



## **Common Medical Billing Mistakes and Solutions: A Local Health Department Perspective**

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Illinois Public Health Association

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## Executive Summary

Medical billing mistakes can lead to delayed payments, claim denials, customer complaints and lost productivity. This is true regardless of whether a healthcare provider is associated with a private medical practice, hospital, local health department, or a local health organization. This paper addresses common medical billing mistakes, with a particular focus on the impact for Local Health Departments (LHDs). Common medical billing mistakes include:

1. Failure to verify insurance – as a result, a LHD might provide services to an individual who is not covered by insurance on the date of service. The resulting claim denial represents both a potential loss of revenue (if the individual cannot pay, then the LHD faces a bad debt write-off) and inefficient use of resources (both the time to submit the claim, as well as the follow-up in trying to resubmit a denied claim or seeking payment from the client).
2. Filing an incomplete claim – a single empty or unchecked box on a claim can be all it takes to incur a denial. Even the most basic fields like gender, date of birth, or date of service are commonly left blank, triggering a claim denial.
3. Coding errors – recent changes to procedural and diagnostic coding systems place an extra strain on limited LHD billing staff resources. Inexperienced LHD staff might fail to recognize the appropriate codes and coding patterns, which will lead to medical billing mistakes and claim denials. Coding errors can arise in a number of different areas, but the net result remains an inefficient use of resources and potential for loss of revenue.
4. Lack of specificity – similar to coding errors, billing errors related to lack of specificity arise in the context of submitting an insurance claim without enough detail to warrant reimbursement. The most common errors include not providing all of the required information on procedural or diagnostic codes, which creates ambiguity and ultimately, leads to claim denial.
5. Missing filing deadlines – Third-party payers can have drastically different windows in which providers can file insurance claims. As a result, LHDs that do not maintain awareness of timely filing deadlines are subject to claim denials. In some cases, previous errors can lead to situations where even if a LHD submits a revised and correct claim, the third-party payer will still deny the claim because the resubmission falls outside the timely filing window.

The best solutions to addressing medical billing mistakes include working with well-trained professionals. Suggestions also include increasing the investment in training for LHD staff, working with third-party medical billing professionals (i.e., outsourcing), putting in action well-documented processes and protocols for medical billing, and increasing internal audits to determine where a LHD is succeeding and failing with respect to medical billing mistakes.

## Medical Billing Mistakes from a Local Health Department Perspective

Local health departments (LHDs) face a complex and dynamic economic and regulatory environment that requires efficient use of resources. Economic forces and health reform continue to shape the public health landscape, requiring changes in the way LHDs conduct business. The effects of the Great Recession continue to linger for LHDs, resulting in funding cutbacks at the federal, state, and local levels. Lower or inadequate funds place a significant strain on a LHD's ability to provide essential services to its community.

In order to address financial challenges, many LHDs have expanded medical billing services and developed the capacity to bill third-party payers. This includes both private insurers as well as public insurers such as Medicare and Medicaid. In 2015, ninety percent of LHDs reported that they billed third-party payers, which represented an increase over 2014.<sup>1</sup> Despite the widespread adoption of billing third-party payers, many LHDs still only bill for a fraction of the services they provide, while others continue to only bill public, and not private, payers. While population demographics can influence the decision to only bill public payers (i.e., client base is overwhelmingly reliant on public insurance), other LHDs have faced challenges in transitioning to private payer billing, which may increase LHD revenue long-term.

Internal capacity is another challenge facing LHDs with respect to billing insurance for public health services. Key factors include the cost and complexity of established billing, workforce capacity, and information technology capacity. As a result, one common perception is that the "process of developing a billing infrastructure is time-consuming and requires a high level of staff engagement and commitment."<sup>2</sup> Nevertheless, medical billing continues to rise in importance for LHDs seeking to stabilize or enhance revenue streams. By doing so, these LHDs can continue providing services within their communities, without sacrificing important clinical services or forsaking a population in need of critical care.

As medical billing rises in prominence among LHDs, so do the potential pitfalls and errors that can undermine the efficient use of LHD resources. Medical billing errors and mistakes can have a significant impact on all parties to a medical transaction, including both the patient and the provider. From a patient perspective, medical billing errors can lead to financial hardships and a loss of trust in a local LHD. From a LHD perspective, errors and mistakes can lead to revenue loss, expending extra resources to rectify mistakes, and a similar loss of trust and clients given the reputational risk inherent in providing quality medical care.

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<sup>1</sup> "The Changing Public Health Landscape. Findings from the 2015 Forces of Change Survey," National Association of County & City Health Officials. Slide 32, available at <http://nacchoprofilestudy.org/wp-content/uploads/2015/04/2015-Forces-of-Change-Slidedoc-Final.pdf>.

