



**MEDICAL BILL  
FORENSICS**  
PROFESSIONAL BILLING AUDITS

**Medical Bill Forensics LLC**  
**Forensic Medical Bill Audit Report**  
**March 10, 2026**

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**Note:** The forensic medical bill audit included in this report contains private and protected health information covered under the Health Insurance Portability and Accountability Act (HIPAA). This report was prepared for: John Doe (“the patient”), named on the itemized bill associated with this forensic audit. If you are not the patient or their authorized representative do not proceed.

**PEAK OF THE MOUNTAIN MEDICAL CENTER**

1000 Summit Way Alpine Peaks, CO 11111

**PATIENT:** John Doe

**ACCOUNT:** 554432

**STATEMENT DATE:** 03/03/2026

**ITEMIZED STATEMENT OF CHARGES**

Date	Rev	Code	Description	Qty	Unit Cost	Total
01/04	0450	99285	EMERGENCY DEPT VISIT - LEVEL 5	1	\$2,100.00	\$2,100.00
01/04	0120	99223	INITIAL HOSPITAL CARE - LEVEL 3	1	\$1,250.00	\$1,250.00
01/04	0480	92941	PCI-ACUTE MI W/ STENT PLACEMENT	1	\$18,400.00	\$18,400.00
01/04	0278	C1874	STENT, DRUG-ELUTING, CORONARY	1	\$4,800.00	\$4,800.00
01/04	0730	93000	ECG-GLOBAL REPORT	1	\$250.00	\$250.00
01/04	0730	93010	ECG-PROFESSIONAL COMPONENT	1	\$150.00	\$150.00
01/04	0300	84484	TROPONIN - QUANTITATIVE	1	\$315.00	\$315.00
01/04	0300	84484	TROPONIN - QUANTITATIVE	1	\$315.00	\$315.00
01/04	0320	71045	RADIOLOGY - CHEST X-RAY 1 VIEW	1	\$420.00	\$420.00
01/04	0300	80053	COMP METABOLIC PANEL	1	\$185.00	\$185.00
01/04	0250	J1644	HEPARIN SODIUM INJECTION/1000U	10	\$65.00	\$650.00
01/05	0124	—	ROOM & BOARD - CARDIAC ICU	1	\$4,500.00	\$4,500.00
01/05	0480	93306	ECHOCARDIOGRAM W/ DOPPLER	1	\$1,800.00	\$1,800.00
01/05	0250	S5570	BRILINTA 90MG TABLET	2	\$85.00	\$170.00
01/06	0124	—	ROOM & BOARD - CARDIAC ICU	1	\$4,500.00	\$4,500.00

Date	Rev	Code	Description	Qty	Unit Cost	Total
01/06	0410	94640	NEBULIZER TREATMENT	2	\$480.00	\$960.00
01/06	0270	A4627	NEBULIZER SUPPLY KIT	1	\$120.00	\$120.00
01/07	0202	—	ROOM & BOARD - TELEMETRY	1	\$3,200.00	\$3,200.00
01/07	0730	93224	ECG MONITOR CONTINUOUS 24HR	1	\$650.00	\$650.00
01/08	0200	—	ROOM & BOARD - DISCHARGE DAY	1	\$3,200.00	\$3,200.00
01/08	0120	99238	HOSPITAL DISCHARGE MGMT	1	\$450.00	\$450.00
MISC	0250	—	PHARMACY - ASPIRIN 325MG	4	\$45.00	\$180.00
MISC	0270	—	SUPPLIES - STERILE GLOVES	12	\$15.00	\$180.00

#### ACCOUNT SUMMARY

- Total Gross Charges: \$52,175.00
- Adjustments / Contractual Allowances: \$0.00
- Insurance Payments Received: \$0.00
- **TOTAL AMOUNT DUE: \$52,175.00**

## I. Forensic Audit Overview

Medical Bill Forensics LLC operates under the legal, and federally mandated principle that a healthcare financial demand (e.g., an itemized bill of charges) is only legally “allowable” if it adheres to the HIPAA Administrative Simplification Standards (45 CFR Part 162).

