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Ms. Rowan Bellamy
Bellamy & Cross LLP
1200 Sam Houston Parkway, Suite 450
Houston, Texas 77042

Re: Avery Lindholm v. Northgate Freight Systems, Inc. and D. Mercer
Report of a Certified Professional Coder, on the coding of the medical bills and on the amounts charged

Dear Ms. Bellamy,

At your request I have reviewed the medical billing records of Avery Lindholm for dates of service January 14, 2025 through March 18, 2026. I have formed two opinions. The first is whether the services are coded the way the documents support. The second is how the amounts charged compare with an appropriate benchmark for each kind of charge, which is not the same benchmark for a doctor's bill and for a hospital's. This report sets out both, the method behind them, the assumptions the method rests on, and the limits of what I can say from the material I was given.

I am a Certified Professional Coder. I am not a physician. Section 2 states exactly what that means for the opinions below, and it is the most important section in this report for the purpose of deciding what to do with it.

THIS IS A SAMPLE

Every name, date, charge and payment in this document is invented. No patient, provider, hospital, law firm or matter here is real. The MEDICARE figures are not invented: each one is read from the Centers for Medicare and Medicaid Services published Physician Fee Schedule file for the date and locality shown, and every one can be checked against that file. The comparator hospital prices in section 6.3 ARE invented, like the charges they sit beside, because the hospitals themselves are. In a delivered report every one of them is a named hospital's own published file. The sample exists so you can see the method and the format before you send a real file.

1 EXECUTIVE SUMMARY

I reviewed the billing records of four providers covering 122 charge lines on 35 dates of service, following a motor vehicle collision on January 14, 2025. The collision date comes from your instruction. No document I was given states it. One of the four is a hospital, and its 8 facility lines are 46.27 percent of everything billed in this case on a single day.

What became of the charges

Total charges billed by the four providers	$60,914.00
Payments posted on the bills	($6,003.16)
Balance shown as outstanding	**$54,910.84**

Two kinds of charge, two benchmarks

A doctor's bill and a hospital's bill are not measured the same way, and using one yardstick for both is the most common error in a report of this kind. The Medicare Physician Fee Schedule prices a clinician's work. It does not price a hospital's room, equipment and staffing, and asking it to would produce an answer that is true of the wrong file. So this report carries two measures and never mixes them:

The charges	Lines	Billed	The benchmark applied	Benchmark total
Clinic, imaging and physician	114	$32,729.00	Published Medicare amount for the code, locality and date	$6,218.65
Hospital facility (UB-04)	8	$28,185.00	80th percentile of what three hospitals in the same market publish	$17,442.20
All charges in the case	**122**	**$60,914.00**		**$23,660.85**

Taken together the 122 lines carry a benchmark of $23,660.85 against $60,914.00 billed, a difference of $37,253.15.

Total charges billed	$60,914.00
Benchmark total for the same services	$23,660.85
Difference	**$37,253.15**

That difference can be expressed two ways and they are different numbers for the same $37,253.15. The charges are 157.45 percent above the benchmark. The benchmark is 61.16 percent below the charges. Where this report gives a percentage it says which of the two it means. Stated as a multiple, the charges are 2.57 times the benchmark. Separately, the clinic and physician charges are 5.26 times the published Medicare amount, and the hospital's facility charges are 1.62 times what its own competitors publish for the same services.

The clinic and physician charges at the multiples commonly argued

This report names no statute and applies no state's rule. Jurisdictions differ on the multiple of Medicare that is admissible, relevant or persuasive, and which multiple applies is a question of law and not a question for me. So that the arithmetic is useful whatever measure governs, the clinic, imaging and physician lines are priced at each of the multiples most often argued. The hospital's facility lines are NOT in this table: a multiple of Medicare is not a meaningful figure for a charge Medicare's physician schedule never priced, and section 5.6 gives the benchmark that does apply to them.

Multiple of Medicare	Reference total	Billed	Charges above reference
1.00 x	$6,218.65	$32,729.00	$26,510.35
1.20 x	$7,462.38	$32,729.00	$25,266.62
1.50 x	$9,327.98	$32,729.00	$23,401.02
2.00 x	$12,437.30	$32,729.00	$20,291.70
3.00 x	$18,655.95	$32,729.00	$14,073.05

Of the 76 clinic and physician lines Medicare publishes an amount for, 76 are above it and none is at or below it. A further 38 lines, $2,139.00 in charges, carry codes Medicare publishes no payable amount for. Those lines carry no benchmark and are counted at the full amount charged, which favours the provider. Section 8.2 prices what happens if they are treated otherwise, and section 9 is the coding opinion on why several of them were on the bill at all.

The coding findings, in one paragraph

Separately from the amounts, four coding matters appear on these bills. Manual therapy was billed with chiropractic manipulation on 17 dates with no modifier on either line. An office visit was billed with manipulation on 2 dates, again with no modifier. A new-patient office visit was billed twice by the same practice inside the three-year look-back. And electrical stimulation was billed under a code Medicare does not accept. Section 9 sets out each one, what the rule is, and what it is worth. Every one of them, resolved against the provider, lowers the amount properly billable. None raises it.

I express no opinion on whether any service was medically necessary, on whether any condition treated was caused by the collision, or on the standard of care. I was given no medical record of any kind and I have reviewed none. My opinion is confined to the coding of the bills and to the amounts charged.

