Medical Billing Compliance in 2026

Risk Areas Every Practice Must Monitor

For Independent Practices, Group Practices,
Specialty Clinics & Billing Managers

Whitepaper

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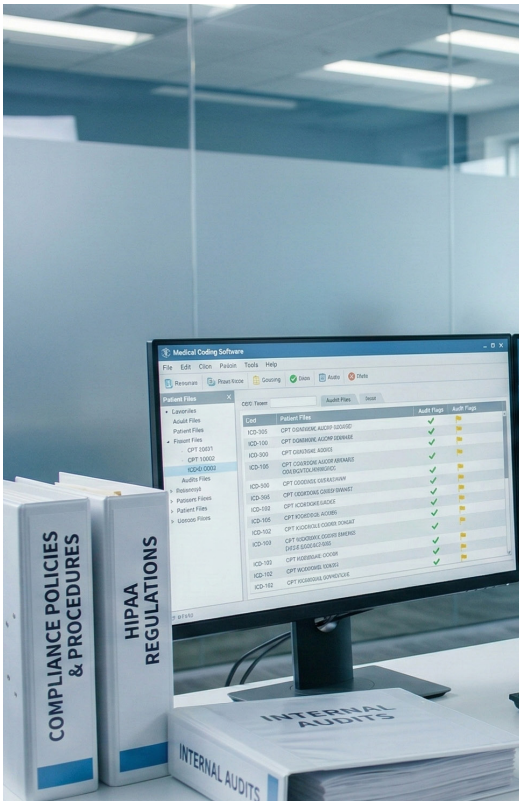
Executive Summary

Federal and state enforcement agencies are increasing audit activity, payers are tightening claim rules, and the cost of billing errors, whether from incorrect coding, missed authorizations, or documentation gaps, is rising fast. For practices of every size and specialty, compliance failures reflect directly on denied claims, revenue loss, and in serious cases, regulatory penalties.



This white paper, prepared by the Liberty Liens billing and compliance team, identifies the most critical risk areas affecting medical practices today. It is written for physicians, practice managers, and billing staff who want a clear, practical understanding of where billing risk lives in 2026, and what to do about it.

Throughout this paper, you will see how Liberty Liens' medical billing service directly addresses each of these risks, protecting your revenue while freeing your clinical team to focus on patient care.

WHO THIS PAPER IS FOR

Independent practices, specialty clinics such as orthopedic, pain management, chiropractic, mental health, primary care, cardiology, group practices, urgent care facilities, and ambulatory surgical centers that want to stay compliant, reduce denials, and maximize reimbursement.

The Stakes: Why Billing Compliance Matters More Than Ever

The United States healthcare billing environment has grown significantly more complex over the past three years. Three converging pressures are driving this shift:

Increased Payer Scrutiny

Commercial insurers and the Centers for Medicare & Medicaid Services (CMS) are running more advanced claim audits, using data analytics to flag outlier billing patterns by specialty, provider, and geography. A 2024 Statista study found that 19% of health insurance claims are initially denied, a number that has been climbing as payers like Aetna and Blue Cross tighten their documentation requirements.

Regulatory Enforcement Activity

The Office of Inspector General (OIG) Work Plan continues to expand its list of audit targets, and the Department of Justice (DOJ) has increased False Claims Act settlements in healthcare. Practices that rely on outdated billing practices or staff not current on coding changes are at heightened risk.

Coding Complexity

Annual updates to CPT and ICD-10 code sets, combined with specialty-specific bundling rules and modifier requirements, mean that billing errors are increasingly easy to make and increasingly expensive to overlook.

19%	25%	$125B+	4%–10%
Of claims initially denied	Denial reduction with expert billing	Lost annually to billing errors	Typical billing service cost of collections

Against this backdrop, practices that manage billing in-house without dedicated expertise are playing a losing game. Those that partner with a specialized billing service gain not just efficiency, but a compliance shield.