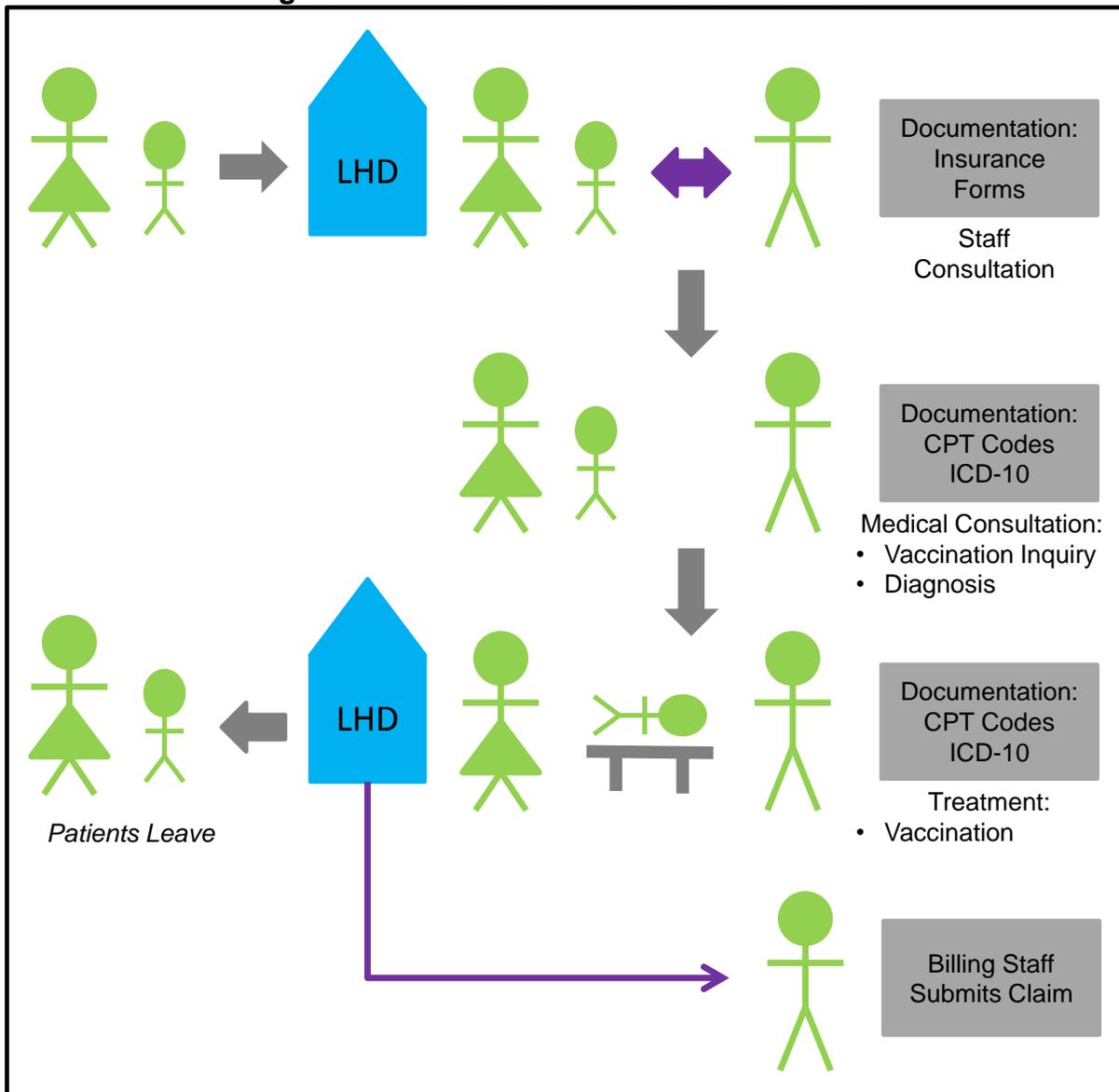
<sup>2</sup> Ibid, slide 35.

In spite of the challenges inherent in increased medical billing activity, including potential errors, billing for LHD clinical services of insured individuals is a common sense approach to not only increasing public and private payer participation, but also alleviating some of the financial burden resting with federal, state, and local sources. As a result, LHDs can become savvier with respect to medical billing by learning which common medical billing mistakes to avoid. By avoiding errors, these LHDs will create a more stable revenue stream, increase workforce efficiency, and continue to build trust with their client base.

### **Understanding the Billing Process**

Medical providers, including local health departments (LHDs), offer a variety of medical services that are subject to third-party billing. At the heart of the provider-patient transaction is the exchange of information. This includes not only administrative or clerical information, but also guidance and resources provided by the provider or LHD to the patient as part of the medical visit. As a result, different types of information, provided at different points in time, feed into the medical billing process. As an example, Figure 1 provides an overview of the general provider-patient interaction, including critical steps where information relevant to medical billing is obtained as part of the visit.

**Figure 1 – LHD / Patient Interaction Process**



At the outset, the medical billing process begins when a patient visits a LHD, either through a set appointment or as a walk-in patient. The first interaction and instance of information exchange is obtaining insurance information from the patient. This may be private insurance, public insurance such as Medicare or Medicaid, or secondary insurance. Even if the individual has been to the LHD before, the process of collecting insurance information should be followed each time, to capture any changes.