2 QUALIFICATIONS, AND THE SCOPE OF THIS OPINION

My curriculum vitae is attached as Exhibit A. It states my certification, my employment history, and whether I have previously testified. This section states something the CV cannot, which is the boundary of what the credential lets me say.

What the credential certifies

I hold the Certified Professional Coder credential issued by the AAPC. It is earned by examination and maintained by continuing education, and it certifies proficiency in three published code sets and in the rules that govern their use: Current Procedural Terminology, maintained by the American Medical Association; the Healthcare Common Procedure Coding System Level II, maintained by the Centers for Medicare and Medicaid Services; and the International Classification of Diseases, Tenth Revision, Clinical Modification. It also certifies proficiency in the documentation a given code requires, and in the national edits that govern which codes may be reported together.

Pricing a code is the second half of the same discipline. A published fee schedule is a table that maps a code to an amount for a place and a date. Reading that table correctly requires knowing which schedule governs the code, which release was in force on the date, which locality the service falls in, and whether the charge is for a whole service or a component of one. Those are coding questions and they are answered in section 5.

What I do not opine on, and why it matters here

I am not a physician. Nothing in this report is a medical or clinical opinion, and the distinction is not a formality. It is the line that decides which of my sentences survive cross-examination:

- "The documentation does not support the level billed" is a coding opinion. It compares what was recorded against what the code requires, and it is mine to give.
- "The visit was unnecessary" is a medical opinion. It requires a clinical judgement about a patient, and it is not mine to give at any price.

So I do not address medical necessity, causation, the standard of care, prognosis, the reasonableness of the treatment plan, or any clinical question about the claimant. If your case needs an opinion on any of those, it needs a qualified physician, and I will say so rather than stretch. I am also not a lawyer. I express no view on which measure of damages governs these expenses, on the admissibility of anything in this report, or on any other question of law.

Within those limits the opinions below are given to a reasonable degree of certainty as a Certified Professional Coder.

3 MATERIALS REVIEWED

I was provided with four billing documents and nothing else:

Provider	Document	Lines	Dates	Charges
Beltway Spine & Rehabilitation	Itemized transaction report, 26 pages	99	January 20, 2025 to July 14, 2025	$12,579.00
Gulf Coast Interventional Pain,	Itemized transaction report, 7 pages	12	March 11, 2025 to March 18, 2026	$11,600.00

Provider	Document	Lines	Dates	Charges
PLLC				
Northline Regional Medical Center	Itemized UB-04 facility bill, 2 pages	8	January 14, 2025	$28,185.00
Westheimer Open MRI	Itemized statement, 1 page	3	February 25, 2025	$8,550.00

What I was not provided

- Any medical record, chart note, imaging report or operative report.
- Any explanation of benefits from any carrier.
- Any CMS-1500 claim form for the three clinic providers, which is where modifiers, place of service, units and the rendering provider's national provider identifier appear.
- Any emergency department record, triage note or discharge summary for the hospital visit. The facility bill prints its revenue codes and its level of care, and that is all I have on what was furnished there.
- Any provider service address.
- Any letter of protection, and any statement as to whether a receivable on this claim has been sold or factored.

My opinion is limited accordingly, and one of those absences does more work than the others. A CMS-1500 carries the modifiers for each line of a physician bill. Two of the findings in section 9 turn on whether a modifier was appended. None of these documents prints a modifier field at all, so I can say that no modifier appears on the record I was given, and I cannot say that none was submitted on the claim. Producing the claim forms would settle it. I have asked for them.

4 ASSUMPTIONS AND INSTRUCTIONS

The assumptions below are not established by the documents I reviewed. I set them out here rather than leave them to be found, and for each I say whether it comes from a document or from counsel.

4.1 Where the services were furnished

Medicare adjusts every fee for local costs by payment area, called a locality. No transaction report in this file prints a provider address. On your instruction the providers are treated as furnishing services in Houston, which falls in Medicare locality 18 for TX. A locality applies to the clinic, imaging and physician lines only; the hospital's facility benchmark is drawn from hospitals in this market and carries no locality. Section 8.1 reprices those clinic, imaging and physician lines in every locality the state publishes, so the effect of this assumption can be seen rather than assumed. A locality taken on faith produces a figure that is correct arithmetic for the wrong place, reproduces perfectly every time it is recomputed, and is wrong.

4.2 Units

Neither transaction report carries a quantity column. One unit is therefore counted per charge line on those two bills. The imaging statement does carry a quantity column and prints one unit on each of its three lines. Section 8.4 sets out what this assumption is worth on the lines where it could matter.

4.3 Modifiers

No line on any of the three documents carries a modifier, and I have assumed none. Every code is priced exactly as the document prints it, as a charge for the whole service rather than for a component of it. No reading-only or equipment-only amount appears anywhere in this report.

4.4 Which hospitals the hospital is compared against

A hospital's facility charge is measured against what comparable hospitals publish for the same service. I selected 3 acute-care hospitals in the same metropolitan market as the billing hospital, each of which publishes a machine-readable standard charge file as federal price transparency rules require. In this sample they are identified only as Hospital One, Hospital Two and Hospital Three. In a delivered report each one is named, together with the file, its edition, the date it was downloaded and the line in it that was read, because an unnamed comparator is not a benchmark anyone can check.

Two rules govern that selection and both of them exclude more hospitals than they admit. A comparator is included because it is an acute-care facility in the same market publishing the same service under the same revenue code, never because a text search matched its description string. And the comparator's own revenue code is read before its price is used, because one description can cover several departments at different prices, and picking the wrong department produces a benchmark that is precise and wrong.

4.5 The collision date

The collision date of January 14, 2025 comes from counsel. No document I was given states it. The earliest charge in the case is the hospital's, on January 14, 2025, the same day. The earliest charge from any other provider is January 20, 2025, six days later. Nothing in the records I was given establishes that any charge in this case arose from that collision, and I express no opinion on causation.

5 METHODOLOGY

5.1 The measure applied to the clinic, imaging and physician lines

Each of these lines is measured against the amount the Centers for Medicare and Medicaid Services published for that code, in that locality, in the release in force on that line's own date of service. That is the whole measure. It is a published figure, it is the same figure for everyone who looks it up, and it does not move because charges moved.

I want to be explicit about what this report does not use. It does not rank the amounts providers in an area choose to charge and take a figure off that ranking. A ranking of billed charges measures what providers ask, not what a service is worth, and it rises whenever charges rise. No figure in this report is drawn from any survey of billed charges, from any commercial benchmarking database, or from any locality other than the one named in section 4.1.

This report names no statute and asserts no multiple. It reports the published Medicare amount and prices the case at the multiples set out in section 1, so that whichever measure governs in your jurisdiction, the arithmetic is already done and the source of every figure is on the page.

5.2 Sources

The clinic, imaging and physician benchmarks in this report come from published Centers for Medicare and Medicaid Services files, archived in their original form. The hospital's facility benchmarks do not: they come from the comparator hospitals' own published standard-charge files, for the reason set out at section 5.6. Both sets are archived. The CMS releases used in this case are:

- CMS Physician Fee Schedule, release pfs-2025-01
- CMS Physician Fee Schedule, release pfs-2025-04
- CMS Physician Fee Schedule, release pfs-2025-07
- CMS Physician Fee Schedule, release pfs-2025-10
- CMS Physician Fee Schedule, release pfs-2026-01

- CMS Part B drug payment limit (average sales price), release asp-2025-04
- CMS Part B drug payment limit (average sales price), release asp-2025-07
- CMS DMEPOS fee schedule, release dmepos-2025-04
- CMS DMEPOS fee schedule, release dmepos-2025-07
- CMS DMEPOS fee schedule, release dmepos-2026-01

Each file is kept as downloaded. A link is not a source: a published file is revised, moved and withdrawn, and an opinion that rests on a URL cannot be reproduced once it moves. Every figure below can be recomputed from the archived files without reference to me.

5.3 How one line is priced

The method is the same on every clinic, imaging and physician line. Taking the largest single charge of that kind that Medicare publishes an amount for as the worked example. The hospital's facility lines are priced the other way: section 5.6 sets out that measure and the table at section 6.3 applies it line by line.

- The bill charges $2,950.00 for CPT 62323 (injection, epidural, lumbar, with imaging) on March 18, 2026.
- The published file governing that date is CMS release pfs-2026-01. Every figure in the next step is read from it.
- The Physician Fee Schedule non-facility amount for 62323 in TX locality 18 (Houston) on that release is $274.36.
- The benchmark for the line is therefore $274.36. The charge of $2,950.00 is 10.75 times it.

Exhibit C sets out this derivation for every code, every charged amount and every fee schedule release in the case, so that any figure in Exhibit B can be recomputed from the published files.

5.4 The rules applied to every line

- THE BENCHMARK PRICES THE SAME SERVICE THE BILL CHARGES FOR. Where a bill charges for a whole imaging study, it is compared against the amount for the whole study, not against the amount for reading and interpreting it. The reading-only figure is a fraction of the whole and using it would overstate the gap. It appears nowhere in this report.
- NO LINE IS CREDITED ABOVE WHAT WAS CHARGED. Where a provider billed less than the benchmark, the reference total takes the amount actually billed. A benchmark is a ceiling on what is reasonable, not a floor, and totalling the benchmark across all lines would credit the provider with money it never asked for.
- THE RATE IS THE ONE IN FORCE ON THE DATE OF SERVICE. This case spans several fee schedule releases. Each line is priced from the release in force on its own date, not from the current one.
- ONE LOCALITY, STATED AND TESTED. Every line the physician schedule prices is priced in the locality named at section 4.1, and section 8.1 reprices all of them in every other locality the state publishes.
- NON-FACILITY SETTING. Each service is priced at the non-facility amount, which is the amount for a service furnished in a physician's office. It is the higher of the two settings on every code where they differ, so the assumption runs in the provider's favour.
- MODIFIERS ARE NOT INVENTED. No line carries one and none is assumed.
- A DRUG IS NOT PRICED ON THE FEE SCHEDULE. Injectable drugs are excluded from the Physician Fee Schedule and are paid from the Part B drug payment limit, which is national and carries no locality. Asking the wrong file and reporting the answer would be true of the wrong file.

- A CODE WITH NO PUBLISHED AMOUNT CARRIES NO BENCHMARK, NOT A BENCHMARK OF ZERO. Zero asserts that the service is worth nothing. The truth is that the published schedules do not price it, so the line is counted at what was charged and the reason is printed in Exhibit B.

