

10 Ways to Improve Medical Coding and Billing Accuracy

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Strive for Accuracy

The best way to prevent claims denials and improper payments is to keep them from happening in the first place. Before submitting a claim, be on the lookout for the following 10 common errors:

- 1. Noncovered charge:** The most common billing error is claiming a charge that insurance doesn't cover. This can be avoided by simply verifying coverage prior to rendering the service. Consult the General Exclusions section of the Medicare Benefit Policy Manual (Chapter 16) when in doubt about a Medicare claim.
- 2. Missing or incorrect information:** When patient, provider, or insurance information is missing or entered incorrectly, a denial will occur. A seemingly easy mistake to avoid, it has a higher likelihood when many people handle one claim. Whether you are the first or last person to handle a claim before submission, always check the spelling of names, insurance ID numbers, and other identifying information.
- 3. Double billing: Double** (i.e., duplicate) billing occurs when two providers attempt to get paid for the same service or when billing for the same service more than once. It is extremely important to verify that a service has not already been billed — if duplicate billing happens too often, government agencies may accuse your practice of fraud and impose fines.

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4. Unbundling: Unbundling refers to listing multiple charges separately for services that should be billed under a single code. Incorrectly unbundling services, whether in error or to obtain higher reimbursement, is fraudulent. Always check National Correct Coding Initiative edits to learn which codes are bundled and when unbundling is permitted.

5. Up-coding: When a code is incorrectly used to reflect a more severe diagnosis or treatment, resulting in a higher reimbursement rate, this is called “up-coding.” This illegal practice is a violation of the federal False Claims Act and should be avoided at all costs to avoid legal action against the provider.

6. Under-coding: Failing to report the full extent of services/procedures, or “under-coding,” does not help a practice avoid denials and audits. Under-coding results in loss of revenue for the practice and incorrect reporting that could result in negative outcomes for the patient.

7. Insufficient documentation: When a doctor does not document a patient encounter in detail, the coder does not have all the information needed to code correctly. This often leads to a denial citing lack of medical necessity. Communicate with your doctors for clarification when you believe their documentation does not support the level of service being billed.

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8. Overuse of modifier 22: Modifier 22 Increased procedural services is for use with surgical procedures only; it is not intended for use with evaluation and management (E/M) services codes. CPT® guidelines tell us we may append modifier 22 “when the work required to provide a service is substantially greater than typically required.” However, “substantially greater” is not clearly defined, so many providers use their own interpretation. Make sure documentation supports the use of this modifier and be prepared for payers to request documentation.

9. Failure to use up-to-date coding: Code set revisions after the January 1 update are common. Check for code updates throughout the year to make sure you are using the most current codes when filing claims.

10. Expenses incurred prior to coverage: Trying to claim payment for services performed before insurance coverage goes into effect will always result in a denial. Again, always verify coverage prior to a patient’s visit