
MEDICAL BILL
FORENSICS
PROFESSIONAL BILLING AUDITS

Medical Bill Forensics

Forensic Audit Report

March 10, 2026

I. Forensic Audit Overview

Medical Bill Forensics LLC is an independent, forensic medical bill auditing firm.

The terms “client” and “patient” as used in this forensic audit report; these terms may apply to the same individual but are used differently. Medical Bill Forensics LLC is not a HIPAA covered entity (provider, clearing house, or insurer), does not have “patients”, and does not practice medicine. Medical Bill Forensics LLC has “clients” which may be the individual referred to in the provided billing document as the “patient.” Medical Bill Forensics LLC provides independent. third-party forensic analysis of client supplied medical billing documents concerning alleged care the client may have received as a patient of the billing entity identified in the supplied billing documents.

This forensic audit evaluates the structural and coding accuracy of the billing documents provided to Medical Bill Forensics LLC by the client or their legally designated agent. This audit is limited to the information contained in the supplied billing documents; no clinical medical records or provider notes were examined. The purpose of this audit is to identify and substantiate correctly coded line-items and to identify coding deficiencies that render specific line items within the bill unsupported under either HIPAA Title II Administrative Simplification Standards or a corresponding insurer EOB.

The following standards apply to all audited demands:

Mandatory Compliance: Under 45 C.F.R. §§ 162.923 and 162.1002, a covered entity is legally required to conduct healthcare transactions in standard form and to use the applicable HIPAA Standard Code Sets (CPT, HCPCS, ICD-10, and Revenue Codes) when compiling the data component of a healthcare transaction.

Condition of Payment: For Medicare claims, 42 C.F.R. Part 424, "Conditions for Medicare Payment," establishes at § 424.5(a)(6) that the provider must furnish sufficient information to determine whether payment is due and the amount owed. For privately insured claims, equivalent "clean claim" requirements are imposed through the provider's own contract with the health plan and applicable state prompt-pay statutes, which likewise condition payment on accurate, complete claims data. In both contexts, adherence to the standard nomenclatures and code sets adopted under 45 C.F.R. §§ 162.923 and 162.1002 is the operative mechanism by which

"sufficient information" or a "clean claim" is conveyed. A code that is non-standard, unbundled, or incorrectly sequenced fails to convey accurate, sufficient information about what service was actually rendered, regardless of whether the payer is Medicare or a private insurer — and therefore fails the applicable Condition of Payment at its source.

Status of Non-Conforming Codes: Any code or charge that deviates from the standards outlined herein, or specific private provider-payer negotiations, is classified as "Non-Conforming." Depending on the nature of the non-conformance, federal claims processing rules (CMS Pub. 100-04) provide that such charges may be subject to claim rejection, Returned to Provider (RTP) status, or post-payment recoupment.

Forensic Conclusion: A non-conforming code renders the specific line item on a medical claim unsubstantiated. Consistent with standard insurance claims adjudication practice — which similarly rejects non-conforming codes outright and may require clinical substantiation before payment is released — an itemized charge that the billing entity cannot correct or substantiate fails to meet the burden of proof necessary to support a valid demand for payment. The charge is recommended for correction or removal until that burden is met.

II. Forensic Audit Methodology and Universal Review Techniques

While several of the authorities below are codified specifically for the Medicare program, they represent the most authoritative, codified statement of correct coding principles in the United States healthcare system and are widely incorporated into private payer contracts and claims-adjudication systems as the industry standard for coding accuracy. Where the client's coverage is provided by a private insurer rather than Medicare, these standards apply as the governing coding methodology adopted by the payer's own claims processing systems and provider contracts, rather than as a directly binding federal regulation. Non-conforming codes will be outlined within the payer EOB sent to the client. A code can be conforming but not covered by a payer. Example: a correctly coded line-item for an elective, cosmetic procedure not covered by a health insurance plan.

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. Routine Supply and Pharmaceutical Itemization Review. An audit of itemized pharmaceutical and supply charges to determine whether they represent routine items required to be bundled into the daily room rate or primary procedure cost under standard cost-reporting and itemization principles, rather than separately billable items. Charges for routine, non-itemizable supplies or medications are identified as Unallowable Itemization..

