

How are permanent codes different from temporary codes? What could be the result of a system without permanent codes? Provide examples in your answer. Due day 2 in the Main Forum.

Week # 6 Discussion Question 1

Permanent Codes cannot be changed unless all panel members agree. Advisers from private payers also help with input to the workgroup of panel members. After checking with a payer for specific codes an insurance specialist may use a miscellaneous or not otherwise classified code if a permanent code is not available.

Temporary Codes are also used by many payers, and when Temporary Codes change to permanent national HCPCS Level II codes the coding reference indicates the change. There are different codes for different services C codes valid only on Medicare claims used for the hospital outpatient prospective payment system, G codes are for the professional component of services and procedures not found in the CPT. There are also Q codes, K codes, S codes, H codes, and T codes that are all identifiable to a certain service and reimbursable for certain payers (Valerius, Bayes, Newby, Seggem, 2008, p. 192).

The HCPCS Level II permanent codes are released on January 1 of every year, and the Temporary national codes are updated quarterly. The HCPCS website list all updated HCPCS codes and also provides an alphabetical index. The updated temporary codes are also posted on the website and explain the effective dates. The result of a system without permanent codes would increase denied payments, and would also delay payments. Permanent codes are needed because of many new procedures that are being used and introduced, as well as new equipment that can assist patients much better in their everyday living and well-being.

Reference:

Valerius, J., Bayes, N.L., Newby, C., Seggern, J., (2008). Part II claim coding. *Medical Insurance An Integrated Claims Process Approach* (3rd ed.). New York, NY: McGraw-Hill

Permanent national codes are that are used by all government and private payers are maintained by the CMS HCPCS Workgroup. Private payers consist of consultants that participate in the workgroups whose responsibility is to determine the services for which new codes are needed. If each and every one of the group do not agree upon the changing of a code, in that case no code changes can be made. A number of the permanent codes are not categorized as NEC as the ICD-9-CM codes but are categorized as miscellaneous however the codes are used to bill for services and items that do not have permanent codes. The temporary codes will become permanent if there is an indication that service is being regularly used and as the codes become permanent the coding reference will indicates the change. Temporary codes are updated periodically usually every quarter. When temporary codes are established is generally used in ninety days. This ninety day time period is to allow suppliers and health care practices to be notified by means of newsletter or bulletin regarding the new updates. The results of using a system without permanent codes is the physician practices would result in a delay of payments and increase the chances of denied claims. (Valerius et al., 2008)

Reference:

Valerius, J., Bayes, N.L., Newby, C., Seggern, J., (2008). Part II claim coding. *Medical Insurance An Integrated Claims Process Approach* (3rd ed.). New York, NY: McGraw-Hill

Briefly explain the steps used to assign HCPCS codes for billing purposes. Do you believe it is more or less efficient to use different billing procedures for Medicare, Medicaid, or private payers? Why or why not? What are advantages and disadvantages of having unique coding systems for each type of insurance? Due day 4 in the Main Forum.

Week # 6 Discussion Question 2

The steps in coding with HCPCS are very similar to the ICD-9-CM. The first thing is looking up the item or service in the alphabetical index, and then verifying the code using the tabular list of the HCPCS Level II code book. Also when needing to look up drugs there is a table of drugs in the HCPCS code book. When coding with HCPCS the coder needs to also pay attention to symbols that indicate new, revised, or deleted codes. Also it is important to pay attention to the

quantities and the method of administration of a drug as well as the dosage. HCPCS also uses modifiers called Level II modifiers used for coding services, supplies and procedures.

In coding with HCPCS codes I think it less efficient to use different billing procedures for Medicare, Medicaid, or private payers because it can easily get very confusing. Although one of the advantages of having a unique coding system for each kind of insurance lets the payer know the details of a service or a procedure which will indicate if they will pay or reject the claim. A disadvantage of having a unique coding system for each kind of insurance can easily confuse a coder into assigning the wrong code or modifier which can result in a higher rate of rejected claims and denials.

Reference:

Valerius, J., Bayes, N.L., Newby, C., Seggem, J., (2008). Part II claim coding. *Medical Insurance An Integrated Claims Process Approach* (3rd ed.). New York, NY: McGraw-hill

Response 2

To ensure the correct HCPCS coding the same process and guidelines are used as ICD-9-CM and CPT coding. The coder should begin by locating the name of the supply or item in the index. Once the item has been located verify the possible code selection in the Tabular List section of the HCPCS Level II code book then the coder should assign the appropriate modifiers. Assigning drug codes are done by using the Table of Drugs in the HCPCS code book. The drugs are alphabetically arranged followed by the dosage, how the drug is administered such as oral, nasal or intravenously and the HCPCS code. The code chosen by the coder must correctly match the dosage and route documented in the medical record or on encounter form. HCPCS modifiers include two letters or a letter and number and are used to clarify a HCPCS code by making it more specific (Valerius et al., 2008). I believe it would be easier if Medicaid, Medicare and private insurances used one set codes it would cut down on the work load and eliminate billing mistakes. Disadvantages of having a unique coding system for each type of insurance is the coder must continuously verify the code entered for insurance billing to verify it has not changed. Advantages of a coding system are diseases, procedures and equipment used can be distinguished and verified more easily.

Reference: