
MEDICAL BILL
FORENSICS
PROFESSIONAL BILLING AUDITS

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*Medical Bill Forensics LLC welcomes responses from government agencies, legislative bodies, tax professionals, health plan administrators, and individual clients regarding the analysis and recommendations presented in this document.*

# REGULATORY WHITE PAPER EXCERPT

***Statutory Deductibility of Forensic Medical Bill Audit Fees Under IRC § 213(d) as Governed by HIPAA Title II Administrative Simplification Standards***

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## Legal Notice

The analysis regarding forensic medical bill audits contained in this document is not current tax law and does not constitute tax advice for any individual taxpayer. However, the analysis contained within this white paper correctly treats forensic medical bill audits the same way that medical records are treated by the IRS in Pub. 502 as an ancillary medical expense under current tax law. Medical Bill Forensics LLC is in the process of formally presenting this regulatory white paper to the United States Department of the Treasury, the Internal Revenue Service Office of Chief Counsel, the Department of Health and Human Services, the Senate Finance Committee, the House Ways and Means Committee, and the Government Accountability Office for incorporation into federal law and IRS administrative guidance. Until a formal Revenue Ruling or legislative action establishes forensic medical bill audit deductibility under IRC § 213(d), individual clients have two available pathways for deducting the expense of such audits. Business entities may deduct the forensic audit fee as an ordinary and necessary business expense under IRC § 162 as an employee benefit or health plan compliance cost — a deduction that exists under current law without any new ruling. Individual clients who pay the audit fee using Health Savings Account (HAS) funds should retain their audit receipt, their audit itself, and this white paper as substantiation of the legal and regulatory basis for that distribution in the event it is examined during an IRS audit of their HSA expenses. Medical Bill Forensics LLC provides this white paper on its website as well as with client's forensic audits for presentation to their tax preparers, so they are aware of the legal framework supporting the outlined position. Medical Bill Forensics LLC will update this document and notify clients if and when a formal government response is received or when the legal status of this position changes.

# WHITE PAPER EXCERPT: EXECUTIVE SUMMARY

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## CORE LEGAL POSITION

Fees paid for a forensic, line-item medical bill audit constitute an ancillary, qualified medical care expense under IRC § 213(d) and are fully deductible on a federal income tax return. This fee is not a miscellaneous itemized deduction subject to permanent elimination under IRC § 67(g), as amended and made permanent by the One Big Beautiful Bill Act (OBBBA, Pub. L. 119-21, enacted July 4, 2025), nor a tax determination expense under IRC § 212(3). A forensic medical bill audit represents a required regulatory process that serves three inseparable functions simultaneously, the first of which is a direct statutory obligation of every taxpayer who claims a medical expense deduction.

- First, it verifies that a valid, HIPAA-conforming data segment was actually produced for a healthcare transaction by a covered entity using HIPAA conforming data elements — without which no taxpayer can establish the statutory foundation required to claim an IRC § 213(d) medical expense deduction, satisfy the record-keeping mandate of § 6001, or execute Form 1040 under penalties of perjury pursuant to IRC § 7206(1) with reasonable certainty that the claimed deduction reflects actual medical care.

- Second, equally critical, and pursuant to the above, it identifies charges — whether originating from billing error or provider fraud — that do not arise from HIPAA conforming data elements or segments and therefore cannot legally form the basis of any IRC § 213(d) deduction. In doing so the audit flags, for further adjudication or removal, erroneous or fraudulent charges that are currently the basis of an unknown amount of treasury subsidized tax fraud.

- Third, and of systemic consequence, the forensic audit — through its downstream financial ramifications including corrected deductions, amended returns, health plan recovery actions, and improvements in covered-entity billing transparency — serves as a structural mechanism for the reduction of fraud, waste, and abuse across the United States healthcare system. Every audit that identifies erroneous or fraudulent charges arising from non-HIPAA conforming data elements or segments creates a documented evidentiary record that did not previously exist, one capable of supporting insurer recovery actions, enforcement referrals, and provider accountability. Deployed at scale as a tax compliance instrument, the forensic audit is the first operational mechanism capable of generating aggregate FWA data from within the portion of healthcare expenditure that every existing detection system currently accepts as valid — producing systemic transparency that no other instrument can reach.

