10 Common Medical Billing Mistakes That Cause Claim Denials

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Medical coding and billing involve complex processes that can differ depending on the patient, insurer and procedure. Even the most diligent financial services departments experience claim denials, but knowing the most common mistakes can help you take steps to avoid them.

Here, we discuss the first five most common medical coding and billing mistakes that cause claim denials so you can avoid them in your business:

1. **Claim is not specific enough.**

   Each diagnosis must be coded with the highest specificity for that code (the maximum number of digits for the code must be used).

   Remember, ICD-10 codes now include anatomical location including laterality (right or left side) in the code descriptor.

2. **Claim is missing information.**

   Any missing information may be cause for a denial, but the most common missing items are:

   - **Date of accident**
   - **Date of medical emergency**
   - **Date of onset**

   Be sure to scrutinize all claims for missed fields and required supporting documentation.

3. **Claim not filed on time (aka: Timely Filing)**

   If a proper claim is submitted, but it's not within the timing window, it may result in a denial. It is recommended that you check with your Payers regarding their filing deadlines.

   Medicare providers should be aware that the Affordable Care Act reduced the claims-submittal period from between 15 and 27 months down to 12 months. The start date for a Medicare claim is the date the service is provided to the patient or the "From" date on the claim form. The claim must be received by the appropriate Medicare claims processing contractor prior to the end date (exactly one calendar year after the start date). If a claim is sent prior to the end date but received after, it will be denied.

   It is vital that you understand the process in addressing timely issues. **The understanding of what to submit for supporting documentation to receive reimbursement is critical to appealing timely issues.** You will not be reimbursed for the services denied timely if you do not understand how to handle them. Commercial and Medicare have different guidelines that are considered timely filing.

Per Section 6404 of the Patient Protection and Affordable Care Act (ACA), Medicare fee-for-service (FFS) claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. Claims with dates of service January 1, 2010, and later received more than one calendar year (12 months) beyond the date of service will be denied and/or rejected as being past the timely filing deadline.

Other Key Points of Medicare Change Request 7080:

- **For institutional claims** that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim will be used to determine the date of service for claims filing timeliness.
- **For professional claims** (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "From" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items). **BE AWARE:** If a line item "From" date is not timely, but the "To" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.

4. **Incorrect patient identifier information.**

To avoid this **error**, make sure the patient's name is spelled correctly, the date of birth and sex are accurate, the correct insurance payer is entered and the policy number is valid. It's also a good idea to check whether or not the claim requires a group number, the patient's relationship to the insured is accurate, and the diagnosis code matches the procedure performed. Finally, make sure the primary insurance is listed as such in the case of multiple insurances.

5. **Coding issues.**

If you are using an outdated codebook or your coder or biller enters the **wrong code**, your claim could be denied.

The use of outdated coding books either CPT (Current Procedural Terminology), ICD-10 (International Classification of Diseases) or (Healthcare Common Procedure Coding System) HCPCS and/or super bills will result in loss of revenue.

Insufficient documentation occurs when documentation is inadequate to support payment for the services billed or when a specific required documentation element is missing. When coding and submitting claims it is imperative that what is documented is billed. If it is not documented, carriers consider the service(s) were not performed. However, denials related to insufficient documentation, no documentation, and medical necessities are more complicated because providers must be involved in improving the process. Coders unequivocally play a key role in denials avoidance, and they are best suited to proactively identify process deficiencies by using a proactive not reactive approach.

The follow ruling is important to understand how carriers look at errors in billing. Striving to be proactive not reactive to any concerns and wanting to be sure that practices do not ever fall into the violation of 18 U.S.C. § 1347. Under that code section, it is a felony to knowingly defraud any health benefit program or to fraudulently receive payment from any health benefit program, and/or under 18 U.S.C. § 1035, which makes it a felony to willfully make fraudulent statements or representations in connection with the receipt of payments for health care benefits. This is nothing that a practice would ever knowingly do but not using correct billing, procedures and protocols could put you at risk. The practice should take no comfort in claiming lack of knowledge or that they were mistaken about the law should audits occur.