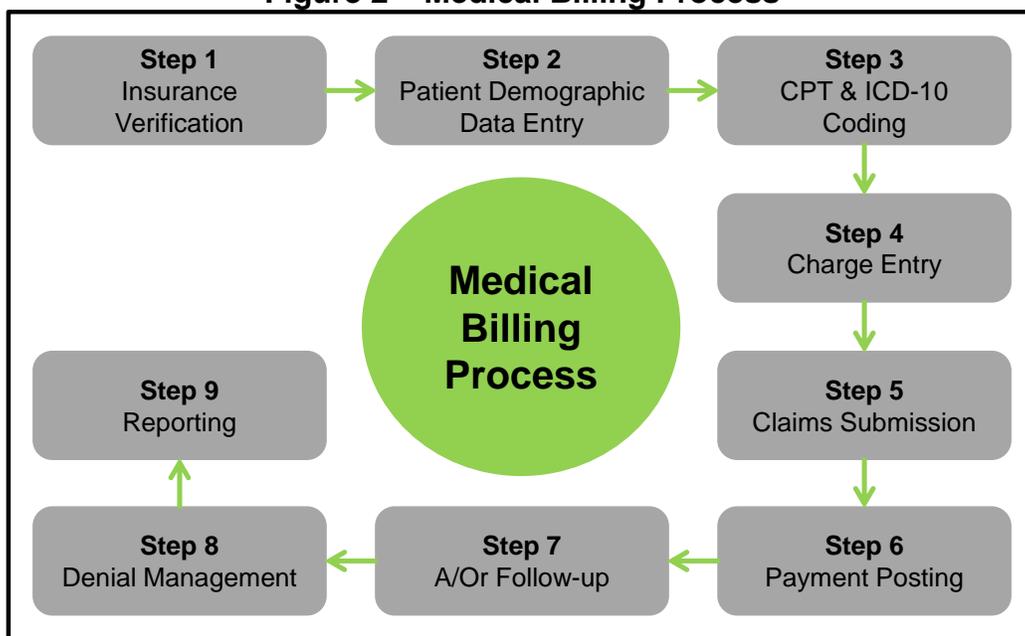
Critical information collected includes verification and eligibility from the insurance provider. In addition, the LHD or provider will collect co-pays, deductibles, or self-pay amounts. The information collected at this point in the process is critical to avoiding billing mistakes and errors. Failing to capture and verify this information leads to insurance claim denials, potential revenue loss and the expenditure of additional staff resources to

track down payment, revise and resubmit claims. Furthermore, it alienates clients who might assume that it is the LHD's responsibility to verify coverage prior to providing services. Once hit with a bill, the client might feel animosity towards the LHD, even though it has always been the client's responsibility.

After the front office interaction, the individual will often meet or engage with the health care professional. This might be a registered nurse, nurse practitioner, physician's assistant, or physician. Information exchanged as part of this process includes the reason for the visit and the steps taken to address any medical issues. This can range from a relatively straightforward immunization to a more complex disease management strategy. Regardless of the specifics, in each instance the provider or LHD captures important information on the procedures and diagnostics used to evaluate and treat a particular individual. This information is gathered through specific codes that are required by third-party payers and indicate with specificity the treatment provided. Although the use of electronic health records has increased in the digital age, some providers and LHDs may still rely on manual entry of information related to the visit.

At the completion of the visit, the provider or LHD and the patient complete the information exchange. In the back-office processes, the provider or LHD will create and submit a medical billing claim based on the specifics of the particular visit and in coordination with the individual's insurance benefits. Even after submission, the provider or LHD needs to maintain oversight of the account reconciliation and payment before closing each account transaction. Figure 2 summarizes the medical billing process.

**Figure 2 – Medical Billing Process**



## Common Medical Billing Mistakes

There are a number of points in the process where critical medical billing errors can arise during the patient-provider interaction. In order to run a cost-effective and efficient medical practice, LHDs need to be cognizant of potential critical billing errors and how to effectively avoid them. This section steps through some of the most common medical billing errors and mistakes.

### ***Medical Billing Mistake #1 – Failure to Verify Insurance***

Insurance issues are the top reason for insurance claim denials. Typically, failure to verify stems from reliance on a routine. As an example, consider a patient that visits frequently. In this case, the staff assumes that the insurance provider or coverage plan has not changed and fails to adequately check eligibility at each occurrence. In reality, insurance information can change at any time, so verification is a critical first checkpoint in the billing workflow for every single patient visit. This means verifying eligibility **prior to rendering services** to a patient so LHDs do not fall victim to these common medical billing issues with respect to insurance:

- *Coverage terminated or otherwise ineligible on date of service.* One of the more common occurrences is a change in insurance status that either cancels a plan or incorporates a shift between private insurance and Medicaid. This is particularly true in fluctuating economic times, where individuals may encounter multiple layoffs or periods of unemployment. **As a result, LHD front office staff needs to evaluate the eligibility of every patient at every visit to ensure that the patient is covered on the date of service and whether the patient is eligible under more than one program or health plan.** A related point is the extent to which a LHD is considered a participating provider in the health plan. If LHD staff fails to verify eligibility or provider status, this can lead to after-the-fact claim denial, which then puts the burden on the LHD to track down self-pay, which patients may or may not be able to provide.
- *Services not authorized.* In other cases, an individual may be an active member of a health plan, but the plan will not authorize certain clinical services the individual is seeking or requires from the LHD. While this is less of an issue with public insurance, it remains a concern for LHDs in terms of recouping the costs associated with treatment. Committing this medical billing mistake leads to denied claims because the payer had not authorized the service and is not willing to pay for the service. Once the service has been provided to the patient, the LHD is under pressure to recoup the associated costs. Obtaining authorization **prior to providing service** fully alleviates this issue.
- *Services not covered by plan.* Similar to authorization issues, front office staff that fail to verify which services a health plan covers can also expose the LHD to denial of insurance claims and related financial risk. In order to provide non-covered services, the LHD should provide the patient with an explanation of the service that

is not covered, whether covered alternatives exist, the cost of the service, and payment terms or arrangements. In certain cases involving third-party insurance, Medicare, and Medicaid, the patient is required to sign a waiver indicating acceptance of the non-covered service and subsequent payment responsibility.<sup>3</sup> This optimal process is only possible if the LHD recognizes what is covered versus non-covered prior to providing service. Otherwise, there remains the possibility the LHD will not have a waiver but still provide non-covered services, which will result in non-payment by the third-party payer.

- *Maximum benefits reached.* In certain cases, an individual may have reached the maximum benefit for a specified time period or occurrence in his or her plan. In this case, a LHD that fails to recognize these limits will face an insurance denial on the resulting claim.

