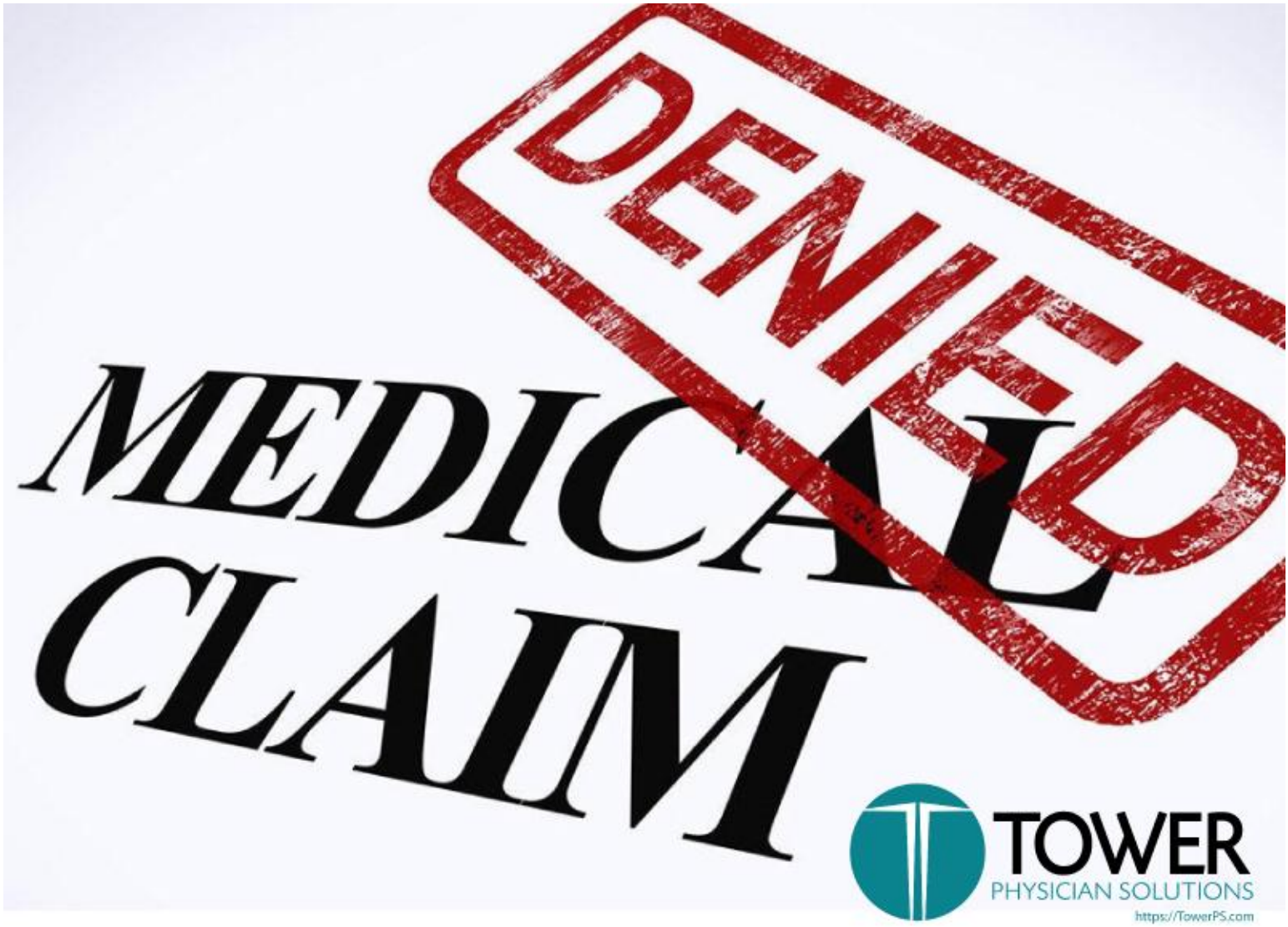

Part 1: Top Medical Billing and Coding Errors

An error in medical billing is usually something along the lines of data entry or typing errors. The problem is that a mistake in medical billing can make the difference between a payment being made – or not. Simple mistakes are easy to make; a human error has to be allowed for, but lost fees can really drain the finances of a medical practice, it's up to the medical billers working hard to keep the mistakes to a minimum. Along with this, effective communication can go a long way to ensuring these mistakes are stopped in their tracks before they even become a problem. It is important to have a highly skilled and experienced team of medical coders onboard to ensure that there are absolutely no errors in the claim. Here are some of the most common medical billing errors -

1. Upcoding Errors

Upcoding errors are the ones when the patients are billed for more complicated and expensive procedures than what they received. These errors occur when the billing department's executive makes an error while entering the treatment and diagnosis codes.

2. Insufficient Data

This error occurs when the medical organization fails to provide the relevant information to the payers to support the claim which leads to claim denial. Employee's mistakes can cause these errors. It can also occur when the physicians fail to provide accurate diagnosis information.

3. Incorrect Procedural Codes

A simple slip of the finger can lead to a major data entry issue and can change the procedural codes. This error mainly occurs when the information is incorrectly documented from the encounter forms and other supporting documents.

4. Unbundling Errors

This involves separating the procedure into several different smaller procedures. Each of them is billed and coded separately when there exists a comprehensive code of the entire procedure. This is an unethical way of billing a patient and can call for an audit. Hence, it is important that your medical coders are aware of this error.

5. Code Not Specific

Some of the ICD-9 codes need a fourth or fifth code to get to the highest specificity. If this is left incomplete, the claim will be rejected. If the coder is unsure about the highest level of specificity, then it is important that they check the codebook or browse the internet to get his facts right.

6. Misinterpretation of Reports

Coders usually do not code the actual medical procedure without the description having the actual operative details. Otherwise, it can lead to misinterpretation of the operative reports and mistakes in the medical billing and coding process.

7. Outdated References

The staff must be updated with the latest changes in the medical codes. The references used by coders must be regularly updated as and when there are changes in the coding system. Any outdated reference must be immediately replaced by the new ones, otherwise, it can lead to revenue loss.

8. Duplicate Billing

This is a human error wherein the same medical procedure is billed more than once. This can result in re-submitting a claim rather than sending in a follow-up claim. These claims are usually categorized into two groups - exact duplicate and suspect duplicate.

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