Insurance Billing Codes: What You Need to Know

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Insurance codes are used by your health plan to make decisions about your prior authorization requests and claims, and to determine how much to pay your healthcare providers. Typically, you will see these codes on your Explanation of Benefits and medical bills.

Several types of codes are used and it's important to understand them so you can confirm that no mistakes were made in the billing process.

Explanation of Benefits
An Explanation of Benefits (EOB) is a form sent to you by your insurance company several days or weeks after you have a healthcare service that was paid by the insurance company.

Your EOB is your medical billing history. Review it carefully to confirm you received the service being billed, the amount your healthcare provider received and your share are correct, and that your diagnosis and procedure are correctly listed and coded.

The coding system
Health plans, medical billing companies, and healthcare providers use three different coding systems. These codes were developed to make sure that there is a consistent and reliable way to process claims. Generally, you will find the following descriptive codes on your EOB or Bill:

- ICD-9 or ICD-10
- CPT Codes
- HCPCS Codes (say “Hickpicks”)

ICD-9 and ICD-10 Codes
International Classification of Diseases, or ICD codes were developed by the World Health Organization (WHO), and are used to identify your health *condition*, or *diagnosis*.

ICD codes are often used in combination with the CPT codes to make sure that your health condition and the services you received match. For example, if your diagnosis is bronchitis and your doctor ordered an ankle X-ray, it is likely that the X-ray will not be paid for because it is not related to bronchitis. However, a chest X-ray is appropriate and would be reimbursed.

A complete list ICD codes can be found on the WHO website.

CPT Codes
Current Procedural Terminology (CPT) codes are used by healthcare providers to *describe the services* they provide. CPT codes are required on claim forms for health plans to pay providers.

CPT codes are developed and updated by the American Medical Association (AMA). However, the AMA does not provide open access to the CPT codes. Access is limited to medical billers only. Your healthcare provider may have a sheet that lists the most common CPT codes used in their office, which they may share with you.

Some examples of CPT codes:

- 99202 through 99205: Office or outpatient visits for a new patient
- 36415: Collection of venous blood by venipuncture (drawing blood)

HCPCS Codes
The Healthcare Common Procedure Coding System (HCPCS) is the coding system used by Medicare. If you do not have Medicare, you do not need to know these codes.

Level I HCPCS similar to CPT codes from the AMA. Medicare HCPCS Level II codes. These are used to identify products, supplies, and services that aren't covered under CPT codes, including ambulance services and durable medical equipment (wheelchairs, crutches, etc.), prosthetics, or orthotics that are used outside your doctor's office.

Some examples of Level II HCPCS codes are as follows:

- L4386: Walking splint
- E0605: Vaporizer

HCPCS code information is available to the public on the Centers for Medicare and Medicaid website.

Coding Errors
With a complex three coded system, human and automated mistakes happen. Because your health plan uses the codes to pay your healthcare provider, errors can cost you money.

A wrong code can result in an incorrect reimbursement amount for your healthcare provider and increase your out-of-pocket expenses. Or, your health plan may deny your claim and not pay anything.

If find something is incorrect on your EOB, contact your provider's office and your health plan. Ask them to clarify anything that you don't understand about your medical records and billing statements.