate the reports you will encounter as a coder and help you apply coding principles to actual cases Over 500 illustrations include medical conditions and procedures to help you understand the services being coded Exercises Quick Checks and Toolbox features reinforce coding rules and concepts and emphasize key information Valuable tips and advice are offered in features such as From the Trenches Coding Shots Stop Caution Check This Out and CMS Rules UNIQUE Four coding question variations develop your coding ability and critical thinking skills including one code or multiple code answers Official Guidelines for Coding and Reporting boxes allow you to read the official guidelines wording for inpatient and outpatient coding alongside in text explanations UNIQUE Coders Index makes it easy to quickly locate specific codes Sample Electronic Health Record screenshots in the appendix provide examples similar to the EHRs you will encounter in the workplace Online practice activities on Evolve include questions such as multiple choice matching fill in the blank and coding reports A workbook corresponds to the textbook and offers review and practice with more than 1 200 theory practical and report exercises odd numbered answers provided in appendix to reinforce understanding of medical

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readers will learn how to code a claim correctly link the correct CPT and ICD 9 CM codes for reimbursement understand adjustments as well as how and when to bill patients and determine what to do if there is a denial or rejection Coverage has been thoroughly updated to include information on ICD 10 CM and how it compares to ICD 9 CM CPT coding and modifiers are also discussed as well as more code specific information concentrating on specialty coding and the levels of coding

ICD-10-CM Official Guidelines for Coding and Reporting Centers for Medicare Medicaid Services, National Center for Health Statistics, 2017-03-10 The Centers for Medicare and Medicaid Services CMS and the National Center for Health Statistics NCHS two departments within the U S Federal Government s Department of Health and Human Services DHHS provide the following guidelines for coding and reporting using the International Classification of Diseases 10th Revision Clinical Modification ICD 10 CM These guidelines should be used as a companion document to the official version of the ICD 10 CM as published on the NCHS website The ICD 10 CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings The ICD 10 CM is based on the ICD 10 the statistical classification of disease published by the World Health Organization WHO These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD 10 CM the American Hospital Association AHA the American Health Information Management Association AHIMA CMS and NCHS These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD 10 CM itself The instructions and conventions of the classification take precedence over guidelines These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD 10 CM but provide additional instruction Adherence to these guidelines when assigning ICD 10 CM diagnosis codes is required under the Health Insurance Portability and Accountability Act HIPAA The diagnosis codes Tabular List and Alphabetic Index have been adopted under HIPAA for all healthcare settings A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation code assignment and reporting of diagnoses and procedures These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported The importance of consistent complete documentation in the medical record cannot be overemphasized Without such documentation accurate coding cannot be achieved

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