5.5 Rules I did not apply, and what they are worth

Medicare applies reductions when certain services are billed together. This report does not apply them, because each produces the amount Medicare would allow on a particular claim rather than the published fee schedule figure, and because each of them lowers the benchmark and so runs against the provider. Section 8.3 states what they are worth, so the choice is visible and can be reversed by anyone who disagrees with it.

5.6 The measure applied to the hospital's facility lines

The hospital bill is not priced on the Physician Fee Schedule, and that is a rule rather than a preference. That schedule prices a clinician's work. A UB-04 facility line prices the room, the equipment, the supplies and the staffing that stand behind the clinician, and the schedule has no amount for any of it. A report that runs an emergency department charge through the physician schedule produces a figure that reproduces perfectly and means nothing.

What a hospital facility charge can be measured against is what other hospitals charge for the same thing. Since 2021 federal price transparency rules have required every hospital to publish its standard charges in a machine-readable file, so the comparison is against published data rather than against a survey or a proprietary database. For each facility line I took the published charge for the same service, under the same revenue code, at each of the 3 comparator hospitals identified at section 4.4, and used the 80th percentile of that set as the benchmark.

- THE 80TH PERCENTILE, NOT THE AVERAGE, AND NOT THE LOWEST. A benchmark set at the average would call half of a normal market unreasonable. The 80th percentile says that a charge is not unreasonable until it exceeds what four hospitals in five publish, which is a standard the billing hospital's own market sets rather than one I chose for it. Section 8.5 prices the case at the median as well, so the effect of that choice can be seen.
- THE LEVEL OF CARE IS READ OFF THE REVENUE CODE, NEVER INFERRED FROM THE PRICE. An emergency department visit billed under revenue code 0450 at a level 4 is compared against other hospitals' level 4 emergency department charges. Reasoning backwards from the amount to the level of care assumes the answer.
- A COMPARATOR IS NAMED AND ITS FILE IS ARCHIVED. The edition of the comparator's published file must be the one in force when the subject bill was issued. Comparing a 2025 charge against a 2023 published file is a comparison across two different years of price increases, and it is invisible in the arithmetic.
- NO LINE IS CREDITED ABOVE WHAT WAS CHARGED, the same rule as the professional lines.

This is a comparison of published charges against published charges. It is not an opinion about what any payer would allow, what the hospital would accept in settlement, or what its costs were. I have no access to any of those and I say nothing about them.

6 FINDINGS BY PROVIDER

6.1 Beltway Spine & Rehabilitation

Beltway Spine & Rehabilitation billed 99 lines on 26 dates between January 20, 2025 and July 14, 2025, totalling $12,579.00. The Medicare reference for the same services is $3,788.01. Of the lines Medicare publishes an amount for, 64 are above it and none is at or below it.

Charges billed	$12,579.00
Payments posted	($1,934.39)
Of which carried at the amount charged (35 lines, no published Medicare amount)	$1,574.00
Medicare reference total	$3,788.01

6.2 Gulf Coast Interventional Pain, PLLC

Gulf Coast Interventional Pain, PLLC billed 12 lines on 7 dates between March 11, 2025 and March 18, 2026, totalling $11,600.00. The Medicare reference for the same services is $1,860.02. Of the lines Medicare publishes an amount for, 9 are above it and none is at or below it.

Charges billed	$11,600.00
Payments posted	($608.77)
Of which carried at the amount charged (3 lines, no published Medicare amount)	$565.00
Medicare reference total	$1,860.02

6.3 Northline Regional Medical Center

Northline Regional Medical Center is an acute-care hospital. It billed 8 facility lines for a single emergency department visit on January 14, 2025, totalling $28,185.00, which is 46.27 percent of everything billed in this case. The bill prints a revenue code on every line and a level 4 emergency department visit as its largest single charge. Measured against the 80th percentile of what the 3 comparator hospitals publish for the same services, the benchmark is $17,442.20. Every one of the 8 lines is above it.

Charges billed	$28,185.00
Payments posted	($2,418.00)
Benchmark total	$17,442.20

Rev	Code	Service	Charged	Hospital One	Hospital Two	Hospital Three	80th pct	Times
0450	99284	Emergency department visit…	$11,850.00	$4,390.00	$6,210.00	$8,357.00	$7,498.20	1.58x
0350	70450	CT head or brain, without…	$8,940.00	$3,077.00	$4,860.00	$5,882.00	$5,473.20	1.63x
0320	72040	X-ray, cervical spine, 2-3 views	$2,180.00	$461.00	$1,120.00	$1,503.00	$1,349.80	1.62x
0320	72100	X-ray, lumbar spine, 2-3 views	$2,180.00	$470.00	$1,142.00	$1,530.00	$1,374.80	1.59x
0260	96374	Injection, intravenous push…	$1,120.00	$427.00	$640.00	$975.00	$841.00	1.33x
0300	80048	Basic metabolic	$890.00	$212.00	$340.00	$498.00	$434.80	2.05x

Rev	Code	Service	Charged	Hospital One	Hospital Two	Hospital Three	80th pct	Times
		panel						
0305	85025	Complete blood count with…	$640.00	$168.00	$275.00	$402.00	$351.20	1.82x
0250	J1885	Ketorolac tromethamine, 15 mg	$385.00	$42.00	$88.00	$140.00	$119.20	3.23x

The comparator hospitals are anonymised in this sample and named in a delivered report. Section 4.4 says why.

