Eliminate Medical Coding Mistakes and Improve Accuracy

Does your Health Information Management (HIM) coding staff suffer from outdated processes that yield rejections and denials--which then hurt your financials through poor cash flow, delayed A/R, or too many write-offs?

Rein in Administrative Waste and Control Costs

- 15 to 30% of all healthcare spending goes toward wasted administrative time and resources by staff and facilities.
- Inefficient and manual process, as seen in medical coding, are part of the admin waste contributing significantly to rising healthcare costs.[1]
- Federal agencies are stepping up audits that could drive penalties such as takebacks for overpayment recoveries.[2]

Frequent Claim Denials

Three out of four denials fall into five categories that are avoidable with support from a medical coding partner.[3]

- Registration and eligibility
- Missing or invalid claim data
- Medical documentation requested
- Authorization and precertification
- Service not covered

Common Coding Mistakes Impacting Your Revenue

1. **Not coding to the highest level of specificity.** A solid knowledge of procedural and diagnostic coding, abstracting of medical data elements, and capturing the most information from the documentation for accurate coding ensures compensation that aligns with the appropriate level of care for high-risk patients.[4]
2. **Poor quality or missing documentation.** Unclear, incomplete, or illegible reports from providers lead to troubles, including rejected or denied claims.[5]
3. **Undercoding.** Coding for each procedure and service rendered is essential to maintain a patient's treatment record and to ensure accuracy and completeness.[6]
4. **Not using updated code sets.** Experienced and novice coders need continuing education to stay current to navigate through 78,000+ and any future diagnosis codes.[7]
5. **Overusing and incorrect usage of modifiers.** Coders must ensure the correct documentation rationalizing a procedure as well as the correct use of modifiers.
6. **Not checking NCCI edits.** Knowledge of the analysis process for a Medicare patient receiving service on a certain date by the same provider offsets the chance of a denial.[8]

Tracking for these reduces the possibility of rejected or denied claims, claim underpayment, penalties, fines, or even takebacks.

Opportunities for Revenue Integrity

Automation mitigates the impact of poor-quality coding with technologies that can predict coding, incorporate natural language processing (NLP), and monitor and optimize work inventory at all stages via a robust workflow tool.

Outsourcing delivers ROI from day one through improved coding accuracy, compliance, billing, and payer relationships.

Omega Healthcare improves your coding accuracy and compliance through technology-enabled medical coding services, with:

- Expertise from 110+ million charts coded
- Over 6,000 medical coders
- Experience in facility, pro fee and risk adjusted coding
- Conducting industry training to educate coding employees and clients, plus coders at large

Download our white paper "The Risk and Impact of Medical Coding on Revenue Integrity"

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Sources

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7 "Changes to ICD-10-PCS Codes: CMS Updates Effective October 2022," Mikki Fazzio, Health Catalyst, July 20, 2022

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