This forensic audit evaluates the structural and coding accuracy of the certified itemized bill provided to Medical Bill Forensics LLC by the patient. This audit is limited to the information contained in the itemized bill; no medical records, claim forms, or internal hospital charge master data were reviewed. The purpose of this audit is to identify structural coding deficiencies, duplicate charges, missing modifiers, or other discrepancies that render specific line items in the bill unsupported as presented.

### **The following standards apply to all audited demands:**

**Mandatory Compliance:** Under 45 CFR § 162.923, a healthcare provider is legally required to use the applicable HIPAA Standard Code Sets (CPT, HCPCS, ICD-10, and Revenue Codes) when conducting a financial transaction.

**Condition of Payment:** Adherence to these standard nomenclatures and their official guidelines is a prerequisite for reimbursement. A code that is non-standard, unbundled, or incorrectly sequenced fails to meet the federal Condition of Payment.

**Status of Non-Conforming Codes:** Any code or charge that deviates from these standards is classified as Non-Conforming. Federal claims processing rules (CMS Pub. 100-04) dictate that such demands are unprocessable and must be Returned to Provider (RTP) for correction or removal.

**Forensic Conclusion:** A non-conforming code renders the specific line item invalid. Until the error is corrected to meet the National Uniform Billing Standards, the demand remains an unsubstantiated claim for which no payment obligation exists. As a matter of law, if the non-conforming code cannot be substantiated, it must be removed from a demand.

## II Forensic Audit Methodology and Universal Review Techniques

In harmony with HIPAA Under 45 CFR § 162.923, the following coding standards and methodology were utilized to produce the forensic bill audit included within this report:

### **1. National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP)**

**Analysis:** This technique involves cross-referencing all reported Current Procedural Terminology (CPT) codes against federal edit tables. It identifies "unbundling," where a single comprehensive service is illegally separated into multiple smaller charges to inflate revenue. Charges failing this analysis are identified as "Impermissible Bundling" and are **Unallowable** as they represent a duplicate request for payment.

- **Authority:** *Centers for Medicare and Medicaid Services (CMS) NCCI Policy Manual, Chapter 1 (General Correct Coding Policies).*

**2. Medically Unlikely Edit (MUE) Adjudication** A review of "Units of Service" (UOS) against the maximum number of units a provider would reasonably report for a single patient on a single date based on biological and clinical plausibility. Any units exceeding the published limit without a justifying modifier are identified as "**Excessive Units**" and are **Unallowable** as they are clinically improbable.

- **Authority:** *Social Security Act, Section 1833(e); CMS MUE Adjudication Indicators (MAI).*

**3. Revenue Code Cross-Walking** An audit of the relationship between Revenue Codes (the hospital department billing the service) and the specific Procedure Codes. This identifies "Upcoding," where low-intensity services are billed through high-cost departments. If the Revenue Code does not align with the Healthcare Common Procedure Coding System (HCPCS) definition, the charge is **Unallowable** in its current form and must be reclassified.

- **Authority:** *National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications.*

**4. Evaluation and Management (E/M) Level Validation** A qualitative assessment to ensure the complexity of the visit (e.g., Level 5 Emergency Department vs. Level 3 Inpatient) is supported by the patient's documented clinical acuity. If documentation does not support the intensity of the billed code, the excess portion is **Unallowable** as an "Upcoded" service.

- **Authority:** *CMS Claims Processing Manual, Publication 100-04, Chapter 12; 1995/1997 Documentation Guidelines for Evaluation and Management Services.*

**5. Anatomical and Technical Modifier Forensic Review** This technique operates on the principle that an itemized bill is a final representation of services. If a code requires a modifier to establish its validity (such as distinguishing a repeat test or a separate procedure) and that modifier is absent, the code is Invalidated. An invalidated code is legally considered an Unallowable Overcharge.

- **Authority:** *CMS Claims Processing Manual, Publication 100-04, Chapter 23.*

**6. Fair Market Value (FMV) & Cost-to-Charge Benchmarking** The analysis of pharmaceutical and supply markups against the National Average Drug Acquisition Cost (NADAC) and the facility's reported Cost-to-Charge Ratio (CCR). Charges for routine supplies that are not specifically itemizable under federal guidelines are identified as Unallowable Itemization because they should be included in the daily room rate or primary procedure cost.