6.4 Westheimer Open MRI

Westheimer Open MRI billed 3 lines on 1 date February 25, 2025, totalling $8,550.00. The Medicare reference for the same services is $570.62. Of the lines Medicare publishes an amount for, 3 are above it and none is at or below it.

Charges billed	$8,550.00
Payments posted	($1,042.00)
Medicare reference total	$570.62

The payments already posted on this account, $1,042.00, exceed the Medicare reference for the whole of its charges, $570.62, by $471.38. I offer that as an observation on the figures and not as a conclusion about any of them.

7 THE PAYMENT RECORD

A report of this kind is of limited use unless it also states what has been paid and what remains outstanding. Both are printed on the bills and both are set out here.

7.1 How the payments are posted, and when they stop

A word first on how to read the payment columns of Exhibit B, because these bills post money in a way that looks wrong if it is not explained. A payer on these accounts does not pay a service. It pays a claim, which is one visit, and the transaction report posts the whole of that payment once, against the first service listed for the visit. Exhibit B reproduces the bill exactly, so it does the same. That is why 0 of the 122 lines carry a payment larger than their own charge. Those figures are the bill's, not an allocation of mine. No payment has been split, moved or apportioned between lines anywhere in this report. Read the payment column down to a total, or against a visit. Do not read it against the charge on the same row.

Read in date of service order the payments also say when the money stopped. Payments run from January 14, 2025 to April 21, 2025 and total $6,003.16. On the 54 charge lines dated after April 21, 2025, billed at $13,516.00, nothing was paid at all.

I state what the payment record shows and I go no further with it. I was given no policy, no declarations page and no explanation of benefits, so I do not identify the coverage, its limit, or whether any benefit remains, and I express no view on what any of it means in law.

8 LIMITATIONS, AND THE FIGURES PRICED BOTH WAYS

Where a choice in this report could reasonably have gone another way, I have priced it both ways rather than describe it. A limitation with a number attached can be weighed. One without a number cannot.

8.1 The locality

The locality at section 4.1 rests on your instruction rather than on a printed provider address. I therefore repriced the clinic, imaging and physician lines in each of the 8 Medicare localities TX publishes, line by line, on the same dates of service. The hospital's facility lines are not in this table and cannot be: their benchmark is what hospitals in this market publish, which carries no Medicare locality at all. The figure being tested is therefore the $6,218.65 professional reference from section 1, not the $23,660.85 case total.

Locality	Payment area	Professional reference total	Difference from the figure used
09	Brazoria	$6,175.27	−$43.38
11	Dallas	$6,180.48	−$38.17
15	Galveston	$6,169.02	−$49.63
18	Houston	$6,218.65	used in this report
20	Beaumont	$5,941.75	−$276.90
28	Fort Worth	$6,162.05	−$56.60
31	Austin	$6,258.22	+$39.57
99	Rest Of State	$6,032.85	−$185.80

No TX locality moves the professional reference by more than $276.90 from the figure used here, and the whole spread across the 8 is $316.47, which is 0.52 percent of the amounts billed. Six of the other seven produce a lower reference total and therefore a larger difference than the one reported here, so the locality used is not the one that puts these providers in the worst light. If the locality assumption is wrong, the conclusion of this report does not change.

8.2 Lines carried at the amount charged

38 lines in all, $2,139.00 in charges, carry codes for which the published schedules give no payable amount. They are counted at the full amount charged, which is 34.40 percent of the clinic and physician benchmark. That is the single largest place where this report favours the provider, and it deserves a number rather than a footnote. The reasons are not the same and they do not carry the same answer:

Codes	Lines	Charges	Why there is no published amount
97010	17	$544.00	Status B: bundled. Payment is made, and is included in the payment for the service it is incident to.
97014	17	$935.00	Status I: not valid for Medicare. Medicare requires a different code for this service. See section 9.4.
98943	1	$95.00	Status N: non-covered. The code is on the fee schedule and Medicare does not cover the service. Extraspinal manipulation is outside the chiropractic benefit, which reaches spinal manipulation only.
A4550	3	$565.00	On none of the schedules searched: the Physician Fee Schedule, the Part B drug payment limit and the supply schedule.

The status B lines are the ones where a second reading is genuinely available. Medicare's own published definition of status B is that payment for such a service is made and is included in the payment for the

service it is incident to. Read that way those 17 lines would carry a benchmark of zero rather than no benchmark, and that benchmark would fall from $6,218.65 to $5,674.65. If the status I lines were treated the same way it would fall to $4,739.65. I have made neither change. Which reading is correct is a coding question, it is mine to answer, and section 9 answers it rather than referring it elsewhere.

8.3 Medicare's multiple procedure reductions

When Medicare adjudicates a claim it pays the highest-priced imaging study in a session in full and reduces each subsequent study in the same session. It applies a comparable reduction to the practice expense of therapy services billed on the same day. Those reductions produce an amount Medicare allows on a particular claim, not a published fee schedule figure, and this report compares each charge against the published figure. They are therefore not applied here, which favours the provider. Applying the imaging reduction to the three studies billed in one session would lower this case's reference total. It would not raise it.

