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LESLIE PADÍN ROSARIO,
RN, BSN, RHIA

# Common Medical Abbreviation and Terms for Medical Coding & Billing

## Featuring

- Medical Abbreviations
- Coding and Billing Terminology
- Explanation of other terms in coding

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# MEDICAL TERMINOLOGY AND ABBREVIATION TERMS FOR INPATIENT CODING

This dictionary serves as a guide for professionals who want to enhance or update their skills in understanding medical terms used in an inpatient setting and coding. It is an ideal resource for individuals working in medical coding scenarios, and serves as an excellent complementary tool to prepare for advancing in their professional career.

**With this dictionary you will be able to:**

Improve your medical coding skills by learning to interpret medical terminology accurately.

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Learn and understand the fundamentals in medical coding

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Improve your coding productivity

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## About the Editor:

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### Leslie Padín, RN, BSN, RHIA

Leslie Padín earned her degree from the Medical Sciences Campus in Río Piedras, Puerto Rico. She currently holds the position of Chief Executive at Infinity HIM Consulting, and also serves as a Professor of Medical Auditing at NUC's Online Division. In addition, she is the Residency Administrator for an Internal Medicine Residency Program at a hospital.

# Medical Abbreviations (A-Z)

## A - Medical abbreviations

- a.c.: Before meals. As in taking medicine before meals.
- a/g ratio: Albumin to globulin ratio.
- ACL: Anterior cruciate ligament. ACL injuries are one of the most common ligament injuries to the knee. The ACL can be sprained or completely torn from trauma and/or degeneration.
- Ad lib: At liberty. For example, a patient may be permitted to move out of bed freely and orders would, therefore, be for activities to be ad lib.
- AFR: Acute renal failure
- ADHD: Attention deficit hyperactivity disorder
- ADR: Adverse drug reaction. If a patient is taking a prescription drug to treat high blood pressure disease
- AIDS: Acquired immune deficiency syndrome
- AKA: Above-the-knee amputation.
- ALL: Acute lymphoblastic leukemia
- AMI: Acute myocardial infarction (heart attack)
- Anuric: Not producing urine. A person who is anuric is often critical and may require dialysis.
- ANED: Alive no evidence of disease. The patient arrived in the ER alive with no evidence of disease.
- ADH: Antidiuretic hormone
- ARDS: Acute respiratory distress syndrome.
- ARF: Acute renal (kidney) failure
- ASCVD: Atherosclerotic cardiovascular disease. A form of heart disease.

## B - Medical abbreviations

- b.i.d.: Twice daily. As in taking medicine twice daily.
- bld: Blood. Blood was visible on the patient's scalp.
- Bandemia: Slang for an elevated level of band forms of white blood cells.
- Bibasilar: At the bases of both lungs. For example, someone with pneumonia in both lungs might have abnormal bibasilar breath sounds.
- BKA: Below the knee amputation.
- BMP: Basic metabolic panel. Electrolytes (potassium, sodium, carbon dioxide, and chloride) and creatinine and glucose.
- BP: Blood pressure. Blood pressure is recorded as part of the physical examination. It is one of the "vital signs."
- BPD: Borderline personality disorder. A personality disorder.

BSO: Bilateral salpingo-oophorectomy. A BSO is the removal of both of the ovaries and adjacent Fallopian tubes and often is performed as part of a total abdominal hysterectomy.

**C - Medical abbreviations**

- C&S: Culture and sensitivity, performed to detect infection.
- C/O: Complaint of. The patient expressed concern.
- cap: Capsule.
- Ca: Cancer; carcinoma. For example, a patient who underwent treatment for cancer should ensure that they are eating and drinking enough fluids daily, both during and after treatment.
- CABG. Coronary artery bypass graft. A surgery involving the heart.
- CBC: Complete blood count.
- CC: Chief complaint. The patient's main concern.
- CDE: Complete dental (oral) evaluation.
- cc: Cubic centimeters. For example, the amount of fluid removed from the body is recorded in ccs.
- Chem panel: Chemistry panel. A comprehensive screening blood test that indicates the status of the liver, kidneys, and electrolytes.
- CPAP: Continuous positive airway pressure. Treatment for sleep apnea.
- COPD: Chronic obstructive pulmonary disease.
- CT: Chemotherapy. A type of treatment therapy for cancer.
- CVA: Cerebrovascular accident (Stroke).

