THE MEDICAL BILLING EXPERT / CASE STUDY

E/M CODING / COMPLIANCE REVIEW

A 200-claim review found 86% billed incorrectly.

A review of evaluation and management (E/M) claims found frequent coding inaccuracies and a reported overpayment amount that warrants claim-level reconciliation.

200	14%	$9,879.78
CLAIMS REVIEWED	RECORDED ACCURACY RATE	AMOUNT NOTED IN REVIEW

01 / THE COMPLIANCE QUESTION

When coding patterns become a risk

Fraud, waste, and abuse remain central concerns in compliance reviews. A billing pattern can create overpayments even when intent is not established. The distinction between an error, abuse, and fraud depends on the facts; a claim review can identify exposure without deciding intent.

02 / WHAT THE SAMPLE SHOWED

E/M levels did not consistently match the review standard

Over the course of a year, 200 claims were audited. The review notes report a 14% accuracy rate, meaning 86% of the sampled claims were billed incorrectly. The sample was the review set, not the provider’s complete claim population.

CODE IN NOTES	AMOUNT IN NOTES	DIFFERENCE
99214	$135.61	
99215	$192.39	$56.78 per claim

The recorded amounts and code-level comparison are taken from the review notes. They are not presented as a universal fee schedule.

Identify the exposure. Validate the numbers.

A high error rate is a signal to investigate the underlying claims and documentation carefully. It is not, by itself, a finding of fraud or proof of intent.

REPORTED OVERPAYMENT	$9,879.78

03 / WHY IT MATTERS

A sample can reveal a broader control problem

The 200-claim review identified a substantial accuracy concern within the reviewed sample. If coding and documentation practices are not corrected, similar errors may continue across claims outside the sample. The full scope cannot be inferred from these 200 claims alone.

04 / A DEFENSIBLE FOLLOW-UP

Reconcile claim by claim before quantifying exposure

Compare each reviewed claim with the record and applicable coding guidance; confirm which claims were actually overpaid; calculate the amount using the claim-level paid values; then document the corrective steps and any required payer response. The notes do not state whether these follow-up actions were completed, so this case study does not claim a final repayment or enforcement outcome.

CALCULATION CHECK

The notes state 14% accuracy across 200 claims (172 claims not accurate) and a $56.78 difference per claim. If all 172 were overpayments at that difference, the result would be $9,766.16. The recorded total is $9,879.78, a $113.62 difference. Reconcile the claim count and claim-level amounts before publishing or relying on the aggregate.

Case details and provider identity are omitted. Figures are reproduced from the supplied review notes and should be confirmed against source workpapers. This summary is informational and does not determine intent, legal liability, or payer recoupment.