Without this audit, no individual charge on an institutional bill can be confirmed as HIPAA-conforming or excluded as non-conforming — because the determination is line-item specific and cannot be made from any non-granular document. The forensic audit is the exclusive mechanism capable of making that determination at the line-item level, and its cost is therefore an indispensable prerequisite to filing a legally accurate medical expense deduction under any

circumstances. Critically, the OBBBA's permanent elimination of all miscellaneous itemized deductions makes correct IRC § 213(d) classification the only available deduction pathway for this expense — there is no longer a fallback category.

## THE PROBLEM: AN OBSOLETE SUBSTANTIATION STANDARD

Since HIPAA's enactment in 1996, covered entities have been required to construct healthcare claims using federally mandated code sets — ICD-10-CM/PCS, CPT, HCPCS, code modifiers, and revenue codes. These code sets define the data elements which create data segments that must accurately represent the clinical encounter at the line-item level. A service line segment that does not accurately reflect a clinical encounter as required by federally mandated standards is non-conforming under HIPAA Title II and cannot legally form the basis of an IRC § 213(d) deduction, as it does not represent actual medical care within the meaning of the statute. The IRS has and continues to accept non-granular summary bills such as Explanation of Benefits (EOBs), receipts, and balance-due invoices as substantiation for IRC § 213(d) medical expense deductions. These documents prove only that a financial demand was made by a covered entity — not that a lawful, HIPAA-conforming data elements were appropriately placed to produce a valid data segment. Because institutional medical bills contain documented billing errors, and because the Department of Justice prosecutes healthcare fraud schemes totaling hundreds of millions of dollars annually, the practical consequence of this substantiation gap (alleged vs. confirmed § IRC 213(d) care) is direct and ongoing: non-HIPAA-conforming charges — representing billing errors and provider fraud arising from non-conforming use of data elements and segments — are being claimed as qualified IRC § 213(d) medical expense deductions on filed federal returns every year.

The direct consequence of the above is that the federal treasury is unknowingly subsidizing fraudulent charges through improper tax deductions, and the taxpayer filing the return may be signing a materially false document under penalty of perjury because the taxpayer had sufficient reason to know that a category of document (medical bill) was unreliable and proceeded anyway. Insurance adjudication does not cure this defect: carrier algorithms verify formatting and contract rates, not the clinical truth of the data found within a medical service line data segment on a bill. An EOB confirms only that an insurer was billed — not that the care it describes was ever lawfully delivered, ever HIPAA-conforming in its coding, or ever eligible for deduction. Privately negotiated contractual arrangements between a provider and a health plan do not affect this analysis. Amounts absorbed by the insurer under a provider contract never reach the patient's out-of-pocket responsibility and therefore never enter the § 213(d) deduction calculation — IRC § 213(a) limits the deduction strictly to amounts the taxpayer actually paid during the taxable year. What the insurer paid under contract is between the insurer and the provider and has no bearing on the patient's tax position.

The forensic audit concerns itself exclusively with the data elements and segments underlying the patient's specific financial responsibility — the charges the patient paid and seeks to deduct. The IRS's failure to modernize its substantiation standard since 1996 is not an administrative inconvenience — it is the structural mechanism through which provider-generated error and fraud enters and survives the federal tax system undetected.

## THE SUBSTANTIATION PARADOX

IRC § 6001 places the affirmative record-keeping obligation on the taxpayer to maintain records sufficient to substantiate claimed deductions, and Form 1040 is signed under penalties of perjury. IRC § 7206(1) makes willful subscription of a materially false return a federal felony.