**D - Medical abbreviations**

- **D/C or DC**: Discontinue or discharge. For example, a doctor will D/C a drug. Alternatively, the doctor might DC a patient from the hospital.
- **DCIS:** Ductal Carcinoma In Situ. A type of breast cancer. The patient is receiving treatment for Ductal Carcinoma In Situ.
- **DDX:** Differential diagnosis. A variety of diagnostic possibilities are being considered to diagnose the type of cancer present in the patient.
- **DJD:** Degenerative joint disease. Another term for osteoarthritis.
- **DM**: Diabetes mellitus.
- **DNC, D&C, or D and C**: Dilation and curettage. Widening the cervix and scrapping with a curette for the purpose of removing tissue lining the inner surface of the womb (uterus).
- **DNR**: Do not resuscitate. This is a specific order not to revive a patient artificially if they succumb to illness. If a patient is given a DNR order, they are not resuscitated if they are near death and no code blue is called.
- **DOE**: Dyspnea on exertion. Shortness of breath with activity.

- DTR: Deep tendon reflexes. These are reflexes that the doctor tests by banging on the tendons with a rubber hammer.
- DVT: Deep venous thrombosis (blood clot in a large vein).

**E - Medical abbreviations**

- ETOH: Alcohol. ETOH intake history is often recorded as part of patient history.
- ECT: Electroconclusive therapy. A procedure used to control seizures (convulsions).

**F - Medical abbreviations**

- FX: Fracture.

**G - Medical abbreviations**

- g: gram, a unit of weight. The cream is available in both 30 and 60-gram tubes.
- GOMER: Slang for "get out of my emergency room."
- GvHD: Graft vs. host disease. It is complicated by the syndromes of acute and chronic graft-vs-host disease (GVHD).
- gtt: Drops.

**H - Medical abbreviations**

- H&H: Hemoglobin and hematocrit. When the H & H is low, anemia is present. The H&H can be elevated in persons who have lung disease from long term smoking or from disease, such as polycythemia rubra vera.
- H&P: History and physical examination.
- h.s.: At bedtime. As in taking medicine at bedtime.
- H/O or h/o: History of. A past event that occurred.
- HA: Headache.
- HRT: Hormone replacement or hormone replacement therapy.
- HTN: Hypertension.

**I - Medical abbreviations**

- I&D: Incision and drainage.
- IBD: Inflammatory bowel disease. A name for two disorders of the gastrointestinal (BI) tract, Crohn’s disease and ulcerative colitis
- ICD: Implantable cardioverter defibrillator
- ICU: Intensive care unit. The patient was moved to the intensive care unit.

- IM: Intramuscular. This is a typical notation when noting or ordering an injection (shot) given into a muscle, such as with B12 for pernicious anemia.
- IMP: Impression. This is the summary conclusion of the patient's condition by the healthcare professional at that particular date and time.
- ITU: Intensive therapy unit
- in vitro: In the laboratory
- in vivo: In the body
- IPF: Idiopathic pulmonary fibrosis. A type of lung disease.
- IU: International units.

**J - Medical abbreviations**

- JT: Joint.

**K - Medical abbreviations**

- **K**: Potassium. An essential electrolyte is frequently monitored regularly in intensive care.
- **KCL**: Potassium chloride.

**L - Medical abbreviations**

- **LCIS:** Lobular Carcinoma In Situ. A type of cancer of the breast. The patient is receiving treatment for Lobular Carcinoma In Situ.
- **LBP**: Low back pain. LBP is one of most common medical complaints.
- **LLQ**: Left lower quadrant. Diverticulitis pain is often in the LLQ of the abdomen.
- **LUQ**: Left upper quadrant. The spleen is located in the LUQ of the abdomen.
- **Lytes**: Electrolytes (potassium, sodium, carbon dioxide, and chloride).