8.4 Units on the drug line

The transaction report prints no quantity. The injectable steroid is defined by Medicare in 1 mg units, so a bill that does not print a quantity cannot be priced on the dose actually given. Each is counted at one unit. The effect is worth stating precisely: the charge is $185.00 against a published amount of $0.09 at one unit. Had ten units been given and not reported, the comparison would be $185.00 against $0.90, and the answer would not change. The quantity assumption cannot rescue this line. Only a claim form printing the units could.

8.5 The percentile chosen for the hospital lines

Section 5.6 sets the hospital benchmark at the 80th percentile of the comparator set. The median is the other defensible choice and it is a lower, harsher benchmark, so the difference runs against the provider and I state it rather than rely on it:

Benchmark	Hospital benchmark total	Hospital charges above it	Charges as a multiple
80th percentile (used in this report)	$17,442.20	$10,742.80	1.62x
Median of the same comparators	$14,675.00	$13,510.00	1.92x

The verdict does not turn on the choice. Every facility line in this case is above the benchmark on both definitions, so no line changes its answer and the figure moves by $2,767.20. Had a line been reasonable on one definition and unreasonable on the other, I would have said so on that line rather than picking the definition that suited the conclusion.

8.6 Other limits on this opinion

- I reviewed no medical record and express no opinion on medical necessity or causation.
- I did not examine the claimant and did not speak to any treating provider.
- The hospital comparison is published charge against published charge. It is not an opinion on what any payer would allow, what the hospital would accept in settlement, or what the service cost the hospital to provide. I was given none of that.
- This report prices the charges as billed. It does not audit whether the services were furnished.
- The first two findings in section 9 rest on the absence of modifiers in the documents I was given. None of the three prints a modifier field, so I can say that none appears and not that none was submitted. Production of the claim forms would settle those two one way or the other. The third and fourth findings do not turn on a modifier, and section 9.4 says so on its face.

9 CODING FINDINGS

Everything above measures the amounts. This section is the other half of the engagement and it is the half a fee schedule cannot reach: whether the services are coded the way the documents support. Four matters appear on these bills. For each I state the rule, what the documents show, and what the finding is worth. Every one of them, resolved against the provider, lowers the amount properly billable. None raises it.

The first two turn on the same missing document. None of the three bills prints a modifier field, so each of those findings is stated as what the record shows and not as a conclusion about what was submitted on the claim. Production of the CMS-1500 forms would resolve both. The third and fourth do not depend on a modifier and are visible on the face of the bills.

9.1 Manual therapy billed with chiropractic manipulation, no modifier

On 17 dates of service Beltway Spine & Rehabilitation billed manual therapy, CPT 97140, together with chiropractic manipulation of three to four regions, CPT 98941. Medicare's National Correct Coding Initiative pairs those two codes with a procedure-to-procedure edit carrying a modifier indicator of 1. That indicator means the pair may be reported together only where the record supports a bypass modifier, which requires that the manual therapy was furnished to a separate anatomic region, or in a separate session, from the manipulation. No line on the report carries a modifier and no record was produced to support one. The manual therapy billed on those dates comes to $2,550.00.

9.2 Office visit billed with manipulation on the same date, no modifier

On 2 dates Beltway Spine & Rehabilitation billed an established-patient office visit, CPT 99213, on the same date as chiropractic manipulation. A pre-service evaluation is already included in the manipulation code. A separate office visit is reportable only where the evaluation was significant and separately identifiable from the manipulation, and that is signalled by appending modifier 25 to the visit. No modifier appears. The visits billed on those dates come to $530.00.

9.3 A new-patient office visit billed twice by the same practice

Gulf Coast Interventional Pain, PLLC billed a new-patient office visit, CPT 99204, on March 11, 2025, and billed a new-patient visit again on February 10, 2026. The two are 336 days apart, which is 11 months. A patient is new only where no face-to-face service has been furnished by the physician, or by another physician of the same specialty in the same group practice, within the previous three years. The second visit is therefore an established-patient service unless the two rendering clinicians are of different specialties, and the transaction report does not print either clinician's specialty. The charge for the second visit is $845.00. Coded as established, its published Medicare amount falls from $180.49 to $137.41, a difference of $43.08 on that line.

9.4 Electrical stimulation billed under a code Medicare does not accept

On 17 dates Beltway Spine & Rehabilitation billed unattended electrical stimulation as CPT 97014. That code carries Medicare status I, which means it is not valid for Medicare purposes because Medicare requires a different code for the same service. For unattended electrical stimulation that code is G0283. This is the one finding in this section that does not depend on a missing modifier: the code on the bill is not the code the payer's own schedule recognises, and that is visible on the face of the document. Billed correctly as G0283, each of those lines would carry a published amount of $12.52 against the $55.00 charged, and the 17 lines would carry a benchmark of $212.84 in place of the $935.00 they are counted at in this report.

One further opinion belongs here, although it is not one of the four above because it changes the benchmark rather than the coding of a service. It concerns the status B lines discussed at section 8.2. Medicare's own

definition of status B is that payment is made and is included in the payment for the service the code is incident to. My opinion is that those 17 lines, $544.00 in charges, are not separately billable, and that the benchmark stated in this report is therefore $544.00 higher than a strict reading supports. I have left the figure unchanged rather than move it, so that the number in section 10 is the one that favours the provider and no one has to take my word for the adjustment.

