Coding Audits

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Adding a few additional steps to your coding audit can help ensure your billing process is working at peak efficiency. While pulling charts, orders/scripts, reports, and other data for your coding audit and during the audit process, add the following steps for a full analysis of the claim's entire lifecycle:

- Pull or print the patient demographic, insurance, insurance verification, and financial history from your system for the date of service being audited. Be sure to pull all financial activity for the date of service, not simply on the procedure you are reviewing
- Pull any other financial data which may be stored in another format, area, or in the chart such as patient intake and/or insurance verification notes, copies of insurance cards, etc.
- In addition to your normal coding audit process, compare the accuracy, timeliness, and completeness of the following:
  - The order/script and patient demographic/insurance information provided by the patient or referring physician against the scheduled appointment date, time, and type to ensure proper scheduling
  - Insurance verification performed including appointment reminder calls to discuss balances due with patients in advance of their visit and notation of any pre-service instructions
  - Patient demographic and insurance data entry
  - Notation on the account of the correct amount to collect from the patient, collection of that amount prior to treatment, entry into your payment log, deposit into your bank, and entry into your practice management system
  - All patient intake paperwork including driver's license and insurance card copies, orders/scripts, reports, and other pre-service documentation required including its entry where applicable
  - Patient check-in time, wait time, room assignment, and any other service documentation not related to coding
  - Entry of the charge and diagnoses as per the Charge Ticket/SuperBill (SB)
  - Entry of any changed or modified information on the patient intake documentation or SB
  - Billing of the charge including any electronic billing edits/returns
  - Receipt and posting of all payments and denials, claim corrections made, and rebills produced. Analyze all denials for patterns related to processing issues and against all previously reviewed data to enhance prevention
  - Collection of the correct amount due per the payer; any underpayments or variances to loaded reimbursement schedules; staff time involved and actions taken to resolve the claim; proper billing to secondary insurance or the patient; and notation of all collection actions including all calls to/from payers, patients, or others
  - Reasons for any bad debt adjustment or collection agency placement and prevention techniques to avoid future collection loss or delay

Use all this information to develop your process or staff issues list, update your policies and procedures manual, and/or to support or justify additional resources required. Review all issues with your staff, including positive reinforcement or reward for low error rates. As always, save this data in each staff member's performance review file for future monitoring and use during performance evaluations.

While not typically included in the coding audit process, implementing the above review steps will enhance your audit and provide invaluable insight as to the effectiveness of both your overall processes and staff performance.