The statutes governing health care fraud do not provide leniency for a provider's lack of knowledge therefore protocols should be in place for your office to make sure should you have an audit that you have mitigated your risk and liability.

6. **Duplicate billing.**

Many times, a duplicate bill is the result of human error. However, duplicate bills can result from resubmitting a claim instead of a follow up or canceling a procedure or test but not removing it from the patient account. All claims processing systems contains criteria to evaluate all claims received for potential duplication.

The claims are placed into two categories: exact duplicate or suspect duplicate. Due to the nature of the service, some claims may only appear to be duplicates. Proper coding of the service with the applicable condition codes or modifiers will identify the claim as a separate payable service, not a duplicate. **Exact duplicate claims will contain the following:**

- HIC number
- Provider number
- From date of service
- Through date of service
- Type of service
- Procedure code
- Place of service
- Billed amount

7. **Upcoding or unbundling.**

Upcoding refers **to** intentionally using a higher-paying code on a claim to receive a higher reimbursement or billing a covered Medicare service in place of a not-covered service. Unbundling refers to submitting bills piecemeal to maximize reimbursement for tests or procedures that are required to be billed together.

Upcoding refers to a provider's use of CPT Codes to bill a health insurance payer (private, Medicaid or Medicare) for providing a higher-paying service than was performed. It is critical to

understand that upcoding is illegal. It is considered fraudulent practice used by providers who bill for additional services not documented and/or performed.

Another common example of improper coding called "*unbundling*," also known as "*fragmentation*." Some health care providers seeking to increase profits will "unbundle" the tests and/or procedures and bill separately for each component of the group, which totals more than the special reimbursement rates. We must be aware that doing this by adding modifiers does not make this practice acceptable or legal.

Medicare reimburses surgeries based on a package of care (global surgery package). When unbundling for the purpose of receiving additional payments although may seem profitable is illegal. It is very important to understand the usage of modifiers and there purpose in the role of coding. Surgeries are designated in the CMS Medicare Physician Fee Schedule Database (MPFSDB) with 0, 10, or 90 global days.

8. **Further documentation requested to support medical necessity.**

Sometimes a payer requires medical records before it can adjudicate a claim. This may include the patient's medical history, physical reports, physician consultation reports, discharge summaries, radiology reports and/or operative reports.

Medicare and private payers recognize medical necessity as a deciding factor for claims payment and processing. Each payer might have its own definition but the outcome is the same. The best way to stay within the bounds of medical necessity is to think of each element of the history and physical exam as a separate procedure performed only if there is a clear medical reason to do so. The key is always to have documentation to support level of service should records be requested. No documentation equals no services performed. According to section 1862(a)(1)(A) of the Social Security Act, Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

9. **Referral or prior authorization required.**

Some payers require you to obtain prior authorization or a referral prior to certain services or procedures being performed. When there is a referral or prior authorization that is sometimes required, it is important to understand the difference.

The primary care physician, who sends the patient to another healthcare provider for treatment or tests, issues a referral.

The payer to perform the necessary service(s) issues a prior authorization. It is understood by carriers that obtaining prior authorization is still not a guarantee of payment.

The submitted claim must still be;

1) Supported by medical necessity,

2) Filed within the timely filing requirements, and

3) Filed by the provider mentioned in the referral or authorization.

10. **Services not covered/coverage terminated.**

Because insurance information can change at any time, it's critical to verify eligibility every time services are provided. Make sure the patient's coverage has not been terminated, their maximum benefit has not been met (for things like physical therapy and behavioral health) and the service you're providing is covered by their plan. Understanding the patients plan and the services you are providing is important.

With some plans, services have a cap although if following correct guidelines and supporting documentation these services will still be covered. Some examples of these are physical therapy, speech or occupational therapy and the use of correct modifiers.

Coverage can change therefore it is important to verify and receive updated coverage from your patients. Ask them each time – they will forget to tell you. Again, a proactive approach is needed.

It is also very important to verify before doing procedures and providing services requiring prior authorization under the terms of a member's plan. If prior authorization is required then it needs to be supplied when filing the claim.