



Bluespine

Medical Billing Overcharges Report

Overview

Bluespine conducts a comprehensive assessment of all claims payments made by the administrator on behalf of our clients through our exclusive electronic claim edit system.

Bluespine AI engine learns the current customer policy and agreement details and formulates customized rules specific to the objectives of this test.

In total, over 3500 rules were generated and put into action for this report purpose.

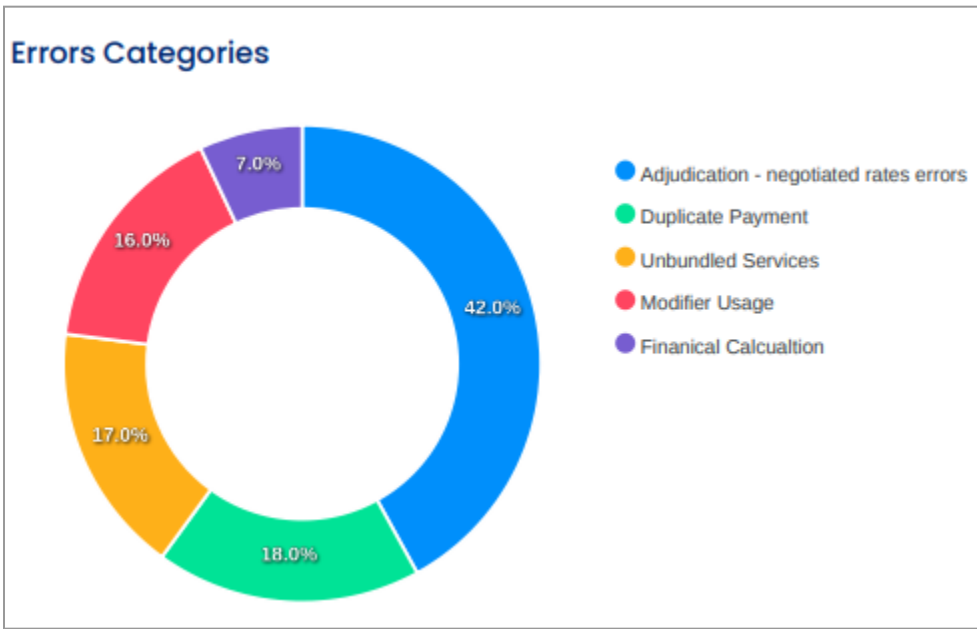
These rules serve the purpose of pinpointing potential instances of overpayments in various claim areas, including eligibility, pricing, duplicate claims, and medical coding errors.

We conducted a scan of claims exceeding \$8.5 million in value, revealed an error rate of 8.8%, equivalent to \$750,000

Summary

Scanned Claims +3K	Potential Saving \$750K <small>Total Cost: \$8.5M</small>	Reviewed Rules +3500
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General: A total of 3,134 claims were subjected to scanning, during which over 3,500 rules were examined. Of these rules, 2,300 were tailored to the specific policies of the customer.



Top Categories :Signifies coding, education, and administrative mistakes

Detailed Findings

Duplicate Payment

The duplicate claim inquiries differ based on matches and discrepancies in fields such as patient information, provider details, service date, billed charges, and procedure codes.

Although many clients may anticipate duplicate claims to be infrequent, they are actually quite prevalent in healthcare claims payments and typically lead to overpayment recovery

Negotiated rates errors

Errors related to negotiated rates occurred when the service pricing broker's agreement differed from the actual claims.

Coding Error - Unbundled Services

Unbundling in medical claims involves charging separately for individual components of a procedure instead of billing for the entire service. For instance, if a surgery includes anesthesia and post-operative care, unbundling might mean billing for these elements separately. This practice can lead to overpayment and is considered fraudulent if used to inflate reimbursements.

Coding Error - Modifier Usage

Overbilling due to a missing modifier occurs when a healthcare provider doesn't include the right modifier to indicate an additional procedure during a service. For example, if a dermatologist removes a skin lesion during a routine visit without using the appropriate modifier, they might get reimbursed at a higher rate, leading to overbilling. Using modifiers accurately is vital to avoid this issue and ensure proper billing for services rendered.

Eligibility - Ex Employee

Employer groups submit retroactive employee's terminations to the TPA, creating a potential for overpayments unless the administrator has established a procedure to detect and reclaim such claims.