- **Authority:** *CMS Provider Reimbursement Manual (Pub. 15-1), Section 2102.1; standard industry itemization practice.*

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. Client Supplied Documents

Privately negotiated contractual arrangements between the billing entity and a health plan are outside the scope of this audit. Amounts paid entirely by the insurer under contract produce no patient financial liability and cannot form the basis of a § 213(d) deduction under IRC § 213(a), which limits deductibility to amounts the taxpayer actually paid. This audit evaluates the HIPAA Title II conformance of data elements and segments underlying the patient's specific financial responsibility — not the contractual relationship between the provider and the payer. Payer documents are employed in this audit as proof of the difference, if any, between what the patient was billed and what the payer covered.

In order to capture the full billing and coding scope of a clinical episode, the standard forensic medical bill audit from Medical Bill Forensics LLC includes the following corresponding, client supplied documents.

1. Itemized medical bill

2. Explanation of benefits (if an insurer received a claim from the billing entity)

3. CMS-1450/UB-04 (if an insurer received a claim from the billing entity.

For this audit the client supplied the following document(s).

1. Itemized medical bill from Peak of the Mountain Medical Center.

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

Date	Rev	Code	Description	Qty	Unit Cost	Total
01/06	0124	—	ROOM & BOARD - CARDIAC ICU	1	$4,500.00	$4,500.00
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

IV. Forensic Audit Findings & Rationale

Based on application of the information and methodology outlined within sections II and III above, to the billing documents provided by the client, the following report was developed.

SECTION 1: CORRECT CHARGES

1. 99285 - Emergency Department Visit Level 5 - $2,100.00

- Appropriate for acute MI presentation
- High complexity medical decision making justified

- No NCCI conflicts

2. 92941 - PCI with Stent (Acute MI) - $18,400.00

- Primary procedure appropriately coded
- No NCCI conflicts as primary procedure
- Note: Pricing is borderline high (see Section 3)

3. C1874 - Drug-Eluting Stent - $4,800.00

- Separately billable supply code
- No bundling issues

4. 93306 - Echocardiogram with Doppler - $1,800.00

- Medically necessary post-MI assessment
- Appropriately coded

5. S5570 - Brilinta 90mg (2 tablets) - $170.00

- Standard antiplatelet therapy post-stent
- Appropriately billed

6. 99238 - Hospital Discharge Management - $450.00

- Appropriate discharge day code
- Separately billable

7. 84484 - Troponin Quantitative (First) - $315.00

- Essential diagnostic test for MI
- Appropriately coded

8. 80053 - Comprehensive Metabolic Panel - $185.00

- Standard MI workup
- Appropriately coded

9. J1644 - Heparin Sodium 10,000 units - $650.00

- Standard anticoagulation for MI/PCI
- Dosing appropriate

TOTAL CORRECT CHARGES: $28,870.00

SECTION 2: Coding Non-Conformities (NCCI Violations, Errors, or Potential Fraud)

The following represent coding non-conformities that, without clinical substantiation within the medical record, by the provider at the time of service, must be removed.

1. 93000 (ECG Global) + 93010 (ECG Professional Component) - $150.00

- Error Type: NCCI bundling violation
- Rationale: 93000 is global code including both technical and professional components. Billing 93010 separately is double billing for the professional component. NCCI Column 1/Column 2 edit specifically prohibits this combination.
- Correct Billing: 93000 only (already included at $250)
- Erroneous Amount: $150.00

2. 84484 - Troponin Quantitative (Second, same day) - $315.00

- Error Type: Duplicate billing / Medically Unlikely Edit violation
- Rationale: Two separate line items for same CPT code on same date without modifier or documentation of medical necessity. Medicare MUE for 84484 is limited to 1 per day without use of a modifier or medical necessity. This is duplicate billing.
- Correct Billing: One troponin per date
- Erroneous Amount: $315.00