10 SUMMARY OF OPINION

On the assumptions stated in section 4, and to a reasonable degree of certainty as a Certified Professional Coder, my opinions are these.

First, on the amounts, and they are measured two ways because the case contains two kinds of charge. The published Medicare amount for the 114 clinic, imaging and physician lines, each priced in the locality at section 4.1 from the release in force on its own date of service, is $6,218.65 against $32,729.00 billed. The 80th percentile of what 3 hospitals in the same market publish for the 8 hospital facility lines is $17,442.20 against $28,185.00 billed. Together the benchmark is $23,660.85 against $60,914.00 billed, so the charges exceed it by $37,253.15, which is 157.45 percent above it and represents 61.16 percent of the amounts billed.

Second, on the coding. Four matters set out in section 9 affect what is properly billable: manual therapy reported with manipulation on 17 dates without a supporting modifier, an office visit reported with manipulation on 2 dates without one, a new-patient visit reported twice by the same practice inside the three-year look-back, and 17 lines reported under a code the payer's schedule does not accept.

Of the reference total, $2,139.00 is charges I was unable to benchmark and have therefore counted in full, and section 8.2 gives my opinion that $544.00 of that is not separately billable at all. Applying that opinion, or the reductions at section 8.3, or any of the section 9 findings, lowers the figure. Nothing I found in these records would raise it.

The providers have already received $6,003.16 and $54,910.84 of the billed charges remains outstanding. Which measure of damages governs either amount is a question of law on which I express no opinion.

11 FEES

This report was prepared on a flat fee. There is no hourly charge for the review, no charge for the time spent on any part of it, and no charge that depends on what the review finds.

The fee was quoted before the engagement began. Deposition and trial testimony are quoted separately.

If the report is not something you would put in front of a judge, you do not pay for it.

DISCLAIMER

The findings in this report are made to a reasonable degree of certainty as a Certified Professional Coder, based on the records provided to me and listed in section 3. I am not a physician and I express no opinion on medical necessity, on causation, or on the standard of care. I am not a lawyer and I express no opinion on any question of law, including which measure of damages applies to these expenses or whether anything in this report is admissible. I reserve the right to amend this report on the availability of further information or the discovery of any error. In particular I expect to amend it if the claim forms requested in sections 3 and 9 are produced.

Respectfully submitted,

_____

The signing expert
Certified Professional Coder
Fair Measure Billing Experts
Date: _____

EXHIBIT A · CURRICULUM VITAE

A delivered report attaches the signing expert's curriculum vitae here. The sample leaves it out, because everything else in this document is invented.

EXHIBIT B · THE CHARGE LINES

In a delivered report this exhibit carries EVERY charge line of every bill, which in this case is 122 rows, with the date of service, the code, the amount charged, the payments posted against it, the published Medicare amount and the source of that amount. What follows is an extract, so that the format can be seen without reproducing the whole table.

Read the payment column down to a total, or against a visit. Do not read it against the charge on the same row. Section 7.1 says why.

Provider	DOS	Code	Description	Charged	Paid	Medicare
Northline	01/14/25	99284	Emergency department visit, level 4	$11,850.00	$2,418.00	$7,498.20
Northline	01/14/25	70450	CT head or brain, without contrast	$8,940.00	–	$5,473.20
Northline	01/14/25	72040	X-ray, cervical spine, 2-3 views	$2,180.00	–	$1,349.80
Northline	01/14/25	72100	X-ray, lumbar spine, 2-3 views	$2,180.00	–	$1,374.80
Northline	01/14/25	96374	Injection, intravenous push, initial	$1,120.00	–	$841.00
Northline	01/14/25	80048	Basic metabolic panel	$890.00	–	$434.80
Northline	01/14/25	85025	Complete blood count with differential	$640.00	–	$351.20
Northline	01/14/25	J1885	Ketorolac tromethamine, 15 mg	$385.00	–	$119.20
Beltway	01/20/25	99203	Office visit, new patient, low MDM	$485.00	$118.40	$112.01
Beltway	01/20/25	72040	X-ray, cervical spine, 2-3 views	$295.00	–	$38.95
Beltway	01/20/25	72100	X-ray, lumbar spine, 2-3 views	$295.00	–	$38.95
Beltway	01/27/25	98941	Chiropractic manipulation, 3-4 regions	$185.00	$146.18	$38.99
Beltway	01/27/25	97140	Manual therapy, each 15 minutes	$150.00	–	$27.54
Gulf	03/11/25	99204	Office visit, new patient, moderate…	$780.00	$196.22	$167.92
Gulf	04/08/25	62323	Injection, epidural, lumbar, with…	$2,450.00	$412.55	$250.42
Gulf	04/08/25	A4550	Surgical tray	$185.00	–	no published amount
Gulf	04/08/25	J1100	Dexamethasone sodium phosphate, 1 mg	$185.00	–	$0.09
Gulf	06/17/25	99213	Office visit, established patient	$395.00	–	$91.00
Westheimer	02/25/25	72141	MRI, cervical spine, without contrast	$2,850.00	$1,042.00	$189.88
Westheimer	02/25/25	72146	MRI, thoracic spine, without contrast	$2,850.00	–	$190.21
Westheimer	02/25/25	72148	MRI, lumbar spine, without contrast	$2,850.00	–	$190.53

Extract of 21 rows from 122. The delivered exhibit also carries a Fair Charge column, a per-provider subtotal and a source note naming the release each figure came from.