Report Finding

Name	Type	Amount	\$ Errors
Negotiated rates errors	Financial Mistake	1252	\$315000 (42%)
Duplicate Payment	Financial Mistake	1030	\$52500 (7%)
Unbundled Services	Policy Violation	452	\$120000 (16%)
Modifier Usage	Policy Violation	173	\$127500 (17%)
Ex-Employee	Financial Mistake	86	\$135000 (18%)

Appendix A - Claims Sampling

Negotiated rates errors

Claim ID	Date	Provider NPI	Patient ID	Billing Type	In Network	Service	Negotiated Price	Actual Price	Diff
85371	2022-06-19	2722286370	2248	Institutional	false	MRI Scan	\$500	\$680	\$180
94295	2022-07-06	7000693721	3166	Professional	false	Lab Tests	\$50	\$364	\$314
65666	2022-01-20	9721962561	8825	Professional	false	X-Ray	\$200	\$556	\$356
60927	2022-04-21	4243466052	1586	Institutional	true	Physical Exam	\$100	\$355	\$255
25832	2022-12-05	1839271301	3613	Professional	false	MRI Scan	\$500	\$648	\$148
71342	2022-02-02	7451097032	9794	Professional	true	Lab Tests	\$50	\$968	\$918
99779	2022-01-18	2180112751	2944	Professional	false	X-Ray	\$200	\$652	\$452
29317	2022-05-27	3556425103	7401	Institutional	false	Physical Exam	\$100	\$870	\$770
12030	2022-05-14	1109018701	4261	Professional	true	MRI Scan	\$500	\$751	\$251
95115	2022-02-13	4199394532	6201	Professional	false	Lab Tests	\$50	\$751	\$701
51368	2022-12-03	5973876098	4184	Institutional	true	X-Ray	\$200	\$371	\$171
69190	2022-09-07	6063025858	6113	Professional	true	Physical Exam	\$100	\$689	\$589
58404	2022-08-04	3827036425	7100	Professional	false	MRI Scan	\$500	\$773	\$273
33195	2022-12-04	2918892482	5114	Professional	true	Lab Tests	\$50	\$772	\$722

Sampling (Duplicate Payment)

Claim ID	Date	Duplicate Claim Id	Level	Amount
95847	2022-02-27	19668	Whole Claim	\$883
77393	2022-09-03	55179	Individual Service	\$1000
26900	2022-12-14	88563	Whole Claim	\$615
15467	2022-03-02	41869	Individual Service	\$1051
40692	2022-09-03	15986	Whole Claim	\$394
86660	2022-08-19	54604	Individual Service	\$517
25947	2022-03-15	25039	Whole Claim	\$731
81719	2022-10-11	44191	Whole Claim	\$740
12078	2022-07-18	53895	Whole Claim	\$1069
90053	2022-08-06	66811	Individual Service	\$890
78948	2022-07-12	13265	Individual Service	\$637
49304	2022-03-21	71047	Individual Service	\$512
24991	2022-05-04	12014	Whole Claim	\$372
44204	2022-02-25	77904	Individual Service	\$1138
84243	2022-02-20	86394	Whole Claim	\$817

Duplicate - Claim example

⚠ Charging was applied twice for chest radiology examination (two individual views). Following the policy, these charges cannot be justified, particularly due to the relatively short time sequence.

📄 Rule 2963

🔒 High Confidence



Claim details


24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	
	From			To					(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER	
1	10	08	22	10	08	22	11		71045	
2	10	08	22	10	08	22	11		71045	


Sampling - Unbundled Service

Claim ID	Date	#items	Amount
95286	2022-04-21	4	\$896
82335	2022-12-02	4	\$373
83248	2022-05-21	2	\$820
92363	2022-08-10	5	\$510
61989	2022-10-07	3	\$653
10745	2022-05-19	2	\$771
56988	2022-08-02	4	\$930
77327	2022-03-06	5	\$338
91008	2022-05-04	2	\$541
66338	2022-04-19	3	\$298
93384	2022-08-25	4	\$925
12130	2022-10-22	3	\$152
78192	2022-12-20	5	\$621
45309	2022-07-03	3	\$250
24827	2022-03-14	4	\$955

Unbundled Service - Claim example

⚠ As per the policy, breast biopsies should be combined under a single code instead of being divided into two separate codes. The use of a modifier is recommended.

 Rule 1300

 High Confidence


Claim details

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	
	From			To					CPT/HCPCS	MODIFIER
	MM	DD	YY	MM	DD	YY				
1	21	05	22	21	05	22	22		19100	LT
2	21	05	22	21	05	22	22		19100	RT