3. 99223 - Initial Hospital Care Level 3 - $1,250.00

- Error Type: NCCI bundling violation
- Rationale: Cannot bill both 99285 (ED visit) and 99223 (initial hospital care) on same date of service. NCCI edits bundle 99223 as Column 2 code with 99285 (Column 1). This is double billing for admission service.
- Correct Billing: 99285 only (already billed)
- Erroneous Amount: $1,250.00

4. A4627 - Nebulizer Supply Kit - $120.00

- Error Type: Unbundling violation

- Rationale: NCCI guidance states supplies integral to a procedure are included in the procedure code. Nebulizer supplies are bundled into 94640 (nebulizer treatment). Separate billing is unbundling.
- Correct Billing: Bundled into 94640
- Erroneous Amount: $120.00

5. 93224 - ECG Monitor Continuous 24hr (while in Telemetry unit) - $650.00

- Error Type: Duplicate billing / Unbundling
- Rationale: Patient is in telemetry unit (Rev Code 0202) which includes continuous cardiac monitoring as part of the room rate. Billing separately for monitoring service that is included in room charge is duplicate billing.
- Correct Billing: Included in telemetry room rate
- Erroneous Amount: $650.00

6. Room & Board - Discharge Day Full Charge - $1,600.00

- Error Type: Improper billing practice
- Rationale: A full-day room charge on discharge day requires the billing entity to substantiate 24-hour occupancy, which is not possible where the documented discharge time falls within the billing day — making the full-day charge erroneous as billed. The full charge is $3,200, so the erroneous portion is $1,600 assuming the patient was at the facility a half-day on day-of-discharge.
- Correct Billing: $1,600 (50% of daily rate in this case)
- Erroneous Amount: $1,600.00 (see section 3)

TOTAL ERRONEOUS CHARGES: $4,085.00

Error Breakdown:

- **NCCI Bundling Violations:** $2,170.00
- **Duplicate Billing:** $965.00
- **Improper Billing Practice:** $1,600.00
- **Unbundling:** $350.00

SECTION 3: BORDERLINE CHARGES (Excessive Pricing, Questionable Medical Necessity)

Pricing comparisons in this section are based on publicly available CMS Medicare reimbursement rate data and published hospital pricing transparency data as of the report date and are provided as illustrative benchmarks only. The client should question these charges with the billing entity as they may be either excessively high and negotiable or be correct and part of a provider-insurance payer negotiated, contractual amount.

Where the billing entity has made its standard charge data publicly available pursuant to the CMS Hospital Price Transparency Rule (45 C.F.R. Part 180, implementing Section 2718(e) of the Public Health Service Act), that publicly posted chargemaster data was retrieved and utilized as an additional reference in evaluating the charges contained in this audit. All hospitals operating in the United States are required by federal law to make this information publicly accessible.

1. 92941 - PCI with Stent - $18,400.00

- Issue: Excessive pricing
- Rationale: Price at high end of range. Single-vessel PCI typically $12,000-18,000. National median approximately $15,000. $18,400 is 23% above median.
- Reasonable Rate: $15,400
- Potential Reduction: $3,000.00

2. Room & Board - Cardiac ICU (2 days) - $9,000.00 ($4,500/day)

- Issue: Excessive pricing
- Rationale: National average cardiac ICU rate is $2,500-3,500/day. $4,500/day is 28-50% above typical rates. Even accounting for geographic variation, rate is excessive.
- Reasonable Rate: $3,200/day
- Potential Reduction: $2,600.00 ($1,300 × 2 days)

3. Room & Board - Telemetry - $3,200.00

- Issue: Excessive pricing
- Rationale: National average telemetry rate is $1,800-2,500/day. $3,200 is 28-78% above typical rates. Telemetry should be significantly less than ICU.