Risk Area 1:

Coding Accuracy for Evaluation and Management (E/M), CPT, and ICD-10

What Is at Risk

Coding errors are the single most common cause of claim denials and the most frequent trigger for payer audits. Every claim submitted to Medicare, Medicaid, or a commercial insurer requires a precise combination of diagnosis codes (ICD-10), procedure codes (CPT), and in many cases modifiers and place-of-service codes. An error in any of these can result in a denial or a reduced payment.

The Specific Risks in 2026

1. Evaluation and Management (E/M) Level Misassignment

Since the 2021 changes to office visit coding, Evaluation and Management (E/M) levels are no longer based on how many history and physical exam elements are documented. Instead, the level of service is determined by either:

- Medical Decision Making (MDM) complexity, or
- Total time spent on the date of the encounter

In simple terms, it's no longer about how much you document. It's about how complex the patient's care is or how much time you actually spend managing it. Medical Decision Making looks at three key factors:

- The number and complexity of problems addressed
- The amount and/or complexity of data reviewed
- The risk of complications or morbidity

If a practice is still using outdated documentation templates or relying heavily on EHR auto-populated notes, it may be selecting E/M levels based on volume of documentation rather than true MDM complexity or time. This often leads to incorrect code assignment, either overcoding or undercoding.In short, accurate E/M coding today depends on reflecting the clinical complexity or time spent, not on checking boxes in the record.

2. Upcoding Exposure

Selecting a higher-level E/M code than the documentation supports, even if it happens unintentionally due to EHR auto-population, can significantly increase audit risk.

Payers closely monitor billing patterns, not just individual claims. They analyze the distribution of E/M codes by specialty and compare providers against their peers. If a provider consistently bills higher-level codes more frequently than others in the same specialty, that pattern is flagged as an outlier.

Outliers don't automatically mean wrongdoing, but they do trigger scrutiny. This can lead to record requests, audits, payment recovery, or even broader compliance reviews.

In short, coding must align with documented Medical Decision Making or time. Even small, consistent discrepancies can attract attention when payer analytics identify patterns that fall outside the norm.

3. Undercoding Revenue Loss

The opposite problem is equally costly. Many providers intentionally or unintentionally undercode out of caution, selecting lower-level evaluation and management (E/M) services even when the documentation supports a higher level.

While this may feel safer, it leaves legitimate revenue on the table. Over time, consistent undercoding can significantly impact a practice's financial performance.

This is particularly common in specialties such as orthopedics and pain management, where patient encounters often involve complex decision-making, including imaging review, risk assessment, medication management, and surgical planning. Even when procedures are involved, the associated evaluation and management work may meet higher Medical Decision Making (MDM) levels.

In short, accurate coding is about balance. Overcoding increases audit risk, while undercoding reduces appropriate reimbursement. The goal is precise alignment between documented complexity, time, and the selected evaluation and management service (E/M) level.

4. ICD-10 Specificity Failures

Submitting unspecified diagnosis codes when a more specific code is available can create both financial and compliance challenges.

Many payers require the highest level of specificity supported by the documentation. When an unspecified code is used despite clear clinical details in the record, claims may be denied, delayed, or flagged for review. This slows reimbursement and increases administrative rework.

Beyond denials, repeated use of unspecified codes can signal weak documentation practices. Payers and auditors may interpret this as a lack of clinical detail, poor coding oversight, or insufficient documentation controls.

In short, diagnosis coding should reflect the full clinical picture documented in the medical record. Using the most specific, accurate code available supports clean claims, faster payment, and a stronger compliance posture.

How Liberty Liens Address This

Every claim processed by Liberty Liens is coded by trained, specialty-aware billers who review documentation before assigning codes. We do not rely on auto-generated code suggestions without human review. Our coders stay current on annual CPT and ICD-10 updates and apply payer-specific rules to every submission, minimizing both upcoding risk and revenue left on the table.

Risk Area 2:

Claim Denials and the Hidden Revenue Drain

What Is at Risk

A denied claim is not just an administrative inconvenience. It is revenue at risk. The average cost to rework and resubmit a denied claim is estimated at $25 to $118 per claim, and practices that do not have systematic denial management processes in place often simply write off denied claims rather than appeal them. Over time, this becomes one of the most significant sources of revenue leakage in any practice.