EXHIBIT C · HOW EVERY BENCHMARK WAS DERIVED

One row for each combination of code, amount charged and fee schedule release among the clinic, imaging and physician lines, so a code billed at two different amounts, or in two different years, appears on more than one row. Each row can be recomputed from the published CMS files without reference to this report. The hospital's facility lines are not in this table because they are not priced from a CMS file; their derivation is the comparator table at section 6.3.

Code	Description	Lines	Charged	Medicare	Release	Schedule / why not
62323	Injection, epidural, lumbar, with…	1	$2,450.00	$250.42	pfs-2025-04	PFS
62323	Injection, epidural, lumbar, with…	1	$2,950.00	$274.36	pfs-2026-01	PFS
64483	Injection, transforaminal…	1	$2,850.00	$239.62	pfs-2025-07	PFS
72040	X-ray, cervical spine, 2-3 views	1	$295.00	$38.95	pfs-2025-01	PFS
72100	X-ray, lumbar spine, 2-3 views	1	$295.00	$38.95	pfs-2025-01	PFS
72141	MRI, cervical spine, without…	1	$2,850.00	$189.88	pfs-2025-01	PFS
72146	MRI, thoracic spine, without…	1	$2,850.00	$190.21	pfs-2025-01	PFS
72148	MRI, lumbar spine, without…	1	$2,850.00	$190.53	pfs-2025-01	PFS
97010	Hot or cold packs	7	$32.00	–	pfs-2025-01	PFS status B: Medicare publishes no payable…
97010	Hot or cold packs	9	$32.00	–	pfs-2025-04	PFS status B: Medicare publishes no payable…
97010	Hot or cold packs	1	$32.00	–	pfs-2025-07	PFS status B: Medicare publishes no payable…
97014	Electrical stimulation, unattended	7	$55.00	–	pfs-2025-01	PFS status I: Medicare publishes no payable…
97014	Electrical stimulation, unattended	8	$55.00	–	pfs-2025-04	PFS status I: Medicare publishes no payable…
97014	Electrical stimulation, unattended	2	$55.00	–	pfs-2025-07	PFS status I: Medicare publishes no payable…
97110	Therapeutic exercise, each 15…	7	$145.00	$29.17	pfs-2025-01	PFS
97110	Therapeutic exercise, each 15…	8	$145.00	$29.17	pfs-2025-04	PFS
97110	Therapeutic exercise, each 15…	2	$145.00	$29.17	pfs-2025-07	PFS
97140	Manual therapy, each 15 minutes	7	$150.00	$27.54	pfs-2025-01	PFS
97140	Manual therapy, each 15 minutes	9	$150.00	$27.54	pfs-2025-04	PFS
97140	Manual therapy, each 15 minutes	1	$150.00	$27.54	pfs-2025-07	PFS
98940	Chiropractic manipulation, 1-2…	3	$155.00	$26.90	pfs-2025-01	PFS
98940	Chiropractic manipulation, 1-2…	4	$155.00	$26.90	pfs-2025-04	PFS
98940	Chiropractic manipulation, 1-2…	1	$155.00	$26.90	pfs-2025-07	PFS
98941	Chiropractic manipulation, 3-4…	7	$185.00	$38.99	pfs-2025-01	PFS
98941	Chiropractic manipulation, 3-4…	9	$185.00	$38.99	pfs-2025-04	PFS
98941	Chiropractic manipulation, 3-4…	1	$185.00	$38.99	pfs-2025-07	PFS
98943	Chiropractic	1	$95.00	–	pfs-2025-07	PFS status N:

Code	Description	Lines	Charged	Medicare	Release	Schedule / why not
	manipulation…					Medicare publishes no payable…
99203	Office visit, new patient, low MDM	1	$485.00	$112.01	pfs-2025-01	PFS
99204	Office visit, new patient…	1	$780.00	$167.92	pfs-2025-01	PFS
99204	Office visit, new patient…	1	$845.00	$180.49	pfs-2026-01	PFS
99213	Office visit, established patient	1	$265.00	$91.00	pfs-2025-01	PFS
99213	Office visit, established patient	1	$265.00	$91.00	pfs-2025-04	PFS
99213	Office visit, established patient	1	$395.00	$91.00	pfs-2025-04	PFS
99213	Office visit, established patient	1	$395.00	$91.00	pfs-2025-10	PFS
A4550	Surgical tray	1	$185.00	–	dmepos-2025-04	A4550 is on neither the DMEPOS nor the PEN…
A4550	Surgical tray	1	$185.00	–	dmepos-2025-07	A4550 is on neither the DMEPOS nor the PEN…
A4550	Surgical tray	1	$195.00	–	dmepos-2026-01	A4550 is on neither the DMEPOS nor the PEN…
J1100	Dexamethasone sodium phosphate, 1…	1	$185.00	$0.09	asp-2025-04	ASP
J1100	Dexamethasone sodium phosphate, 1…	1	$185.00	$0.12	asp-2025-07	ASP