- **Authority:** *CMS Medicare Prescription Drug, Improvement, and Modernization Act (MMA); CMS Provider Reimbursement Manual (Pub. 15-1), Section 2102.1.*

**7. Global Package & Redundancy Detection** Identifying "double-billing" scenarios where a facility bills for a global service while simultaneously itemizing the professional or technical components of that same service. These charges are Unallowable as they represent a secondary charge for work already compensated in the global rate.

- **Authority:** *CMS Claims Processing Manual, Publication 100-04, Chapter 12 (Global Surgery and Diagnostic Test Rules).*

### **III. Forensic Audit Findings & Rationale**

Based on application of the information and methodology outlined within sections I and II above, to the itemized bill provided by the patient, the following charges are identified as non-conforming and therefore unallowable in their current form:

1. **Concurrent Evaluation and Management (E/M) Levels:** The statement includes charges for both an Emergency Department visit and Initial Hospital Care on January 4th. Under established billing architecture, the outpatient ED visit is considered inclusive to the

inpatient admission service. Billing both represents a structural overlap of physician work for the same clinical episode.

2. **Redundant Technical Itemization:** The audit identified "Global" service codes that, by definition, include both the technical and professional components. The inclusion of a secondary, separate charge for professional interpretation constitutes a redundancy in the billing of a single diagnostic event.
3. **Procedural Unbundling:** On January 6th, a single treatment was fragmented into multiple line items. The itemization of a "supply kit" alongside the comprehensive treatment code represents an unbundled billing structure, as the kit is a necessary component of the primary procedure and not a separate billable event.
4. **Unsupported Laboratory Duplication:** The statement reflects identical laboratory tests billed multiple times on the same date of service. Under the Common Coding Framework, repeat testing requires specific clinical modifiers to validate the occurrence of a secondary test. Absent these modifiers, the additional units are structurally unsupported.
5. **Non-Conforming Discharge Day Charges:** A Room & Board charge was applied to January 8th, the date of patient discharge. National Uniform Billing Committee (NUBC) standards specify that the date of discharge is not a billable room day, rendering this specific line item a non-conforming demand for payment.
6. **Non-Itemizable Routine Overhead:** The statement itemizes routine supplies (e.g., sterile gloves) and minor over-the-counter medications (e.g., aspirin) as separate billable charges. Regulatory guidelines classify these as non-itemizable overhead, as they are bundled into the primary procedure rate or the daily Room & Board fee.

## Tabular Summary of Findings

Service Date	Rev	CPT/HCPCS	Description	Total	Forensic Rationale for Unallowable Status
01/04	0450	99285	ED VISIT - LEVEL 5	\$2,100.00	<b>Overlapping E/M Levels:</b> The facility billed both an Emergency Dept visit (99285) and Initial Hospital Care (99223) on the same date. Per CMS NCCI Guidelines, when a patient is admitted from the ED, the ED visit is inclusive to the admission. This represents a duplicate charge for the "work of admission".
01/04	0730	93010	ECG-PROF COMP	\$150.00	<b>Impermissible Bundling:</b> Code 93010 (Professional Component) was billed alongside 93000 (Global Report). A "Global" code by definition includes the professional interpretation. Billing both constitutes a double-billing error for the same physician service.
01/04	0300	84484	TROPONIN - QUANT	\$315.00	<b>Duplicate Charge:</b> Two separate units of 84484 were billed at \$315.00 each. Under the Common Coding Framework, repeat labs on the same day require a Modifier 91 to substantiate clinical necessity. Absent this modifier, the second unit is structurally unsupported.
01/06	0410	94640	NEBULIZER TREAT	\$960.00	<b>Redundant Itemization:</b> Two units were billed at \$480.00 each. Because a "Nebulizer Supply Kit" (A4627) was also itemized, the standalone treatment charge (94640) becomes redundant as the kit typically facilitates the service. This is a "fragmented" billing error.
01/08	0200	N/A	ROOM & BOARD	\$3,200.00	<b>Discharge Day Error:</b> Rev Code 0200 was billed for 01/08. National Uniform Billing Committee (NUBC) standards dictate that the day of discharge is not a billable "room day." This charge represents a non-conforming demand for payment.
MISC	0250	N/A	ASPIRIN 325MG	\$180.00	<b>Unallowable Itemization:</b> Revenue Code 0250 (Pharmacy) was used to itemize routine, over-the-counter (OTC) Aspirin. Per CMS Provider Reimbursement Manual, minor oral medications are inclusive to the general Room & Board rate and are not separately itemizable.
MISC	0270	N/A	STERILE GLOVES	\$180.00	<b>Routine Supply Itemization:</b> 12 units of sterile gloves were billed under Rev Code 0270. Routine medical supplies used during standard care are not individually billable and must be bundled into the primary procedure or room rate.