- Reasonable Rate: $2,200/day
- Potential Reduction: $1,000.00

4. Room & Board - Discharge Day (corrected base rate) - $1,600.00

- Issue: Excessive base rate
- Rationale: After correcting the improper full-day charge (Section 2), the remaining $1,600 is based on a $3,200/day rate. National average general floor is $1,500-2,200/day. Reasonable discharge day charge would be $1,100 (50% of $2,200).
- Reasonable Rate: $1,100
- Potential Reduction: $500.00

5. 71045 - Chest X-Ray 1 View - $420.00

- Issue: Excessive pricing
- Rationale: Medicare allowable is approximately $40-60. Typical hospital charge is $150-250. $420 is 68-180% above typical hospital charges and 700% above Medicare rate.
- Reasonable Rate: $200
- Potential Reduction: $220.00

6. 94640 - Nebulizer Treatment (2 treatments) - $960.00 ($480 each)

- Issue: Excessive pricing and questionable medical necessity
- Rationale: Typical charge for nebulizer treatment is $150-250. $480 is 92-220% above typical. Additionally, no documented respiratory distress or pulmonary complication for acute MI patient. Medical necessity questionable.
- Reasonable Rate (if necessary): $200 × 2 = $400
- Potential Reduction: $560.00 (or $960.00 if not medically necessary)

7. Pharmacy - Aspirin 325mg (4 tablets) - $180.00 ($45/tablet)

- Issue: Excessive pricing / Unconscionable markup
- Rationale: Retail cost is $0.01-0.05 per tablet. Reasonable hospital markup would be $1-5 per tablet. $45 per tablet is 900-4,500x retail cost. This represents extreme price gouging.
- Reasonable Rate: $20 total ($5/tablet)
- Potential Reduction: $160.00

8. Supplies - Sterile Gloves (12 pairs) - $180.00 ($15/pair)

- Issue: Excessive pricing
- Rationale: Retail cost for sterile gloves is $1-3/pair. Reasonable hospital charge is $5-8/pair. $15/pair is 87-200% above reasonable. Note: While these may also have bundling issues, the primary concern is excessive pricing.
- Reasonable Rate: $60 ($5/pair)
- Potential Reduction: $120.00

TOTAL BORDERLINE CHARGES: $8,160.00

If medical necessity of nebulizer treatments denied entirely: $8,560.00

Borderline Breakdown:

- **Excessive Procedure Pricing:** $3,000.00
- **Excessive Room Rates:** $4,100.00
- **Excessive Supply/Medication Pricing:** $280.00
- **Excessive Ancillary Service Pricing:** $780.00
- **Questionable Medical Necessity:** $400.00 (additional if nebulizers completely denied)

Note: Many borderline charges were denied by insurance as "non-covered" but remain patient responsibility per EOB. These denials don't mean charges are correct - they mean insurance won't pay them. The client should negotiate these excessive charges.

TOTALS

ORIGINAL BILL: $52,175.00

BREAKDOWN:

- Correct Charges: $28,870.00 (55.3%)
- Erroneous Charges (NCCI Violations, Errors, Potential Fraud): $4,085.00 (7.8%)
- Borderline Charges (Excessive Pricing): $8,160.00 (15.6%)
- Charges with both correct coding and excessive pricing: $11,140.00 (21.3%)

RECOMMENDED REDUCTIONS

Conservative (Erroneous Charges Only):

- Reduction: $4,085.00
- Adjusted Total: $48,090.00
- Percentage Reduction: 7.8%

Moderate (Erroneous + 50% of Borderline):

- Reduction: $8,165.00
- Adjusted Total: $44,010.00
- Percentage Reduction: 15.7%

Aggressive (Erroneous + All Borderline):

- Reduction: $12,245.00
- Adjusted Total: $39,930.00
- Percentage Reduction: 23.5%

RECOMMENDED TARGET:

- Erroneous Charges (Must Remove): $4,085.00
- Borderline Charges (Negotiate): $8,160.00
- Total Potential Reduction: $12,245.00
- Adjusted Bill: $39,930.00
- Reduction Percentage: 23.5%

The above categories represent analytical classifications of the charges reviewed and are not mathematically exclusive — some charges appear in more than one category. Percentage figures are rounded.

Further Reduction Strategies

After a billing entity has removed billing and coding errors from billing documents, if charges remain some further reduction strategies are as follows:

1. Ask to Pay 120% of the Current Medicare Amount for Immediate Settlement

Application: Offer the billing entity roughly 120% of the current Medicare rate if the bill is settled immediately. Medicare typically underpays providers by 15-20%

and so offering 120% of the current Medicare rate can be a successful bargaining strategy.