**M - Medical abbreviations**

- **MCL**: Medial collateral ligament.
- **mg**: Milligrams.
- **M/H:** Medical history
- **ml**: Milliliters.
- **MVP**: Mitral valve prolapse.

**N - Medical abbreviations**

- N/V: Nausea or vomiting.
- Na: Sodium. An essential electrolyte is frequently monitored regularly in intensive care.
- NCP: Nursing care plan.
- NPO: Nothing by mouth. For example, if a patient was about to undergo a surgical operation requiring general anesthesia, they may be required to avoid food or beverage prior to the procedure.
- NSR: Normal sinus rhythm of the heart.

**O - Medical abbreviations**

- O&P: Ova and parasites. Stool O & P is tested in the laboratory to detect parasitic infection in persons with chronic diarrhea.
- O.D.: Right eye.
- O.S.: Left eye.
- O.U.: Both eyes.
- ORIF: Open reduction and internal fixation, such as with the orthopedic repair of a hip fracture

**P - Medical abbreviations**

- P: Pulse. Pulse is recorded as part of the physical examination. It is one of the "vital signs."
- p¯: After meals. As intake of two tablets after meals.
- p.o.: By mouth. From the Latin terminology per os.
- p.r.n.: As needed. So that it is not always done, but done only when the situation calls for it (for example, taking pain medication only when having pain and not without pain).
- PCL: Posterior cruciate ligament.
- PD: Progressive disease. Patients at risk of developing progressive disease of the kidneys include those with proteinuria or hematuria.
- PERRLA: Pupils equal, round, and reactive to light and accommodation.
- PFT: Pulmonary function test. A test to evaluate how well the lungs are functioning.
- PERRLA: Pupils equal, round, and reactive to light and accommodation.
- Plt: Platelets, one of the blood-forming elements along with the white and red blood cells.

- PMI: Point of the maximum impulse of the heart when felt during the examination, as in beats against the chest.
- PMS: Premenstrual syndrome
- PT: Physical therapy
- PTH: Parathyroid hormone
- PTSD: Post-traumatic stress syndrome
- PUD: Peptic ulcer disease. A type of ulcer of the stomach.

**Q - Medical abbreviations**

- q.d.: Each day. As in taking medicine daily.
- q.i.d.: Four times daily. As in taking a medicine four times daily.
- q2h: Every 2 hours. As in taking a medicine every 2 hours.
- q3h: Every 3 hours. As in taking a medicine every 3 hours.
- qAM: Each morning. As in taking medicine each morning.
- qhs: At each bedtime. As in taking medicine each bedtime.
- qod: Every other day. As in taking medicine every other day.
- qPM: Each evening. As in taking medicine each evening.

**R - Medical abbreviations**

- RA: Rheumatoid arthritis. A type of joint disease.
- RDS: Respiratory distress syndrome
- R/O: Rule out. Doctors frequently will rule out various possible diagnoses when figuring out the correct diagnosis.
- REB: Rebound, as in rebound tenderness of the abdomen when pushed in and then released.
- RLQ: Right lower quadrant. The appendix is located in the RLQ of the abdomen.
- ROS: Review of systems. An overall review of concerns relating to the organ systems, such as the respiratory, cardiovascular, and neurologic systems.
- RUQ: Right upper quadrant. The liver is located in the RUQ of the abdomen.

**S - Medical abbreviations**

- s/p: Status post. For example, a person who had a knee operation would be s/p a knee operation.
- SAD: Season affective disorder. A type of depression that occurs during the winter months when there is little light.
- SOB: Shortness of breath.
- SQ: Subcutaneous. This is a typical notation when noting or ordering an injection (shot) given into the fatty tissue under the skin, such as with insulin for diabetes mellitus.

