**Health Care Bills: Codes and Claims**

Most of the time, your health care provider will submit claims to your health insurance plan for you, and you don’t need to know how information is entered on the claim. However, sometimes you may have to submit a claim yourself, or your plan may deny a claim. When that happens, you will want to know more about claims and the billing codes used on them.

Why would I need to worry about codes?

When you see a provider who does not participate in your health plan’s network, you might have to file a claim with the plan yourself. Filing a claim means asking the plan to pay its portion of the health care provider’s bill. In order to process the claim, your health plan will need to know the proper codes. You will need to get an invoice from your provider that includes the codes to submit with your claim.

Your health plan may also deny a claim. When you contact your health plan, you might be told that the wrong code was used. Knowing how codes are used can help you get your bill paid.

How are codes used on a claim?

Information is entered on claims using codes. These codes are used as a way to describe the service you received. There are diagnosis codes, which may also be called the ICD-10 codes. Diagnosis codes describe the reason that you received treatment. There are procedure codes, which may be called the CPT codes. These codes describe the treatment you received. There are also codes used by facilities and hospitals to describe the services or supplies they provided.

All of these codes make it possible to send the insurance company detailed information in a condensed way. There are standard references that define the codes, often with very specific details. When a code is used, it gives a summary of a detailed diagnosis or service, using a few numbers.

Why would the health plan deny a claim based on the code?

A health plan may deny a claim if the code does not match the services that were performed or the services the plan expected based on the diagnosis. The definitions of codes can be detailed, and if the medical records don’t record each detail of a code definition, the claim may be denied for an incorrect code. There may be another code that describes the services better.

When you see a doctor for what are called evaluation and management services, there are different levels of codes. Most visits to your family physician are evaluation and management services. The doctor asks about your medical history, examines you, and makes a decision about how to treat you. The level of the service depends on how complex these steps are and how long they take. There are five levels of these services. If the doctor’s office bills for a higher level than was provided, the claim may be denied.

There are other reasons that a claim may be denied based on the code that was used. You can call your health plan to ask questions, and also ask the provider’s billing office to check the code. You can also file an appeal of a denied claim.