Example: If Medicare paid $1000 for an MRI based on a billing entity's listed chargemaster pricing, and the entity is billing you $4000, offer $1200 to settle the bill immediately. This strategy shifts $1200 in liquid assets to the balance sheet of the billing entity immediately.

2. Ask for a 20% Total Discount for Immediate Settlement

Application: If the billing entity will not accept 120% of the Medicare rate ask for a 20% total discount for settling the bill immediately. Many organizations will provide this level of discount to anyone asking for immediate settlement.

Example: If the billing entity is charging you $4000 for an MRI ask to pay $3200 for immediate settlement.

3. Strategy 3: The 501(r) Amounts Generally Billed (AGB) Ceiling

Application: Exclusively for non-profit hospital facilities (which make up nearly 50% of all US hospitals).

Under Internal Revenue Code Section 501(r)(5), tax-exempt hospitals are statutorily prohibited from charging self-pay or financial-assistance-eligible patients more for emergency or medically necessary care than the Amounts Generally Billed (AGB) to individuals who have commercial insurance or Medicare.

Hospitals must calculate this AGB percentage annually (typically using a look-back method of what they actually collected from private insurers and Medicare over the prior 12 months). If the hospital refuses a prompt settlement, force them to apply their own published AGB discount rate. Because gross chargemaster rates are heavily inflated, the AGB percentage often slashes the total balance by 50% to 70% from the beginning.

Example: A non-profit hospital bills an uninsured or underinsured patient $20,000 for an inpatient stay. The hospital's publicly available 501(r) policy states their AGB percentage is 35% (meaning they typically collect 35% of gross charges from insured plans). Demanding the statutory 501(r) adjustment immediately forces the facility to cap the maximum collectible balance at $7,000 before any further prompt-pay discounts are even discussed.

Strategy 4: The Cost-to-Charge Ratio (CCR) Anchor

Application: Primarily for facility fees, inpatient stays, and high-dollar outpatient procedures at both for-profit and non-profit hospitals.

Every hospital participating in Medicare must file an annual CMS Form 2552-10 (Hospital Cost Report). This public data explicitly outlines the hospital's actual internal operating costs to deliver care across specific departments (radiology, laboratory, intensive care, etc.) relative to what they charge.

By pulling the hospital's specific Cost-to-Charge Ratio (CCR) for that exact cost center, you can determine exactly what it cost the hospital in raw overhead, labor, and equipment to perform the service. A highly effective defense under *quantum meruit* (paying the reasonable value of services rendered) is to calculate the hospital's true cost, add a reasonable 15% to 25% margin for profit/administrative overhead, and offer that as a final settlement. It is incredibly difficult for a hospital's legal department to argue in court that their own federally reported cost plus a healthy profit margin is not "reasonable value."

Example: A hospital bills $10,000 for a series of complex CT scans and contrast. According to their latest filed CMS Cost Report, the radiology department operates at a CCR of 0.12—meaning it only costs the hospital $1,200 in true economic output to provide those scans. Offering the true cost ($1,200) plus a 20% margin ($240) results in a firm settlement offer of $1,440, completely stripping away the remaining $8,560 of pure chargemaster fluff.

V. Certification of Forensic Auditor and Process

The undersigned auditor certifies that the framework and methodology described in Sections II and III were applied to the billing documents provided by the client to Medical Bill Forensics LLC for the purpose of completing this forensic audit. The findings represented in Section IV are based strictly on the application of the framework and methodology outlined herein, in accordance with the regulatory authorities cited therein. This audit was conducted independently, without bias, and is a true representation of the coding architecture found within the reviewed billing documents. The undersigned auditor has no ability to alter the audited documents themselves as they are legal documents and fall under state or federal jurisdiction. All billing negotiations or resolutions are strictly between the client, or their legally appointed representative, and the billing entity and neither undersigned auditor nor Medical Bill Forensics LLC is a party to any billing negotiation or resolution.

