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# The anatomy of an overcharged inpatient claim

A line-by-line walk through a real-world style hospital bill: a duplicate scan, an upcoded visit, an unbundled panel, and an overstated stay that added up to a five-figure recovery.

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The best way to understand recovery is to walk through a claim. What follows is an illustrative inpatient bill, built to mirror the patterns we see rather than any single named client. The claim totaled far more than the care supported, and the errors were of exactly the kinds that a disciplined audit is built to catch. Each one is paid dollars that belong back in the plan.

## The starting point: the itemized bill

The explanation of benefits showed a single large paid amount. That is where most reviews stop. The itemized bill, requested from the provider, is where the detail lives: every medication, procedure, supply, and room charge, each carrying its own code. The comparison between what the plan paid and what the itemized lines actually justify is where every finding below came from.

## Finding one: a duplicate scan

A chest x-ray, two views, appeared twice on the same date of service at the same charge. The clinical record supported one. The second was a duplicate charge, billed and paid a second time for a service performed once. Duplicate charges are among the most common inpatient errors because a busy chargemaster can post the same item more than once. The remedy is straightforward: remove the duplicate and return its amount.

## Finding two: an upcoded visit

An evaluation and management visit was billed at the highest complexity level. The physician's note described a routine follow-up that supported a lower level. This is upcoding: the code claimed more than the documentation showed. The correction is to reprice the line to the level the record actually supports and recover the difference.

## Finding three: an unbundled panel

A basic metabolic panel was billed as fourteen separate assays rather than the single panel code that covers them. Under correct coding rules, the comprehensive panel code should have been used. Billing the components separately inflated the charge well above the panel price. This is unbundling, and the National Correct Coding Initiative edits are the standard that says the parts should have been billed as one.

## Finding four: an overstated stay

Room and board was billed for four days. The admission and discharge records supported a three-day

stay. The extra day of room charges, along with the ancillary charges that rode along with it, was billed for time the patient was not there. Length-of-stay errors are among the largest single-line recoveries on an inpatient claim because a day of inpatient room and board is expensive.

## Finding five: balance billed to the plan

A balance that should have been resolved within the contracted rate was passed through and paid. Reviewing the amount against the plan's terms and the expected allowed amount showed it should not have been paid as billed. Catching this required reading the claim against the plan document, not just the provider's statement.

## The result

Individually, several of these lines look small. Together, on one inpatient claim, they added up to a five-figure recovery returned to the plan. None of them required a fight. Each required the itemized bill, the plan's terms, an objective coding or pricing standard, and a clearly documented request to correct the claim. That is the whole method, applied to one bill.

### References

1. Illustrative composite claim; figures represent typical recovery patterns and are not tied to a named client.
2. CMS National Correct Coding Initiative (NCCI) edits (unbundling standard).
3. American Medical Association CPT code set (procedure coding).