- T - Medical abbreviations
- T: Temperature. Temperature is recorded as part of the physical examination. It is one of the "vital signs."
- T&A: Tonsillectomy and adenoidectomy
- t.i.d.: Three times daily. As in taking medicine three times daily.
- tab: Tablet
- TAH: Total abdominal hysterectomy
- TAH: Total abdominal hysterectomy. A type of surgery to remove a woman’s uterus, Fallopian tubes, and ovaries.
- THR: Total hip replacement
- TKR: Total knee replacement
- TMJ: Tempomandibular joint

**U - Medical abbreviations**

- UA or u/a: Urinalysis. A UA is a typical part of a comprehensive physical examination.
- U or u: Unit. Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (for example, 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so the dose is given in volume instead of units (for example, 4u seen as 4cc).
- ULN: Upper limits of normal
- URI: Upper respiratory infection, such as sinusitis or the common cold
- ut dict: As directed. As in taking medicine according to the instructions that the health care professional gave in the office or in the past
- UTI: Urinary tract infection

**V - Medical abbreviations**

- VSS: Vital signs are stable. This notation means that from the standpoint of the temperature, blood pressure, and pulse, the patient is doing well.

**W - Medical abbreviations**

- Wt: Weight. Body weight is often recorded as part of the physical examination.

**X - Medical abbreviations**

- XRT: Radiotherapy (external). A type of treatment that uses radiation.

# Medical Coding Terms & Definitions

**A**

**Alphabetic Index to Diseases and Injuries**

This is an alphabetical list of ICD-10-CM terms and their corresponding code or category that helps you decide which section to refer to in the Tabular List. It doesn't always supply the full code.

**Alphanumeric**

Consisting of letters and numbers

**B.**

**Bilateral**

A condition that affects both the left and right sides of the body or and organ or gland.

**C.**

**Character X**

Used as a placeholder in ICD-10-CM in certain codes to allow for future expansion and to fill in empty characters when a code that's less than 6 characters in length needs a 7th character.

**Clearinghouses**

In healthcare, clearinghouses are electronic hubs used by healthcare agencies to submit electronic claims to insurance companies securely. This ensures that patients' private health information is protected. Public or private entities, including:

- Billing services
- Repricing companies
- Community health management information or community health information systems
- Value-added networks and switches

**Conventions**

These are the general rules for the classification independent of the guidelines. ICD-10-CM incorporates these conventions within the Alphabetic Index and Tabular List as instructional notes.

**D**

**Diagnosis Codes**

Alphanumeric codes that represent medical terminology for diseases, disorders, or other medical conditions affecting the patient.

**Date of Service (DOS)**

The date the patient was seen by the healthcare service provider.

**Day sheet**

The day sheet summarizes the treatments, charges, and payments received on a specific day.

**Deductible**

You're probably familiar with the word deductible from your own insurance. This is the amount that a patient is required to pay before his or her insurance kicks in.

**Demographics**

A patient's demographics is required when filing a claim. This includes his or her age, race, and gender.

**Downcoding**

If an insurance company doesn't receive adequate documentation in support of a particular level of service, it may decide to reduce that service to a lower level, thereby reducing provider reimbursement.

**Duplicate coverage inquiry (DCI)**

If an insurance company wants to know if another insurance company is providing coverage for a patient, they may submit a duplicate coverage inquiry.

**Durable medical equipment (DME)**

This medical billing and coding term refers to equipment patients use to complete their activities of daily living. This includes walkers, wheelchairs, hospital beds, and portable oxygen equipment

**DRG (Diagnosis-Related Group Codes)**

Medicare and health insurers use Diagnosis-Related Group codes (DRG) to categorize the cost of patients' hospital stays to determine reimbursements. DRGs are comprised of other codes, including International Classification of Diseases, Tenth Revision (ICD-10) and Current Procedural Terminology (CPT), that are based on diagnoses, procedures, and patient demographics.

**EHR (Electronic Health Record)**

An Electronic Health Record (EHR) is the shareable, accessible collection of a patient's health information, from all practices and facets of care. It provides a longitudinal record of a patient's health.