Certified by: _____

Date of Issuance: March 10, 2026

Forensic Audit ID: A00001

VI. Legal Disclaimers and Limitation of Scope

1. Scope of Service and Termination of Engagement (also found in overview)

Medical Bill Forensics LLC is an independent, forensic medical bill auditing firm and is not a law firm, debt management company, accounting firm, medical provider, medical clearinghouse, or health plan.

The terms “client” and “patient” are used herein; these terms may apply to the same individual but are used differently. Medical Bill Forensics LLC is not a provider, clearing house, or insurer and does not have “patients”; Medical Bill Forensics LLC has clients which may be the individual referred to in the provided billing document as the “patient.” This report is provided to the client, as requested by the client, as an independent third-party forensic analysis of their supplied, billing documents concerning care the client received as a patient of the billing entity identified herein.

The individual receiving a forensic audit is not an ongoing client of Medical Bill Forensics LLC beyond the delivery of a forensic audit report with associated post-audit conference. The delivery of a forensic audit report and reception, or waiver, of a post-audit conference concludes the professional engagement for the specific billing documents reviewed. A virtual, post-audit findings conference is available to the client, or their legally designated agent, should they wish to schedule such a conference and review forensic audit report findings with Medical Bill Forensics LLC. Unless a client, or their legally designated agent, completes the virtual, post-audit conference within ten (10) business days from the date of report delivery to their designated email address they automatically waive the right to the conference. This means that the client is no longer a client of Medical Bill Forensics LLC regardless of anything past the time of 11:59:59 pm on the tenth (10th) business day past delivery a forensic audit report to their designated email address.

2. Non-affiliate Statement

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

3. Review of "As-Is" Itemized Bill Only

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 client or their legally designated healthcare surrogate or representative. Medical Bill Forensics LLC will not share or sell any information regarding any client with any third party outside of the client's legally designated healthcare surrogate or representative.

The outlined discrepancies in this report are based strictly on a forensic review of the itemized billing statements 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 non-conformities within the audited documents rests solely with the billing entity.

4. No Legal Responsibility for Client Use of Report

The client agrees to hold harmless and indemnify Medical Bill Forensics LLC from any and all claims, liabilities, or damages arising from the client's use or distribution of this report, including the distribution of this report to the client'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 client and between, or on behalf of, the client and a healthcare provider organization, third-party payer, legal counsel, or healthcare advocate.

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

5. No Tax Advice

Medical Bill Forensics LLC is not a tax advisory firm, CPA, or enrolled agent, and does not provide tax advice. This report identifies correct coding application and also coding discrepancies within the reviewed medical billing documents. Any client intending to use this report for federal or state tax substantiation purposes

should consult a licensed tax attorney or CPA regarding the applicability of this report to their specific tax situation. Clients may provide our tax memo, included with this report, to their tax preparer.

6. Not a HIPAA Covered Entity

Medical Bill Forensics LLC is not a "covered entity" or "business associate" as those terms are defined under HIPAA's Administrative Simplification and Privacy Rule provisions (45 C.F.R. § 160.103). We are not a health plan, health care clearinghouse, or health care provider, and therefore we do not transmit health information in connection with any HIPAA-covered transaction; no HIPAA-covered transaction arises from our business. Accordingly, HIPAA's Privacy and Security Rules do not directly apply to the information Medical Bill Forensics LLC receives, reviews, or stores in connection with this report. Medical Bill Forensics LLC maintains its own data security and confidentiality practices, as described in its Privacy Policy, and clients should review that policy to understand how their information is collected, used, and protected.

7. No Medical Practice

Medical Bill Forensics LLC does not practice medicine and does not provide medical advice, clinical diagnoses, or treatment recommendations of any kind. The forensic audit contained in this report is limited exclusively to the structural and coding accuracy of the billing documents provided — it is a regulatory compliance analysis of data elements and code sets within a healthcare transaction, not a clinical evaluation of the care the client received. No finding in this report should be construed as a medical opinion, a determination of whether care was clinically necessary or appropriate, or advice regarding the client's medical treatment, condition, or health decisions. Clients with questions about the clinical appropriateness of services they received should consult a licensed physician or healthcare provider.