Insurance-related medical billing mistakes typically arise due to breakdowns in patient intake processes and procedures. LHDs should educate and inform clients on the process prior to rendering public health services. This entails following a set of standard operating procedures to collect and verify insurance information and regularly reviewing the process to ensure continued success. Important steps to take on every visit include:

- Obtain copies of the client's insurance card(s), including any secondary insurance
- Ensure that the registration/intake records accurately capture the following information:
  - Insurance name, phone number and claims address
  - Insurance ID and group number (or Medicaid/Medicare member number and ID number)
  - Name of insured and relationship to client (if not the same person)
  - Effective date of the policy (and end date if applicable)
- Determine eligibility:
  - Is the coverage currently active and does the insurance cover the procedure, diagnosis or services to be provided?
  - Is the LHD considered a participating provider by the third-party payer (e.g., is the LHD credentialed)?
- Identify plan limitations or exclusions
- Assess whether any pre-authorizations are necessary for insurance billing purposes

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<sup>3</sup> For example, see the Centers for Medicare and Medicaid Services description of Advanced Beneficiary Notice of Noncoverage, which describes situations where a provider or LHD thinks Medicare will not pay for items or services. Available at: <https://www.medicare.gov/claims-and-appeals/medicare-rights/abn/advance-notice-of-noncoverage.html>.

- Determine if a deductible, copayment or coinsurance is applicable for the requested services
- Provide waiver for non-covered services and payment options

### ***Medical Billing Mistake #2 – The Incomplete Claim***

The billing process involves creation and submission of multiple electronic forms or paper documents. With the advent of electronic health records (EHR), many medical billing systems allow for insurance documentation to be stored in a database or electronic format. As part of the record building process, health care professionals capture information at the various stages, including the initial demographic and insurance data discussed previously, as well as the interaction with the provider. In order to determine the amount to be included on a particular claim, health care providers rely on a “superbill” that captures the services being provided to the clients. The superbill or encounter form includes information on the services provided as well as an explanation of why the services were provided.

If a healthcare provider uses an EHR system, the superbill document will be housed electronically and entered or updated directly on a computer. However, as of 2013, only 22 percent of LHDs surveyed by the National Association of County & City Health Officials (NACCHO) had implemented an EHR system, and only 22 percent more had plans to implement an EHR system.<sup>4</sup> As a result, many LHDs rely on manual entry of insurance claim information, including superbill information. Regardless of whether an LHD uses an EHR system or paper forms, errors can arise in filling out insurance claims due to missing information.

The submission (and subsequent resubmission) of claim forms highlights the importance of putting in place protocols and procedures that accurately capture health care services for submission to a third-party payer for reimbursement. To receive payment for services rendered, providers must collect accurate and reliable information. A single empty or unchecked box on a claim can result in total claim denial. Even the most basic fields such as date of birth are sometimes left blank on a claim form, resulting in third-party payer claim denial. While one might think this is a relatively benign error, it happens all too frequently and remains a pervasive issue related to revenue management as well as patient satisfaction.

As an example, consider Medicare claim submissions, which require capturing information on the CMS-1500 Form. Figure 3 illustrates a sample form, with obvious errors included on the form. Despite the simplicity of the errors shown (incorrect date of birth where the month and day are switched, as well as blank sex category), they may be overlooked by LHD billing staff or the administrative personnel responsible for billing in the event that the LHD does not have a dedicated billing staff. The result is a denied claim that requires the LHD to fix the errors and resubmit the claim, resulting in employee time inefficiencies.

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<sup>4</sup> NACCHO, 2013 National Profile of Local Health Departments, p. 62.

**Figure 3 – Sample Errors on the Form CMS-1500**



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> <input type="checkbox"/> PICA										
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input checked="" type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		
						FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		
								1a. INSI XXXX		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE			4. INSU		
Doe, Jane A.					MM DD YY 18 10 75			SEX M <input type="checkbox"/> F <input type="checkbox"/>		
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED					7. INSU
123 First Street					Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY				STATE		8. RESERVED FOR NUCC USE				CITY
Anytown				IL						
ZIP CODE			TELEPHONE (Include Area Code)							ZIP COI

The scope of this medical billing error is significant. Continuing with the Medicare example, consider that Medicare receives approximately 4.6 million claims per day. Of these, Medicare rejects approximately 2.0 percent due to incomplete or invalid information.<sup>5</sup> This equates to 92,000 claims per day or almost 34 million claims per year being rejected due to errors as simple as an incorrect date of birth or missing sex.

In order to manage the risks associated with submitting an incomplete claim, LHDs can implement processes to minimize the likelihood of incomplete claims. The best remedy entails having a second set of eyes (at a minimum) reviewing claim information on each and every paper or electronic claim filed by the LHD to ensure that all required fields are completed accurately. If the LHD works exclusively with electronic claims, then a check of the software system is in order to ensure that the software flags users to review missing fields and input all required information before allowing them to submit.

Perhaps a bigger issue is the extent to which a LHD has the resources to implement a secondary review of claim submissions. As more and more LHDs realize a greater revenue stream associated with billing third-party payers for clinical services, it might make sense to increase staff dedicated to billing or partner with an outside contractor to provide revenue management oversight with respect to submitting insurance claims.

**Medical Billing Mistake #3 – Coding Errors**

Submission of an insurance claim requires an accurate depiction of the services provided to the client. The claim conveys the services provided by using different diagnostic and procedural codes. Third-party payers currently rely on the existing Current Procedural Terminology (CPT) coding system developed by the American Medical Association

<sup>5</sup> Centers for Medicare and Medicaid Services, available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-29.html>

(AMA) and the Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare and Medicaid Services (CMS). As noted by the AMA, the purpose of the CPT is “to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other health care providers, patients and third parties.”<sup>6</sup> The HCPCS includes all CPT codes (which are numeric), but also includes alphanumeric codes to capture primarily non-physician services such as ambulance services and prosthetic devices.