**E.**

**Electronic claim**

This probably seems self-explanatory, but an electronic claim is a claim that is sent electronically to the payer.

**Electronic funds transfer**

Medical bills used to be paid by cash or check. Now you can pay them electronically via bank transfer, credit cards, and debit cards – all of which are electronic funds transfers.

**Electronic medical records (EMR)**

In days past, healthcare agencies kept paper medical records on each patient. Now these records are kept electronically.

**Electronic remittance advice (ERA)**

This form is sent from a health plan to the healthcare provider about a specific claim. It shares details about the contract agreement, benefit coverage, and the patient's copays and co-insurance information.

**Enrollee**

If the patient is covered by health insurance, they are listed on the policy as the enrollee.

**Explanation of Benefits (EOB)**

The EOB is a statement sent from the health insurance plan to the patient describing the claims they've received, how much they'll cover, and the patient's anticipated portion of the bill.

**F.**

**Fee for service**

A fee for service health plan is one where the insurance reimburses the provider for individual services or procedures performed on behalf of each patient.

**Fee schedule**

Each CPT treatment code has a pre-set cost to be paid to the service provider. That cost is listed on the fee schedule.

**Financial responsibility**

If a patient is responsible for paying a portion of the healthcare costs, those are referred to as being their financial responsibility.

**Fiscal intermediary (FI)**

This is someone who works for Medicare and processes claims.

**Formulary**

Insurance companies have lists of prescription drugs they are willing to pay to cover. This list is called a formulary.

**Fraud**

If a healthcare provider knowingly and intentionally submits a claim for a service or procedure that was not rendered, it is considered fraud. It is also considered fraud if the patient obtains services dishonestly.

## G.

**Group name and number**

Some patients have health plans as part of a group. An example of this is an employer-provided insurance policy or health insurance that is offered on behalf of a union or similar group. The group name and number are used to identify this group.

**Guarantor**

In some cases, someone other than the patient is responsible for health claim expenses not covered by insurance. This person is known as the guarantor.

## H.

**Healthcare Common Procedure Coding System (HCPCS)**

A standardized coding system is used to submit healthcare claims. HCPCS Level I codes include the CPT codes and are used to submit claims for physician services. HCPCS Level II codes are used for non-physician healthcare products and services. HCPCS Level III codes are used by Medicare, Medicaid, and private insurers.

**Healthcare providers**

This is perhaps one of the most frequently used words in the medical billing and coding industry. Providers refer to any facility, hospital, or office that offers healthcare services to patients. Your doctor is a provider and so is your local emergency room.

**Health Insurance Claim (HIC)**

The Social Security Administration designates each Medicare beneficiary with a number. This number is used to process its claims.

**Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 is a federal law designed to protect a patient’s private health information. Under HIPAA, their medical data cannot be released or disclosed without their consent.

**Health Savings Account (HSA)**

If a patient has a health savings account, it means that they have deferred monies, tax-free, into an account that can be used to cover their yearly medical expenses. The 2022 maximums for an HSA are $3,650 for an individual and $7,300 for a family.

**Hospice**

The Hospice Foundation of America explains that hospice is “medical care to help someone with a terminal illness live as well as possible for as long as possible, increasing quality of life.” All of the dying patient’s needs are addressed, as well as the needs of their family.

**I.**

**Indemnity**

Indemnity is another name for a fee-for-service insurance policy.

**In-network**

If a provider is “in-network,” it means that they’ve signed a contract with the insurance company and agree to accept a pre-determined amount for the services rendered. A provider who is in-network is also commonly referred to as “participating.”

**Inpatient**

Patients who are admitted to the hospital for longer than 24 hours fall under this designation.

**Intensive care**

Patients who are severely injured or ill may require care above and beyond typical hospital care. They are often admitted into intensive care, providing them with more intensive monitoring and medical attention.

