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HEALTH CARE BILLS: CODES AND CLAIMS



To get paid for medical care you receive, providers usually bill your health insurer directly using what's known as a "claim" form. However, sometimes you may have to submit a claim yourself. To process a claim correctly, your insurer needs to know the billing codes for the medical care you received. You'll need a detailed bill with billing codes from your provider to send with your claim.

Usually insurers pay claims. But, if your insurer denies a claim, it could be because you or your provider used the wrong billing code on the claim form. Knowing how codes are used can help you get your bill paid.

How are billing codes used on a claim?

Providers use billing codes to describe the service(s) you received. The codes let providers send insurers very detailed information in a condensed way.

There are different types of billing codes. Two types are:

- **Diagnosis codes**, which also may be called the ICD-10 codes. These codes describe the condition for which you received treatment. For example, E10.9 is the diagnostic code for Type 1 diabetes mellitus without complications.
- **Procedure codes**, which include but aren't limited to Current Procedural Terminology® (CPT) codes. These codes describe the treatment you receive. For example, CPT code 95251 is the procedure code for "ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report." You might refer to this simply as glucose monitoring.

Hospitals and other facilities also use billing codes to bundle a group of codes and charge one fee for the various items and services provided. An example is Diagnosis-Related Group (DRG) 638 for Diabetes without complications or comorbidities.

Why would an insurer deny a claim based on a billing code?

An insurer may deny a claim for many reasons. A billing code could be one reason. An insurer could deny a claim if the billing code doesn't exist, your policy doesn't cover it, or if the code doesn't match the other information in the claim.

For example, your provider's billing office could use one of five different levels of codes to code a general visit to your family doctor. Which code it uses depends on the complexity or length of your visit. The insurer could deny the claim if the doctor's office bills for a higher-level code than the medical record describes. Or, it could ask the doctor's office to re-submit the claim with a lower-level code.

If your insurer denies your claim, you should call your insurer to ask questions. If the billing codes were the reason for the denial, ask your provider's billing office to check the code(s) submitted and re-submit the claim.

You also can file an appeal of a denied claim. See the companion guide ***Health Care Bills: How To Appeal A Denied Claim.***