Insurance claims rely on the accurate representation of services provided using CPT and HCPCS codes. In addition, Medicare requires that accurate information is submitted on Form CMS-1500, where section 24 of the form calls for entry of CPT or HCPCS codes and modifiers. Figure 4 illustrates the section of the CMS-1500 form where these entries are found.

**Figure 4 – Coding Section of the Form CMS-1500**

The image shows a portion of the CMS-1500 form. Section 24, 'PROCEDURES, SERVICES, OR SUPPLIES', is highlighted with a black box. This section contains a table with columns for: A. DATE(S) OF SERVICE (From MM/DD/YY to MM/DD/YY), B. PLACE OF SERVICE, C. RVG, D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS and MODIFIER), E. DIAGNOSIS CENTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EXIST. Pkty. Rpt., I. ID. QUAL., and J. RENDERING PROVIDER ID. #. The table has 6 rows, with the first row containing 'NPI' in column J. Other sections visible include 19 (ADDITIONAL CLAIM INFORMATION), 20 (OUTSIDE LAB), 21 (DIAGNOSIS OR NATURE OF ILLNESS OR INJURY), 22 (RESUBMISSION CODE), 23 (PRIOR AUTHORIZATION NUMBER), 25 (FEDERAL TAX I.D. NUMBER), 26 (PATIENT'S ACCOUNTING), 27 (PROSTATE EXAMINATION?), 28 (TOTAL CHARGE), 29 (AMOUNT PAID), 30 (Rev'd for NUCC Use), 31 (SIGNATURE OF PHYSICIAN OR SUPPLIER), 32 (SERVICE FACILITY LOCATION INFORMATION), and 33 (BILLING PROVIDER INFO & PH#). At the bottom, there are instructions: 'NUCC Instruction Manual available at: www.nucc.org', 'PLEASE PRINT OR TYPE', 'APPROVED OMB-0936-1197 FORM 1500 (02-12)', and a 'RESET' button.

In addition to the CPT/HCPCS codes, insurance claims rely on codes to relay information on the diagnosis or nature of the illness. These are drawn from the International Classification of Diseases Tenth Edition (ICD-10), which is a clinical cataloging system for diagnostic services. For reference, providers or LHD billing staff will enter these codes in Section 21 of the CMS-1500 form shown in Figure 4. ICD-10 was effective starting in

<sup>6</sup> American Medical Association, “CPT Process: How a Code Becomes a Code.” Available at <https://www.ama-assn.org/practice-management/cpt%20AE-process-how-code-becomes-code>.

October 2015 and represents a significant change from ICD-9. As noted by the Centers for Disease Control:<sup>7</sup>

- There are nearly 19 times as many procedure codes in ICD-10-PCS than in ICD-9-CM volume 3<sup>8</sup>
- There are nearly 5 times as many diagnosis codes in ICD-10-CM than in ICD-9-CM
- ICD-10 has alphanumeric categories instead of numeric ones
- The order of some chapters have changed, some titles have been renamed, and conditions have been grouped differently

Table 1 summarizes key differences.

**Table 1 – Differences between ICD-9 and ICD-10 Code Sets**

Differences Between ICD-9-CM and ICD-10 Code Sets		
	ICD-9-CM	ICD-10 Code Sets
Diagnosis	14,025 Codes	69,823 Codes
Procedure	3,824 Codes	71,924 Codes

ICD-10 Code Structure Changes (selected details)		
	Old	New
<b>Diagnosis Structure</b>	<b>ICD-9-CM</b>	<b>ICD-10-CM</b>
	- 3-5 characters	- 3-7 characters
	- First character is numeric or alpha	- Character 1 is alpha
	- Characters 2-5 are numeric	- Character 2 is numeric
		- Characters 3-7 can be alpha or numeric
<b>Procedure Structure</b>	<b>ICD-9-CM</b>	<b>ICD-10-PCS</b>
	- 3-4 characters	- ICD-10-PCS has 7 characters
	- All characters are numeric	- Each can be either alpha or numeric
	- All codes have at least 3 characters	- Numbers 0-9; letters A-H, J-N, P-Z

Source: [http://www.cdc.gov/nchs/icd/icd10cm\\_pcs\\_background.htm](http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm)

Errors arise when providers or billing staff make mistakes entering CPT or HCPCS codes on claim forms. Errors can occur both from lack of knowledge (e.g., when a provider writes down the wrong code or code sequence) or accidentally (e.g., perhaps billing staff enters the wrong code by accident). In either case, the result can be a denial of claim or potentially failure to pay for all services rendered.

<sup>7</sup> Centers for Disease Control and Prevention, International Classification of Diseases, (ICD-10-CM/PCS) Transition – Background. Available at [http://www.cdc.gov/nchs/icd/icd10cm\\_pcs\\_background.htm](http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm)

<sup>8</sup> CM stands for Clinical Modification while PCS stands for Procedural Coding System. ICD-10-CM replaced ICD-9-CM volumes 1 and 2, while ICD-10-PCS replaced ICD-9-CM volume 3.

As an example, consider a hypothetical example drawn from the American Academy of Pediatrics.<sup>9</sup> Assume that Derek, a 5-year-old established patient at a local LHD, comes in for a preventive visit. He is scheduled to receive his first Hepatitis A vaccine; his fifth diphtheria, tetanus and acellular pertussis (DTaP); and the intranasal influenza vaccine. The LHD provider counsels Derek and his mother on the risks and benefits of each immunization and provides Vaccine Information Statements. A nurse prepares and administers the Hepatitis A and DTaP vaccines, completes chart documentation and vaccine registry entries, and ensures that Derek does not have any adverse reactions.