**International Classification of Diseases (ICD codes)**

ICD is short for “International Statistical Classification of Diseases and Health Related Problems.” Currently, healthcare providers are operating under the 10th revision of this classification, which is referred to as ICD-10. There are about 68,000 codes within ICD-10 which are used to classify conditions, treatments, and procedures. These are the codes you’ll use as a biller and coder and they replace ICD-9, the ninth revision of this coding system.

**M.**

**Managed care plan**

This type of insurance plan requires enrollees to use healthcare providers that contract with the insurance company, as long as it is not a medical emergency and they are within the coverage area.

**Maximum out of pocket**

Most insurance policies offer a maximum out of pocket amount, meaning that if the insured exceeds this amount, the insurance company will pick up the rest of the eligible medical expenses.

**Medical billing specialist**

A medical billing specialist fills claims to insurance companies so that the provider can be paid.

**Medical coder**

A medical coder is the person responsible for coding patient information. These codes are then used in claims made to payers.

**Medical necessity**

This medical billing and coding terminology refers to any service that is needed for treatment. It does not include services that are cosmetic or experimental.

**Medical record number**

Each patient is assigned his or her own medical record number. It's similar to how each driver has his or her own designated driver's license number.

**Medical savings account**

Some employers provide their employees with medical savings accounts. These are tax exempt accounts used to reimburse employees after paying qualifying health-related bills.

**Medicare Star Rating**

Medicare health insurance plans get a star rating from the CMS based on how well they perform on certain measures. It is intended to rate the quality of individual doctors, hospitals and nursing homes. While the ratings have no effect on payments, they do have implications for marketing, recruitment and overall reputation. Higher Star Ratings translate into more members and increased revenues.

The star ratings are calculated by the CMS based on information submitted to them by the health care providers. The data comes from various sources: survey results, death rates, patient complaints and safety violations.

A rating of one star indicates poor performance, whereas a rating of five stars indicates excellent performance.

**Medical transcription**

Some healthcare providers speak their patient notes and have them converted to writing. This is called medical transcription.

**Medicare**

Medicare is a government insurance program for people ages of 65 and over. Medicare can also expand to people with qualifying disabilities. This includes individuals with permanent kidney failure or Lou Gehrig's disease. Medicare Part A is hospital coverage, Medicare Part B is coverage for outpatient visits, and Medicare Part D is prescription drug coverage.

**Medicaid**

Medicaid is a federal and state government insurance program for low income people and families.

**Modifier**

CPT codes use modifiers to provide even more information about a service provided.

**N.**

**National Correct Coding Initiative (NCCI)**

The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments of Medicare Part B and Medicaid claims.

**O.**

**Outpatient Code Editor (OCE)**

The 'Integrated' Outpatient Code Editor (I/OCE)

The 'integrated' Outpatient Code Editor (I/OCE) program processes claims for all outpatient institutional providers including hospitals that are subject to the Outpatient Prospective Payment System (OPPS) as well as hospitals that are NOT (Non-OPPS). Claim will be identified as 'OPPS' or 'Non-OPPS' by passing a flag to the I/OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.This version of the I/OCE processes claims consisting of multiple days of service. The I/OCE will perform three major functions:

• Edit the data to identify errors and return a series of edit flags.

• Assign an Ambulatory Payment Classification (APC) number for each service covered under OPPS, and return information to be used as input to a PRICER program.

• Assign an Ambulatory Surgical Center (ASC) payment group for services on claims from certain Non-OPPS hospitals.

Hospital Outpatient Prospective Payment System (OPPS)

CMS generally makes payment for hospital outpatient department services through the Hospital Outpatient Prospective Payment System (OPPS). This section discusses different payment policies for hospital outpatient department services.

**Out-of-network provider**

If a provider does not have a contract with a specific insurance company, they are considered an out-of-network or non-participating provider.

**Outpatient**

The term outpatient refers to any service provided in which the patient was treated for 24 hours or less.

**P.**

**Participating**

Participating is another word for in-network, meaning that a healthcare provider agrees to treat patients within a specific network.