The Specific Risks in 2026

1. **Timely Filing Violations**

Every payer has a filing deadline. Missing it, even by one day, makes a claim permanently unrecoverable, regardless of clinical merit. Practices juggling high patient volumes without automated tracking routinely miss these windows.

2. **Missing or Incorrect Prior Authorizations**

Services offered without a valid, payer-specific prior authorization are denied on the front end. This is especially common in surgical specialties, diagnostic imaging, and pain management, where authorization requirements are particularly complex.

3. **Eligibility and Benefits Errors**

Billing a payer for a patient who is no longer covered, or whose deductible and co-insurance amounts have changed, results in immediate denials. Real-time eligibility verification at the point of scheduling, not just at check-in, it is the standard of care.

4. **Unbundling and Bundling Errors**

Billing separate codes for services that payers expect to be bundled, or failing to separately report appropriately distinct services, triggers automated claim edits and denials.

5. **Appeal Deadline Misses**

Even when a denial is improper, practices that do not appeal within the payer's appeal window lose the revenue permanently. Most practices lack the bandwidth to track and meet every payer's unique appeal requirements.

How Liberty Liens Address This

Liberty Liens runs real-time eligibility verification before every claim submission, tracks prior authorization status across all active patients, and operates a systematic denial management workflow that catches, corrects, and appeals denied claims within payer deadlines. Our clients see denial rates drop significantly within the first 60 days of service.

Risk Area 3:

Documentation Integrity and Audit Readiness

What Is at Risk

Medical billing is only as strong as the documentation behind it. When payers audit a claim, whether through a Comprehensive Error Rate Testing (CERT) review, a Recovery Audit Contractor (RAC) audit, or a commercial payer post-payment review, they are evaluating whether the medical record supports the codes billed. If the documentation does not support the level of service claimed, the payment is recouped. If a pattern of unsupported billing is found, the consequences escalate significantly.

The Specific Risks in 2026

1. **Copy-Forward EHR Documentation**

Many practices use EHR copy-forward or auto-populate features that carry forward clinical notes from previous encounters without reflecting the actual work done during the current visit. This practice is widely flagged in audits and constitutes a documentation integrity failure.

2. **Procedure Documentation Gaps**

For surgical practices and proceduralists, operative notes and procedure documentation must specifically support the codes billed, including laterality, approach, complexity, and any additional procedures performed. Missing elements result in downcodes or denials.

3. **Medical Necessity Failures**

Even a perfectly coded claim will be denied if the payer's medical necessity criteria are not documented. This is particularly acute in pain management, cardiology, and home health, where medical necessity thresholds are strict.

4. **Modifier Misuse**

Modifiers such as 25, 59, and technical components communicate important clinical context to payers. Overusing modifier 25 (separate and significant evaluation and management on the same day as a procedure) without adequate documentation of distinct medical decision-making is one of the top audit triggers across all specialties.

How Liberty Liens Address This

Our team reviews documentation completeness before submitting claims, and we flag documentation gaps back to providers before submission, not after a denial. We conduct periodic internal claim audits to identify documentation trends that could expose a practice to a payer audit.

Risk Area 4:

Credentialing, Contracting, and Enrollment Gaps

What Is at Risk

Credentialing failures are among the most financially damaging compliance issues a practice can face, because they can render entire blocks of claims unrecoverable, not just individual claims. When a provider renders services before their payer enrollment is complete, or when a practice bills under a departed provider's credentials, the consequences are severe and often retroactive.

The Specific Risks in 2026

1. **Billing Under Non-Enrolled Providers**

Submitting claims for a provider who is not yet credentialed with the payer results in wholesale denial of those claims. In Medicare, this means the services cannot be billed at all until the provider's enrollment is active, and retroactive billing is only permitted in limited circumstances.

2. **Payer Roster Failures**

When providers join or leave a practice, every payer contract must be updated to reflect the change. Failing to update rosters causes misdirected payments, improper billing, and potential fraud allegations.