When preparing an insurance claim, the billing staff has to enter the appropriate codes to ensure reimbursement for the exact services provided. Attention to detail is important in all cases, but especially for LHDs that do not have a physician on staff. In these cases, the interaction can occur entirely with Registered Nurses (RNs) who are working under standing orders from a Medical Director. An important distinction resides in evaluating whether the individual providing counseling and services is a “physician or other qualified healthcare professional” as opposed to “clinical staff.”<sup>10</sup> If the LHD employs a physician or other qualified healthcare professional that provides counseling and services, the CPT codes are different than if clinical staff members provide the services.

Returning to the hypothetical, if one assumes that the LHD employs a physician on staff, then the appropriate initial coding process includes the following:

- Selecting the appropriate evaluation and management (E/M) code. In this case, the appropriate code is 99393, Preventive medicine service, established patient, age 5 to 11 years.

However, the coding process would be different if the LHD does not have a physician or other qualified healthcare professional on staff. If the RN provided non-vaccine-related preventive services (e.g., counseling on preventive health issues) then the RN would bill to E/M Code 99211, which covers an “office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician performing or supervising these services.” In this hypothetical, Derek is receiving preventive wellness care in addition to vaccines and the RN would bill 99211.

Furthermore, if the counseling received during the visit was **only** immunization-related, the provider (i.e., the RN) should not bill a preventive medicine counseling code and may only bill the vaccine administration fee. With respect to the vaccine administration fees, the appropriate coding includes both the vaccine code and the appropriate administration

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<sup>9</sup> American Academy of Pediatrics, “Coding for Pediatric Preventive Care.” Available at [https://www.aap.org/en-us/Documents/coding\\_factsheet\\_brightfuturespreventivemedicine.pdf](https://www.aap.org/en-us/Documents/coding_factsheet_brightfuturespreventivemedicine.pdf)

<sup>10</sup> As noted by the American Academy of Professional Coders, “QHPs are distinct from clinical staff. The clinical staff is comprised of employees (leased or contracted staff) who work under the supervision of a physician or other QHP to perform, or assist in the performance of, a specified professional service as allowed by law, regulation, and facility policy; but who do not individually report that professional service (payer-specific policies may also affect who may report specific services). Clinical staff includes medical assistants, licensed practical nurses, registered nurses, and the like.” Available at: <https://www.aapc.com/blog/28964-define-a-qualified-healthcare-professional/>.

code. For Derek's Hepatitis A, DTaP and Influenza vaccines, the appropriate codes include:

- 90633, Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use
- 90700, DTaP, for use in individuals younger than 7 years, for intramuscular use
- 90672, Influenza virus vaccine, quadrivalent, live, for intranasal use

The appropriate administration code relies on whether the LHD employs a physician or other qualified health professional on staff, or whether clinical staff (e.g., the RN) provides all services. In determining the appropriate administration code, the LHD provider will consider the following questions:

- Is the patient 18 years or younger?
- If the patient is younger than 18 years, did the physician or other qualified healthcare professional perform face-to-face vaccine counseling, discussing the specific risks and benefits of the vaccine(s)?

If the answer to both of the above questions is "yes," the LHD would select a code from the pediatric Immunization Administration (IA) code family (90460–90461). If the answer to one of the questions is "no," the LHD would select a code from the nonage-specific IA code family (90471–90474). In Derek's case, if a physician provided counseling, the answer to both of the questions is "yes," so the LHD would use the following codes:

- 90460, IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- +90461, each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

These codes are reported per vaccine and LHDs can report multiple units of code 90460 for each first vaccine administered. Code 90461 is considered an add-on code (hence the plus sign) to 90460, where the provider will use 90461 in addition to 90460 if more than one component is contained within a single vaccine administered.

If the LHD relies solely on clinical staff to provide Derek with vaccine counseling and immunizations, then the appropriate codes are:

- 90471, IA through 18 years of age via percutaneous, intradermal, subcutaneous or intramuscular injection(s); first or only component of each vaccine or toxoid administered

- +90472, IA through 18 years of age via percutaneous, intradermal, subcutaneous or intramuscular injection(s); each additional component of each vaccine or toxoid administered
- 90473, IA through 18 years of age by intranasal or oral route; first or only component of each vaccine or toxoid administered (list separately in addition to code for primary procedure)
- +90474, IA through 18 years of age by intranasal or oral route; each additional component of each vaccine or toxoid administered (list separately in addition to code for primary procedure)

Lastly, the LHD includes the appropriate diagnosis codes for Derek’s visit. Using ICD-10, the appropriate diagnosis code is Z23, Encounter for Immunization. In fact, ICD-10 only includes a single diagnosis code for immunization encounters as part of a preventive visit, which is a significant difference from ICD-9. Using this hypothetical example, the appropriate codes are shown in Table 2 for Derek’s visit. The table includes a scenario where a physician or qualified health care provider delivers services, as well as one where only LHD clinical staff provides services.