**Place of Service (POS)**

Place of service (POS) codes are two-digit numerical codes which explain where services were provided. For example, a 01 code means that services were provided in a pharmacy. A code of 14 signifies services provided in a group home.

**Preferred Provider Organization (PPO)**

Like an HMO, a PPO also encourages patients to choose from within its network of healthcare providers. However, it is unlike an HMO in that a referral is not needed in order to see a specialist.

**Protected Health Information (PHI)**

Protected health information is essentially all of a patient's information that is protected under the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Journal explains that information which falls under PHI includes "demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage."

**Referral**

Have you ever gone to your primary doctor and been sent on to a specialist? Your primary doctor provided a referral for the specialist. This is when providers recommend other providers with specialized skillsets.

**R.**

**Relative value units (RVUs)**

This medical billing and coding term refers to a ranking system or scale that is used to determine physician payments. The RVU is determined by the physician's time and effort for that specific service, whether any specialized equipment was needed, and any other necessary resources.

**S.**

**Scrubbing**

Surprisingly, this doesn't refer to wearing scrubs. Instead, scrubbing is the process of checking claims for inaccuracies and errors before sending them for processing. Claims can be rejected for errors, so scrubbing is an important step.

**U.**

**Unbundling**

If more than one treatment code is submitted, even when it isn’t necessary, this is considered unbundling.

**Upcoding**

Healthcare providers who change a patient’s diagnosis code in an attempt to get a higher level of reimbursement are guilty of upcoding.

**V.**

**VBC**

Value-Based Care

Value-Based Care is a healthcare delivery model focused on outcomes and value for patients. Value is determined by the cost it takes to achieve the outcome the patient desires. This framework, based on the research of Harvard professor Michael Porter, includes six key elements:

- Organize Care Around Medical Conditions
- Measure Outcomes & Cost for Every Patient
- Aligning Reimbursement with Value
- Systems Integration
- Geography of Care
- Information Technology.

## Additional Medical Billing and Coding Abbreviations and Acronyms

AMA – American Medical Association
BCBS – Blue Cross Blue Shield
CMS – Centers for Medicare and Medicaid Services
CMS 1500 – Claim form used to submit claims to Medicare and Medicaid
DOB – Date of birth
GHP – Group health plan, i.e. insurance policies provided by employers.
HCFA – Health Care Financing Administration (now CMS)
MAC – Medicare administrative contractor
MSP – Medicare secondary payer
N/C – Non-covered charge
NPI – National provider identifier
OIG – Office of Inspector General
PCP – Primary care physician
PEC – Pre-existing condition
POS – Point-of-service plan
SOF – Signature on file
TAR – Treatment authorization request
TIN – Tax identification number
TOS – Type of service
TPA – Third party administrator
UPIN – Unique physician identification number

## Another Terms and Explanations

### What is SNOMED CT?

SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) is a comprehensive, multilingual clinical healthcare terminology. It is used in over 80 countries.

SNOMED CT represents coded items that may be used to capture, record, and share clinical data for use in healthcare. Rather than a flat list of numbers and terms, it is designed for input into electronic health records (EHRs), outputs, and reports. SNOMED CT is a very detailed model consisting of several hierarchies and relationships, which contains concepts, descriptions, relationships, and reference sets.

A concept is a unique, numeric identifier. One type of description is a fully specified name (FSN), which represents a unique (per dialect) description of a concept's meaning. Respective examples are 22298006 and "myocardial infarction (disorder)."

### What is LOINC?

LOINC (Logical Observation Identifiers Names and Codes) is a standardized universal coding system that facilitates the exchange and pooling of results, such as laboratory tests or vital signs, for clinical care, outcomes management, and research.

### What is a local code in terminology?

Local codes or custom codes in terminology are codes and descriptions generated from either an EMR or other healthcare organizations whose data structure is not standard.

### Why is clinical terminology difficult to manage?

Clinical terminology is difficult to manage because of a combination of the sheer volume of standard, custom, or local codes and the many different types of EMR systems across health systems and clinics, which may all use different codes and descriptions for the same term.