3. **Mid-Level Provider Supervision**

For practices that employ nurse practitioners or physician assistants, the supervision and billing rules for incident-to services are strict. Billing incident-to when the supervising physician is not in the office suite, for example, is off-site seeing patients at a satellite location, is a compliance violation.

4. **Contract Rate Verification**

Many practices do not regularly verify that they are being reimbursed at contracted rates. Payer system errors that underpay contracted services go undetected for months or years without an active AR follow-up process.

How Liberty Liens Address This

Liberty Liens offers credentialing and contracting support as part of our comprehensive billing service. We track provider enrollment status across all active payers, manage roster updates when providers join or leave, and monitor AR to catch underpayments against contracted rates.

Risk Area 5:

HIPAA Compliance in the Billing Workflow

What Is at Risk

Medical billing inherently involves the transmission, storage, and use of Protected Health Information (PHI). Every step of the billing workflow, from eligibility verification to claim submission to payment posting, creates HIPAA obligations. As practices adopt cloud-based EHRs, outsource billing, and use third-party clearinghouses, the number of entities handling PHI expands, and so does compliance risk.

The Specific Risks in 2026

1. **Business Associate Agreement Gaps**

Every vendor or service provider that handles PHI on behalf of your practice, including billing companies, clearinghouses, and software platforms, must have a signed Business Associate Agreement (BAA). Practices that have not executed BAAs with all applicable vendors are out of compliance and fully exposed in the event of a breach.

2. **Breach Notification Failures**

HIPAA requires notification of affected patients, HHS, and in some cases the media within specific timeframes following a breach. Practices that are not prepared to identify and respond to breaches within those windows face civil monetary penalties that scale with the duration of non-compliance.

3. **Electronic Claim Transmission Security**

EDI (Electronic Data Interchange) claim submissions must be transmitted through HIPAA-compliant channels. Using non-compliant clearinghouses or insecure transmission methods creates both a HIPAA violation and a claims processing risk.

4. **Minimum Necessary Standard**

PHI shared in the billing context must be limited to the minimum necessary for the billing purpose. Sharing entire medical records when only billing data is needed is a common, avoidable violation.

How Liberty Liens Address This

Liberty Liens operates as a fully HIPAA-compliant Business Associate. All data transmission is handled through secure, encrypted channels and compliant clearinghouses. Our BAA is standard with every client engagement, and our staff is trained in HIPAA privacy and security requirements. We are HIPAA-compliant across 100% of our operations.

Specialty Billing: Where Compliance Risk Is Highest

While the risk areas described above apply to all medical practices, certain specialties face heightened compliance exposure due to the complexity of their procedure mix, the specificity of their coding requirements, and the intensity of payer scrutiny in their service categories. Liberty Liens provides specialty-calibrated billing for each of the following practice types.

01 Orthopedic Billing

Orthopedic practices deal with some of the most complex procedural coding in medicine. Arthroscopies, joint replacements, fracture care, and spine procedures all require precise code selection, laterality designation, and modifiers. Common risk areas include unbundling of arthroscopic procedure components, incorrect use of fracture care codes, and documentation gaps in operative notes. Liberty Liens' orthopedic billing specialists understand the specific payer rules and bundling edits that apply to musculoskeletal services.

02 Pain Management Billing

Pain management is one of the most audited specialties in the country. Fluoroscopic guidance coding, nerve block documentation, spinal injection bundling rules, and the distinction between diagnostic and therapeutic procedures are all high-risk areas. Prior authorization requirements are also particularly extensive. Our team manages the full prior authorization and documentation workflow for pain management clients to ensure every procedure is both authorized and fully supported.

03 Chiropractic Billing

Chiropractic practices must navigate strict Medicare rules around active care versus maintenance care, the AT modifier requirement to indicate active treatment, and documentation standards for medical necessity. Many chiropractic practices also deal with a high volume of personal injury and workers' comp cases alongside standard insurance billing, requiring fluency across multiple payer types simultaneously.

04 Mental Health Billing

Mental health billing carries unique compliance risks around psychotherapy vs. E/M code selection, the rules for billing concurrent psychotherapy and pharmacological management, and the documentation requirements for crisis services and psychological testing. Telehealth mental health services also have payer-specific coverage rules that differ significantly from in-person rules.