The problem is one which compounds on itself. First, a taxpayer cannot establish which billed medical charges represent valid, HIPAA-conforming data elements or segments within a bill — and therefore which charges, arising from that data, lawfully qualify as IRC § 213(d) medical care expenses — without a forensic audit, because no non-granular document contains the coding data necessary to make that determination. Itemized bills and CMS-1450/UB-04 billing documents are the only extant medical care billing documents able to substantiate the delivery of IRC § 213(d) care. Next, the same taxpayer deducting medical expenses without forensic verification cannot swear under penalty of perjury that they are not submitting a materially false tax return that attempts to deduct non-IRC § 213(d) medical care as bona fide IRC § 213(d) medical care. A taxpayer cannot credibly claim ignorance of a category of risk so thoroughly documented in federal enforcement records, published OIG reports, and public consumer guidance as to constitute constructive knowledge. A forensic audit resolves this by establishing which charges are HIPAA-conforming and therefore deductible; in doing so it necessarily surfaces those that are not — flagging them for correction, resubmission, or removal before a deduction is claimed. Without the audit the treasury subsidizes tax fraud. Denying the deductibility of the audit fee while demanding IRC § 6001 compliance and IRC § 7206 accuracy traps the taxpayer in an unconstitutional catch-22: the government cannot simultaneously require statutory accuracy under penalty of perjury and prohibit the cost of the only mechanism capable of producing it — a construction that violates the due process guarantee against imposing an obligation without affording the means of compliance.

## LEGAL BASIS FOR DEDUCTIBILITY

Under *Jacobs v. Commissioner,* 62 T.C. 813 (1974) and revisited and affirmed under *O'Donnabhain v. Commissioner*, 134 T.C. 34 (2010), an expense is deductible under IRC § 213(d) if it would not have been incurred "but for" the underlying medical condition and treatment. No taxpayer would incur a forensic audit fee absent illness, complex institutional treatment, a billing demand they cannot independently verify, and the Federal Government extending the opportunity to deduct verified medical expenses if they can be sufficiently substantiated as IRC § 213(d) medical care. The audit carries zero personal, lifestyle, or aesthetic utility. It is further supported by Tax Court recognition of ancillary medical expenses — including medical records fees (IRS Publication 502) and legal fees necessary to enable medical treatment (*Gerstacker v. Commissioner*, 414 F.2d 448 (6th Cir. 1969)). The forensic audit's primary function is to establish which charges represent valid, HIPAA-conforming data segments that lawfully qualify as IRC § 213(d) medical care expenses. In performing that determination, it necessarily identifies non-conforming charges — whether originating from billing error or provider fraud — that fail to constitute conforming data segments under federal law and must be flagged for correction, resubmission, or removal before any deduction can be legally claimed. The deductibility of the audit fee rests on the first function; the second follows from it as a structural consequence of the same analysis. The forensic audit fee is the exclusive operational mechanism to convert an unverified commercial invoice into a legally sufficient IRC § 6001 substantiation record.

## THE CONSTITUTIONAL AND STATUTORY PREDICATE

Deductions are a matter of legislative grace, not right. *New Colonial Ice Co. v. Helvering*, 292 U.S. 435 (1934). Congress chose, as a matter of grace, to extend a medical expense deduction under IRC § 213(d). Having made that choice, Congress simultaneously imposed specific statutory obligations on every taxpayer who claims it — to verify, substantiate, and certify under penalty of felony the accuracy of every medical expense on a filed return under IRC §IRC § 213(d), 223, 6001, and 7206. Those are not optional standards. They are binding conditions attached to the

exercise of a congressional concession. If the government extends a deduction by grace and then forecloses the only lawful mechanism by which a taxpayer can claim it without criminal exposure, the concession itself becomes an unconstitutional mechanism. A legislature may choose not to offer a deduction. It may not offer one and simultaneously deny deductibility of the only instrument capable of satisfying the conditions it has attached to claiming it. The forensic audit fee is that instrument. Its deductibility is not a preference — it is the necessary legal consequence of the statutory framework Congress itself constructed.