**Table 2 – Correct Coding for Derek’s LHD Visit under Two Scenarios**

CPT Codes		ICD-10 Codes
<b><i>Physician Present:</i></b>		
99393	Preventive medicine service, established patient, 5–11 years	Z00.129
90633	Hepatitis A vaccine product	Z23
90460	Pediatric IA (hepatitis A vaccine), first component	Z23
90700	DTaP vaccine product	Z23
90460	Pediatric IA (DTaP vaccine), first component	Z23
90461 (x2)	Pediatric IA (DTaP vaccine), each additional component	Z23
90672	Influenza virus vaccine, quadrivalent, live, intranasal	Z23
90460	Pediatric IA (influenza vaccine), first component	Z23
<b><i>Only Clinical Staff (RNs) Present:</i></b>		
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional	Z00.129
90633	Hepatitis A vaccine product	Z23
90471	Pediatric IA (hepatitis A vaccine), first component	Z23
90700	DTaP vaccine product	Z23
90471	Pediatric IA (DTaP vaccine), first component	Z23
90472 (x2)	Pediatric IA (DTaP vaccine), each additional component	Z23
90672	Influenza virus vaccine, quadrivalent, live, intranasal	Z23
90473	Pediatric IA (influenza vaccine), first component	Z23

Within this process, multiple opportunities for coding errors exist. These include:

- Incorrect use of CPT codes 90460-90461 if the LHD fails to recognize that face-to-face counseling was not given by a physician or other qualified health care professional.
- If Derek was seen by a qualified health care professional: Erroneously entering in preventive service code 99382, where either through a typo or incorrect entry, the LHD fails to recognize that Derek turned 5 last week and code 99382 covers children age 1-4, while the correct code, 99383, covers children age 5-11.
- In the case of only clinical staff providing services: Failing to include code 90472 to recognize that DTaP has multiple components. The correct coding would be to include 90471 to reflect the first component (diphtheria), while the second and third components (tetanus and acellular pertussis) are reported with 90472 with 2 units.
- Entering V20.2 as the ICD-10 code, which actually would have been the appropriate ICD-9 code. With the new ICD edition, the correct code is Z23.

#### ***Medical Billing Mistake #4 – Lacking Specificity***

With respect to diagnostic codes, third-party payers often deny claims for not being coded to the highest level of specificity or for being truncated (e.g., unnecessarily or incorrectly shortened). Trained medical billing coders understand that each diagnosis must be coded to the highest level for that code, meaning the maximum number of digits for the code being used. If LHD staff responsible for submitting insurance claims are not highly familiar with coding, the LHD faces an increased likelihood of claim denial.

LHDs can minimize the risk of this type of billing error by training staff to recognize when there is a lack of specificity in the billing codes. The most common errors include leaving off critical digits or letters (e.g., truncation), using an incorrect code from a prior version (ICD-9 instead of ICD-10), or transposing numbers or letters in listing out the ICD-10 codes for a particular visit.

As another example, consider the previous scenario related to Derek and his immunizations. Assume that Derek's mother refuses the DTaP vaccine, as Derek had a severe allergic reaction the first time DTaP was administered. The LHD subsequently records the immunization encounter and also codes in a reason for why the vaccination was not carried out. Table 3 lists the available codes.

**Table 3 – ICD-10 Codes for Reasons Why a Vaccination Was Not Administered**

Z28.01	Acute illness
Z28.02	Chronic illness or condition
Z28.03	Immunocompromised state
Z28.04	Allergy to vaccine or component
Z28.1	Religious reasons
Z28.20	Unspecified reason
Z28.21	Patient refusal
Z28.81	Patient has disease being vaccinated against
Z28.82	Caregiver refusal
Z28.89	Other reason

However, in filling out the health records, the LHD erroneously truncates the code as “Z28.0” While this error may not have any material effect on the reimbursement (since the vaccine was not administered), it could trigger a denial based on a lack of specificity, since the truncated code is ambiguous with respect to the reason.

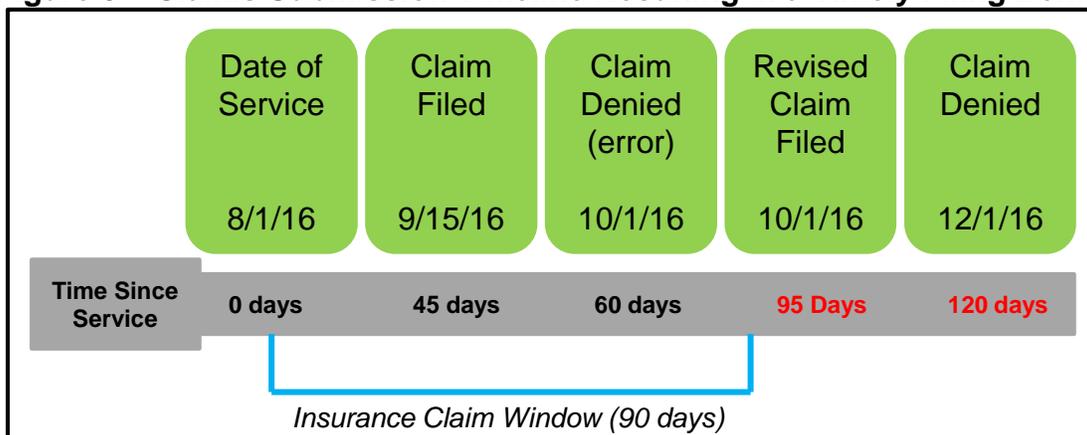
***Medical Billing Mistake #5 – Missing Filing Deadlines***

Timely filing windows can vary significantly depending on the rules adopted by different third-party payers. Some payers have two-year windows for certain types of medical claims, whereas others allow just thirty days to file. With respect to Medicare, Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare Fee-for-Service claims to no more than 12 months, or one calendar year, after the date of service. As a result, if the date of service was November 15, 2016, then the LHD would have up until November 15, 2017 to file the claim. In contrast, Illinois Medicaid has a 180 day timely filing window. Many private payers have even shorter timely filing windows.

