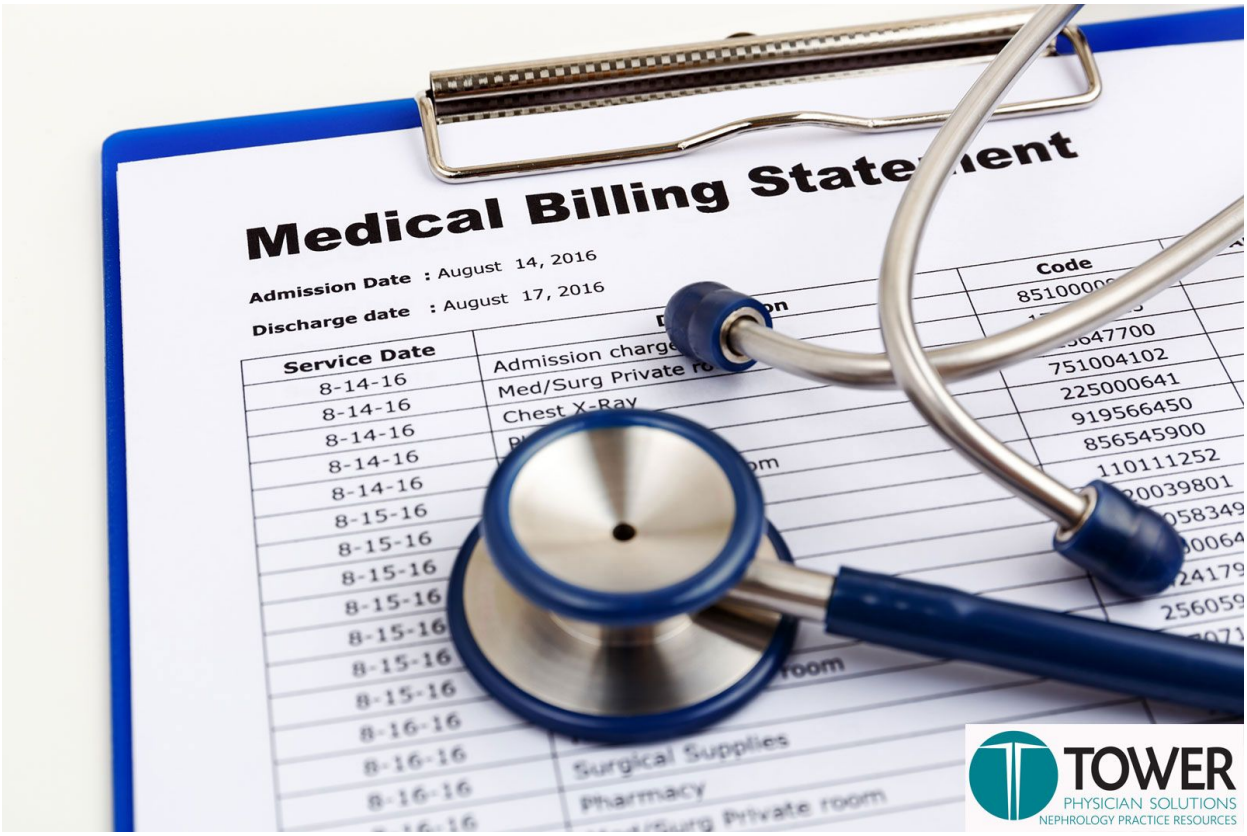
TOWER BILLING AND CODING MESSAGE:



IMPROVING YOUR ICD-10 CODING

Why are there so many ways to submit an ICD-10 cause code? As a medical billing department specializing in Nephrology, we know it can be frustrating to try to sort out the differences in coding requirements among various payors. The more individualized your coding is on claims, the cleaner your claims submissions will be, resulting in more expeditious reimbursement.

Education Improves Coding Accuracy

If your practice management system does not automatically update coding according to the level of service indicated in your visit notes, then it's essential to know how to choose the appropriate codes for service and procedures provided. Not only is this a key step in the revenue cycle, but accuracy at this point may be evaluated in an audit.

There are differences among payors' coding requirements and knowing those intricacies of the billing process can affect your practice revenue and the efficiency of your billing personnel. Reduce redundancies and streamline the process by educating

your staff, or by enlisting the help of an experienced billing contractor like Tower Physician Solutions.

"We keep up to date on payor specific needs when it comes to ICD-10 codes. At Tower, we bill such great volume that we are familiar with the different requirements each payor has," according to Stephanie Knispel, Tower Revenue Cycle Specialist. Here are her tips to improve your coding:

Consistency Builds Quality

Whether bringing aboard new coders or consolidating coding departments across an organization, keep an eye on quality. Consistent coding policies, procedures, and practices form the foundation for coding quality. Consistent coding guidelines must be established and communicated to all practice staff. This includes compliance with published coding guidelines and training on facility-specific practices.

Collaboration Prevents Denials

Establish denial management practices to review all denials due to miscoding. At a minimum, include representatives from revenue cycle, coding, Recovery Audit Contractor (RAC) response, case management, utilization management, and clinical documentation improvement (CDI). a consistent process to research and monitor every coding denial.

Manage the appeal process and communicate with the payer throughout the next level of review. If timelines are tight, reach out to the payer to request an extension. Preventing denials up front is always more cost-effective than researching and responding retrospectively.