**LEGISLATIVE RECOMMENDATION**

Congress should amend IRC § 213(d) to explicitly codify that the deductibility of a medical expense is dependent on the underlying charge constituting a valid healthcare data segment under HIPAA Title II Administrative Simplification Standards. This amendment would establish in statute what currently exists only by logical inference and the IRS's lack of independent authority to define either a healthcare transaction or the data included in one — closing the substantiation gap permanently, eliminating the structural mechanism through which provider-generated fraud enters the federal tax system as a deductible expense, and aligning the medical expense deduction standard with the federal healthcare framework that has governed covered entities since 1996. Without this codification, the dependency remains a legal argument subject to administrative resistance. With it, it becomes the law.

Congress should formally recognize forensic medical bill audit fees as qualifying ancillary medical care expenses under IRC § 213(d) and should direct the IRS to incorporate that recognition into IRS Publication 502, ensuring that taxpayers, tax preparers, and IRS field personnel have clear administrative guidance reflecting the statutory analysis presented in this memorandum.

Congress should direct the IRS and HHS to develop joint substantiation standards for medical expense deductions that incorporate HIPAA Title II data segments as the evidentiary baseline for institutional medical charges, replacing the current non-granular documentation standard that has not been updated since the medical expense deduction was introduced in 1942.

Congress should direct the Treasury Inspector General for Tax Administration to conduct a study of the scope of non-HIPAA-conforming medical expense deductions currently being claimed on filed federal returns, using forensic audit methodology as the detection instrument, and to report findings to the Senate Finance Committee and House Ways and Means Committee.

The legislative actions identified above, taken together, would produce a structural and measurable reduction in the federal treasury's exposure to fraudulent medical expense deductions. By codifying HIPAA Title II conformance as the evidentiary standard for IRC § 213(d) deductibility, formally recognizing the forensic audit as the instrument capable of establishing that standard, and directing the development of joint IRS-HHS substantiation protocols, Congress would eliminate the detection gap through which provider-generated billing error and fraud currently enters and survives the federal tax system as a deductible expense. The treasury loss attributable to this gap is presently unquantifiable precisely because no instrument capable of measuring it has ever been deployed at scale — but the forensic audit, established as a tax compliance mechanism through the actions above, would for the first time generate the aggregate conformance data necessary to calculate the scope of what has been lost and prevent the continuation of losses going forward. The cost to the treasury of implementing these directives is negligible. The cost of continued inaction compounds with every return filed.

## HOW TO REPORT THE DEDUCTION

The forensic audit fee is reported differently depending on the taxpayer's circumstances. Only the HSA and business expense pathways are currently available for audit fee deductibility.

- For individual taxpayers itemizing deductions, the fee is reported as a medical expense on Schedule A, subject only to the 7.5% AGI floor under IRC § 213(a); it is not a miscellaneous itemized deduction and is therefore unaffected by IRC § 67(g)'s permanent elimination under the OBBBA (Pub. L. 119-21, July 4, 2025).

- For HSA holders, the mechanical vehicle for realizing the tax benefit depends on the contribution method, though both pathways successfully bypass the Schedule A itemization requirements and the 7.5% AGI floor. Where contributions were originally made pre-tax through payroll deduction under IRC §§ 106 and 125, the tax benefit was fully locked in at the time of contribution via exclusion from gross income; the forensic audit fee is subsequently paid as a direct, tax-free distribution from the account under IRC § 223(f)(1) as an IRC § 213(d) qualified medical expense. Alternatively, where a taxpayer utilizes a pass-through strategy—making a post-tax contribution to the HSA to cover the audit cost—the taxpayer claims a 100% above-the-line deduction for that contribution under IRC § 223(a) on Form 8889, subsequently executing a tax-free reimbursement distribution from the account to recover their out-of-pocket payment. Crucially, pursuant to the anti-double-dipping mandate of IRC § 223(f)(6), these HSA mechanisms are strictly mutually exclusive with Schedule A; any portion of an audit fee funded or reimbursed through a tax-free HSA distribution is legally barred from being claimed as an itemized medical deduction, ensuring the treasury subsidizes the verification instrument exactly once.

- For business entities, the fee is an ordinary and necessary compliance expense deductible under IRC § 162, ensuring the business does not deduct non-conforming charges in violation of IRC § 162(c)'s prohibition on deducting illegal payments.