Ways to combat common medical billing errors

Medical billing errors arise out of some basic typographical errors and lack of or incorrect data. No matter the mistake, there is a significant amount of time and revenue lost in reworking on the error. Loss or delay in payment drains the practice of the life of any practice, big or small, where a steady flow of reimbursement is required to keep going.

Following are some common medical billing errors that take place-

1- Incorrect Patient Information- Entering the wrong identification number is one of the most common errors that happen. This will give rise to resubmission of claims and a delay in the payment.

2- Unbundling – The term implies charges that are typically supposed to fall under one code are actually listed separately, giving you a higher bill which otherwise would be billed at a package rate.

3- Invalid diagnosis codes- With the diagnosis and procedure codes being updated annually, there would be couple of common codes used by you deleted or changed. In such cases, if you miss entering the updated codes, you will certainly face a denial.

4- Lack of treatment information- If the provider fails to provide the coder with sufficient information about the diagnosis and treatment, there could be a mismatch with the treatment provided and coded for, resulting in rejection of claim due to 'lack of medical necessity'.

Irrespective of the fact that such common errors occur, there are ways to curb them and have a smooth billing process ensuring timely and complete payments.

- Have a checklist and reminders handy that will act as a guide for correct coding which will help in having fewer rejections and denials.

- Verifying insurance is one of the important things to follow as not verifying it can cost you not just dollars but also time. It is imperative that the staff is aware about the new and returning patients. As every policy have its limits and regulations, contacting insurance provider to check the dates, coverage period, deductibles etc. will help confirm on the insurance and minimize instances of denials.

- Having simple inaccuracies leading to denials, a well trained staff will go a long way in reducing basic errors. They must be made familiar with patient chart, double checking patient information, understanding if diagnosis code corresponds with the procedure and the updates that take place. Denials caused by such trivial errors can be refilled but it is until 40-45 days that you will get reimbursed.

- A practice management system can be of great use which can help the staff automate charge captures and manage practice tasks.

Errors will happen due to very basic reasons; however what is important is to learn to work around them and ensure mistakes do not repeat, let face higher denials. The new coding system, ICD-10 will certainly add on to the number of denials. Keeping abreast with latest happening and changes in healthcare and being alert while billing claims will help minimize rejections and denials.