If an LHD fails to file a claim on time, there is typically little recourse. Timely filing denials are among the most difficult to appeal. As a result, LHDs need to remain vigilant in tracking which third-party payers are the most common and the timely filing deadlines for each third-party. Monitoring claim status and checking against the timely filing deadlines will minimize the risk that a third-party payer will reject a claim for missing filing deadlines.

In certain instances, previous errors or mistakes will cause a claim denial due to untimely filing. Figure 5 provides a hypothetical timeline where a LHD receives a series of claim denials, culminating in a final denial due to timely filing.

**Figure 5 – Claims Submission Timeline Resulting in a Timely Filing Denial**



In this case, the LHD submits the original claim to a third-party payer within their 90 day timely filing window. However, the LHD commits a coding error (e.g., common mistake #3) and the third-party payer subsequently denies the claim. The LHD corrects the mistake and resubmits the claim. However, the resubmission occurs after the expiration of the timely filing window and the third-party payer rejects the resubmitted claim. In these cases, in order to receive payment, the LHD has to appeal the denial, which ties up administrative resources and may not be successful.

### **Overcoming Medical Billing Mistakes**

The best way that a provider or LHD can address medical billing mistakes is to proactively seek solutions that minimize mistakes at the outset. The following suggestions, based on industry experience, are potential ways that an LHD can address common and pervasive medical billing mistakes. The suggestions are not mutually exclusive and may not be appropriate for all LHDs. In many cases, factors specific to a particular LHD may dictate how that LHD approaches solutions to medical billing mistakes.

#### ***Recommendation #1: Invest in Staff Training***

Whether an LHD has a dedicated billing staff or individuals with multiple job functions, the level of professional training in medical billing issues directly impacts the number and severity of medical billing mistakes. Given the dynamic regulatory and economic environment, investment in a well-trained workforce is a necessity if a LHD seeks to expand (or stabilize) revenue streams associated with billing third-party payers. This investment can take many forms, including training individuals directly on medical billing issues and coding requirements. While increased staff training sounds like common sense, there is an administrative burden (either financial or human capital) associated with training staff members. In the end, the LHD needs to evaluate whether the costs associated with additional training are sufficient to offset the financial and administrative burden of claim denials.

That said, at a minimum a LHD should invest in staff training to ensure that a second set of eyes reviews every submitted claim. This second review should be tailored towards ensuring that claims meet the minimum requirements with respect to blank fields or obvious errors in items like date of birth or sex.

### ***Recommendation #2: Document Better Procedures and Protocols***

Many medical billing errors arise due to procedural breakdowns in the billing process. In these cases, instituting more rigid protocols or documented procedures can alleviate the potential for claim denials. This is particularly true for LHDs that do not have electronic health records or a revenue cycle management program that assists with staying on top of filing deadlines, flagging in-process claims for potential errors, and alerting LHDs when an issue arises. For those LHDs that still use manual entry and paper submissions, having a list of documented processes and protocols for submitting claims can reduce medical billing errors and result in increased financial and operational efficiency.

### ***Recommendation #3: Outsourcing Some or All of the Billing Process***

In many cases, LHDs can reduce or eliminate medical billing errors by outsourcing the function to a qualified third-party vendor. In these cases, the LHD will free up staff resources to concentrate on other administrative or medical issues. A 2012 Study by the New York State Department of Health Bureau of Immunization and Office of Public Health Practice summarized outsourcing as:

*Some LHDs choose to contract with external companies to provide third party billing services. Such medical billing companies receive service data from providers and use this data to complete the functions of the revenue cycle back end. LHDs may choose to outsource third party billing and may also choose to contract out back end first party billing. Some LHDs find this an efficient way of obtaining specialized services to increase billing efficiency and effectiveness. Such LHDs determine contract specifics including the collections process to ensure that reimbursement is pursued in a manner that meets public health objectives.<sup>11</sup>*

Outsourcing may not be the best option for every LHD, but it certainly can increase revenue by lowering claim denial rates.

### ***Recommendation #4: Audit Claims***

A final recommendation is for LHDs to include an internal audit process of submitted claims. This includes auditing denied claims to analyze what errors or mistakes were made in submitting the claim. If the LHD finds a disproportionately high number of claims

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<sup>11</sup> “Elements for Successful Immunization Billing Practice at New York State’s Local Health Departments.” New York State Department of Health Bureau of Immunization and Office of Public Health Practice, June 2012, p. 19, available at: [http://www.health.ny.gov/prevention/immunization/providers/docs/immunization\\_billing\\_practice.pdf](http://www.health.ny.gov/prevention/immunization/providers/docs/immunization_billing_practice.pdf).

being denied due to insurance coverage issues, then processes can be put in place to address front office staff that might be committing too many errors in the intake and insurance verification stage.

Alternatively, if too many claims are being denied due to miscoding of procedures and diagnoses, then a LHD can focus on increasing the communication between care providers and billing staff. Creating awareness about billing issues should alleviate many of the billing mistakes, particularly if the mistakes follow a particular pattern.

## **Conclusion**

Running a cost-effective, efficient LHD requires a steady and reliable revenue stream. For LHDs, this includes increasing billing activity with third-party public and private payers. However, an increase in medical billing claims also can lead to an increase in medical billing mistakes and errors. This white paper covered several of the major medical billing mistakes and offered recommendations on how providers and LHDs can work towards lowering their error rates. Whether practices or LHDs incur delayed payments, denials, client complaints, or even just lost productivity, medical billing errors hurt the healthcare organization. Eliminating errors is critical to the bottom line, but begins with understanding the most common errors leading to denied claims.