Billing and coding errors

ASSIGN BUSTER

There are several errors that can happen during the coding and billing process. Claims are often rejected or downcoded because of medical necessity errors, coding errors, and errors related to billing. Claims denied for medical necessity are often denied for this because the reported services are not consistent with the diagnosis or do not meet generally accepted professional medical standards of care.

Claims with coding errors could be that you used truncated coding. This means you billed with a non-specific (enough) diagnosis code. Or that you billed a code that does not match the age or gender of the billed patient. Some common billing errors are that you used an inappropriate modifier.

Major strategies to ensure compliant billing are to carefully define bundled codes and know global periods, benchmark the practice's E/M codes with national averages, keep up to date through ongoing coding and billing education, be clear on professional courtesy and discounts to uninsured/low-income patients, maintain compliant job reference aids and documentation templates, and audit the billing process.

The Medicare National Correct Coding Initiative has a lot of influence on the billing and coding process. The CCI edits are computerized screenings designed to deny claims that do not comply with Medicare's rules on claims for more than one procedure performed on the same patient (Medicare beneficiary), on the same date of service, by the same performing provider. The three types of edits are: column 1/column 2 pair codes, in which the first column's code includes any codes in the second column, which should not be billed separately; mutually exclusive edits, which list code pairs that will not

both be paid for the same date of service; and modifier indicators, which note whether the appropriate use of a CPT modifier will allow the claim to bypass the edit.