

Using front-end claim edits



Claims rejections and denials are on the rise significantly impeding cash flow and increasing the cost of doing business. The MGMA estimates the cost of reworking a rejected claim is \$25 and estimates that 50-65% of denied claims are never resubmitted. Utilizing your system's front-end claims editing or scrubbing capabilities, or purchasing and add-on program, can



significantly reduce rejected and denied claims. Claim edits look for errors on a claim and alert the user to the problem before the claim is created or submitted.

Most billing programs have some basic edits in place that assure that all claim fields have been properly populated and formatted. However, other more robust edits are necessary to avoid costly rework and appeals and get claims paid on the initial submittal. Edits that check coding, bundling, and procedure information versus local Medicare and CCI rules, for example. Some of these edits are more complicated and can vary by payer.

Bilateral billing is a prime example of a payer-specific edit. Some payers require a bilateral procedure to be billed on one line with modifier -50. Others require that the procedure be billed on two lines, with modifier -50 on one of the lines. Another example of a useful edit would be in regard to modifier -25. The edit could alert anytime a procedure is billed with an evaluation and management code and modifier -25 is not present. Billing guidelines vary by payer and it is difficult to remember them all, especially if you are contracted with several plans. Utilizing custom claim edits can prevent the wrong billing policy from being applied to the wrong payer.

When choosing a billing system or add-on program, make sure it has the capability to customize and build edits. If your billing system allows you to build edits, rejections and denials can be reduced significantly freeing staff to focus on more pertinent tasks.

Sources: MGMA