05 Primary Care & Family Medicine

High-volume primary care practices face compliance risk from E/M level distribution outliers, Annual Wellness Visit versus Preventive Visit code confusion, and the complex rules around chronic care management billing. Practices that see a broad patient mix across payers also deal with constantly shifting coverage and authorization rules that require up-to-date payer intelligence.

06 Cardiology Billing

Cardiology Billing Cardiology combines E/M coding with a dense mix of diagnostic testing codes, echocardiograms, stress tests, Holter monitors, and catheterizations, each with its own professional/technical component rules, supervision requirements, and bundling restrictions. The distinction between globally billed services and component billing is a frequent audit target.

07 General Surgery Billing

Surgical billing is among the most complex in medicine, involving global surgical periods, assistant surgeon billing, multiple procedure reductions, and the correct use of modifiers 50, 51, 62, and 80. Inaccurate handling of the 90-day global period billing for services that should be included is one of the most common surgical billing errors.

08 Neurology Billing

Neurology practices must navigate the billing of EEG, EMG, and nerve conduction studies alongside E/M services, as well as the documentation requirements for evoked potential testing, polysomnography, and intraoperative neurophysiological monitoring. Sleep study billing in particular has been a focus of payer audits in recent years.

How Liberty Liens Medical Billing Service Addresses Every Risk

The table below maps each compliance risk area covered in this paper to the specific Liberty Liens service that addresses it. Our medical billing service is designed to be end-to-end, from eligibility verification before the patient is seen to payment posting and AR follow-up after the claim is paid.

Compliance Risk Area	Compliance Risk Area	What We Do
Coding Accuracy	Medical Billing & Coding	Specialty-trained coders review every claim before submission
Claim Denials	Denial Management	Systematic denial identification, correction, and appeal within payer deadlines
Eligibility Errors	Eligibility & Benefits Verification	Real-time pre-submission eligibility checks
Documentation Gaps	Claim Scrubbing & Audit	Provider enrollment tracking, roster management, and payer contracting
Underpayments	AR Follow-Up	Active AR monitoring catches underpayments against contracted rates

Why Practices Choose Liberty Liens

There is no shortage of medical billing companies in the market. What distinguishes Liberty Liens is not just the breadth of our service offering, but also the depth of our specialty expertise, the transparency of our reporting, and our commitment to treating every dollar of your revenue as if it were our own.

Ten Plus Years of Experience: Liberty Liens has been supporting medical practices since 2015. We have worked with individual practitioners, specialty clinics, group practices, hospitals, and ambulatory surgical centers across a wide range of specialties.

Specialty-Calibrated Billing: We do not apply a one-size-fits-all approach. Our billers are trained in the specific coding rules, payer requirements, and audit risks that apply to each specialty we serve.

HIPAA-Compliant Operations: Every aspect of our billing workflow is HIPAA-compliant. We operate as your Business Associate, with a signed business associate agreement (BAA), and we handle all Protected Health Information (PHI) through a secure, encrypted channel.

Free Practice Audit Report: Before you commit to anything, we offer a complimentary audit of your current billing processes to identify where revenue is being lost and where compliance risk exists.

Conclusion: Compliance Is Not Optional, But Managing It Alone Is

The five risk areas covered in this white paper, coding accuracy, claim denial management, documentation integrity, credentialing, and HIPAA compliance, represent the most consequential billing challenges facing medical practices in 2026. None of them are new, but all of them are more dangerous than ever, given the intensity of payer scrutiny and regulatory enforcement.

The good news is that every one of these risks is manageable, with the right people, processes, and systems in place. Liberty Liens exists to be exactly that for the practices we serve. We handle the complexity of your revenue cycle so you can focus on the reason you went into medicine: taking care of patients.

Whether you are a solo practitioner frustrated by mounting denials, a group practice looking to scale your billing operations, or a specialty clinic that wants specialty-specific expertise you can trust, Liberty Liens has a solution designed for you.

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Book Your Free Audit Today!

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