SNOMED CT has over 350,000 concepts, while ICD-11 will have over 80,000 concepts. Mapping and coding these concepts is highly complex due to the large numbers and disparate healthcare systems.

**How are mappings among terminology and classification standards managed?**

Mappings among terminology and classification standards are managed, in many cases, with large spreadsheets and proprietary in-house software.

**Unified Medical Language Systems (UMLS)** UMLS stands for Unified Medical Language Systems6 and is only available in English. Its purpose is to support mapping between various terminologies. UMLS contains several million concepts stemming from hundreds of bio(medical) vocabularies, such as ICD-10, MeSH and SNOMED CT as well as medical abbreviations. Liu et al. (2002) extracted 163,666 abbreviations full form pairs from UMLS. To read more about UMLS see Humphreys et al. (1998).

**HEDIS®**

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to help rate and compare health plan performance. HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes

HEDIS Measures Include:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk-Adjusted Utilization
- Health Plan Descriptive Information
- Measures are reported using Electronic Clinical Data Systems.

**Health Maintenance Organization (HMO)**

An HMO refers to a network of healthcare providers who agree to accept pre-determined amounts for specific services. If a patient has an HMO and goes outside this network, they will likely pay more as coverage for these providers is limited.

**Health Level 7 (HL7) Health Level 7 (HL7)**9 is the name of a set of standards for the interoperability between different systems in healthcare, for transferring data between patient records systems, and between patient records systems and laboratory systems or billing systems. See also Health Level Seven International.10 Fast Healthcare Interoperability Resources (FHIR) Fast Healthcare Interoperability Resources (FHIR).

**How is SDOH data captured?**

SDOH data is captured using ICD-10-CM codes within Chapter 21: Factors influencing health status and contact with health services (Z00-Z99). Z-codes are not new to the coding world; however, they have not historically been a primary focus for coders to review and capture.

With a greater focus on addressing health inequities, SDOH is in the spotlight as a strategic initiative of all stakeholders across the healthcare ecosystem. The HHS has recently announced that SDOH is one of the five overarching goals of its Healthy People 2030 initiative: “Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.”

**What are social determinants of health (SDOH) and why are they considered so important?**

The U.S. Department of Health and Human Services (HHS) defines SDOH as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affects a wide range of health, functioning, and quality-of-life outcomes and risks," such as education, safe housing, access to nutritious foods, transportation, and good air and water quality.

According to the World Health Organization, SDOH accounts for 30–55 percent of health outcomes, versus traditional clinical care, and those with unmet needs associated with SDOH are more likely to contribute higher, more costly healthcare utilization, not to mention poor physical and mental health.

**Healthcare Common Procedure Coding System (HCPCS)**

The Healthcare Common Procedure Coding System (HCPCS) uses much of the same information as the CPT classification, but it also includes details about certain medical services that aren't in the CPT codes. Healthcare providers use HCPCS most frequently for reporting services to insurance companies and other entities that offer reimbursements to patients with insurance, like Medicare and Medicaid. Common terminology to know regarding HCPCS codes includes:

- Level 1 codes: The first level of HCPCS codes is identical to CPT codes and describes the procedures, treatments, and services a healthcare provider gives a patient. Medicare and Medicaid consider these codes identical to CPT codes when healthcare providers bill these services to them, while other insurance providers may consider the codes within CPT.
- Level 2 codes: Level 2 of HCPCS refers to codes for medical equipment, specific medications, and some outpatient services the CPT system doesn't include. These codes can be specific, so it's important to be familiar with Level 2 codes to ensure the accuracy of all your coding information.
- Level 3 codes: You may use Level 3 codes within HCPCS to bill local insurance entities, such as state organizations or private insurers. These codes are specific to your location, and you may not use them frequently

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**Created by:**

**Leslie Padin Rosario, BSN, RHIA**
**CEO**

**C-939-284-1465**
**E- info@infinity-him.com**


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