**Total Forensic Discrepancies Identified: \$7,085.00**

**Certification of Forensic Auditor:**

The undersigned certifies that the framework and methodology described in Sections I and II was applied to the itemized billing statement provided by the patient for this audit. The findings represented in Section III are based strictly on the application of the Common Coding Framework to the electronic data provided. This audit was conducted independently, without bias, and is a true representation of the structural discrepancies found within the reviewed demand for payment.

**Certified by:** \_\_\_\_\_

**Date of Issuance:** March 10, 2026

**Forensic Audit ID:** A00001

## **Legal Disclaimers and Limitation of Scope**

### **1. Scope of Service and Termination of Engagement**

Medical Bill Forensics LLC is an independent, forensic medical bill auditing firm and is not a law firm, debt management company, or medical provider. This report is provided to the patient as an independent, third-party forensic analysis of their supplied, itemized billing statement. The patient is not an ongoing client of Medical Bill Forensics LLC, and the delivery of this report concludes the professional engagement for the specific statement reviewed.

### **2. Non-affiliate Statement**

Medical Bill Forensics LLC is not an affiliate of any hospital, clinic, or private insurer. We do not represent, act on behalf of, or receive compensation from any medical facility or insurance carrier. Medical Bill Forensics LLC does not function as a legal representative, agent, or advocate for the patient, and does not engage in mediation, negotiation, or direct communication with hospitals, clinics, or insurance carriers on behalf of the patient.

### **3. Review of “As-Is” Itemized Bill Only**

To ensure HIPAA compliance and maintain forensic independence, Medical Bill Forensics LLC does not accept records, correspondence, or documentation directly from any hospital, clinic, third-party payer, or other patient-contracted representative; we only accept personal itemized medical bills for audit directly from a patient via our HIPAA compliant portal.

The outlined discrepancies in this report are based strictly on a forensic review of the itemized billing statement in isolation, absent the associated medical records. Medical Bill Forensics LLC makes no claim as to whether the charges are clinically substantiated within the medical record. As such, the burden of proof regarding clinical substantiation for coding discrepancies on the reviewed itemized bill rests solely with the billing entity.

### **4. No Legal Responsibility for Patient Use of Report**

The patient agrees to hold harmless and indemnify Medical Bill Forensics LLC from any and all claims, liabilities, or damages arising from the patient's use or distribution of this report, including the distribution of this report to the patient's legal counsel, healthcare advocates, or third-party negotiators. Any use of this

audit as evidence in a formal dispute, appeal, or legal proceeding is conducted at the discretion and direction of the patient and between, or on behalf of, the patient and a healthcare provider organization, third-party payer, legal counsel, or healthcare advocate.

**Trigger of Liability:** The act of utilizing this report—whether for the purpose of achieving a billing reduction, for use in legal proceedings, or for dissemination to third parties (including insurance carriers and healthcare providers)—constitutes an agreement by the patient to assume all risks associated with such actions. Medical Bill Forensics LLC provides an objective analysis of the billing document’s adherence to federal standards; however, the strategic application of these findings is at the sole discretion and risk of the patient.

This audit represents a forensic finding based on the common coding framework and is intended for informational and evidentiary purposes only.