QUICK REFERENCE CHART

FREQUENTLY OVERUTILIZED and/or ABUSED DIAGNOSTIC PROCEDURE CODES

CPT CODE	*DESCRIPTION / PROCEDURE*
70 - - -	MRI - HEAD & NECK
72 - - -	MRI - SPINE & PELVIS
73 - - -	MRI - UPPER & LOWER EXTREMITIES
761 - -	VIDEO FLUOROSCOPY
765 - -	ULTRASOUND OF HEAD & NECK
768 - -	ULTRASOUND OF SPINE
933 - -	ECHOCARDIOGRAPHY
93760	THERMOGRAPHY- CEPHALIC
93762	THERMOGRAPHY- PERIPHERAL
93740	THERMAL GRADIENT
9586 -	EMG – NEEDLE
9583 -	MUSCLE TEST – MANUAL
959 - -	NERVE TESTING - NCV, SSEP, DEP, H-REFLEX, F-REFLEX
922 - -	BRAIN MAPPING - VEP, BAER, EEG,
925 - -	QEEG
958 - -	EEG, NEEDLE ELECTROMYOGRAPHY
97 - - -	PHYSICAL MEDICINE
- - - 99	UNLISTED PROCEDURES

MEDICAL FILE CONSULTANTS, INC. PO Box 623128 Oviedo, Florida 32762-3128
Phone 407.359.0074 Fax 407.365.6536 Toll Free 866.MFC.2748

Evaluation and Management Explanation of Office or other Outpatient Consultations

Code	Minutes Face to Face	# of Req Com – ponents	History Component	Examination Component	Decision Making Component
			NEW PATIENT		
99205	60	3	Comprehensive History	Comprehensive Exam	Medical Decision Making (MDM) of High Complexity
99204	45	3	Comprehensive History	Comprehensive Exam	MDM of Moderate Complexity
99203	30	3	Detailed History	Detailed Exam	MDM of Low Complexity
99202	20	3	Expanded Problem Focused History	Expanded Problem Focused Exam	Straightforward Medical Decision Making (SF-MDM)
99201	10	3	Problem Focused History	Problem Focused Exam	SF-MDM
			ESTABLISHED PATIENT		
99215	40	2 of 3	Comprehensive History	Comprehensive Exam	MDM of High Complexity
99214	25	2 of 3	Detailed History	Detailed Exam	MDM of Moderate Complexity
99213	15	2 of 3	Expanded Problem Focused History	Expanded Problem Focused Exam	MDM of Low Complexity
99212	10	2 of 3	Problem Focused History	Problem Focused Exam	SF-MDM
99211	5	2 of 3	May Not Require Physical Presence		
			CONSULTATION		
99245	80	3	Comprehensive History	Comprehensive Exam	MDM of High Complexity
99244	60	3	Comprehensive History	Comprehensive Exam	MDM of Moderate Complexity
99243	40	3	Detailed History	Detailed Exam	MDM of Low Complexity
99242	30	3	Expanded Problem Focused History	Expanded Problem Focused Exam	SF-MDM
99241	15	3	Problem Focused History	Problem Focused Exam	SF-MDM

CONFIRMATORY CONSULTATION
99271 – 99275

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SIU

Review, inc.®

Evaluation and Management (E & M) Office Level Descriptions

Upcoding: Charging for a higher level (more complex) service than was actually provided.

NEW PATIENT

Code	Approx. minutes face to face
99205	60
99204	45
99203	30
99202	20
99201	10

ESTABLISHED PATIENT

Code	Approx. minutes face to face
99215	40
99214	25
99213	15
99212	10
99211	5

CONSULTATION

Code	Approx. minutes face to face
99245	80
99244	60
99243	40
99242	30
99241	15

Important note: The "consultation code" can only be utilized when the patient is referred to the examining physician by another physician.

The code **99245** includes that of a **HIGH COMPLEXITY DECISION MAKING PROCESS** which is defined as one involving extensive numbers of diagnostic and management options, extensive amounts of data and high risk of complications of **morbidity** and **mortality**.

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MEDICAL FILE CONSULTANTS, INC.

MEDICALLY NECESSARY * REASONABLE * RELATED

File Management

- Arrange file in chronological order.
- Examine medical records.
- Inspect file for inconsistencies.
- Printout of CPT & ICD-9 code summary.
- Printout of CPT & ICD-9 code descriptions by dates & providers.
- Return tabbed file to client.

IME

- Perform Independent Medical Examination to include all necessary medical records arranged in chronological order for examiner.

BI / 3rd Party File Review

- Physician Code / Peer and/or diagnostic review performed.
- Demand is addressed when applicable.
- Chronologically tabbed file returned to client.

Physician Code / Peer Review

Review of Medical Records:

- Request all missing information by certified, return receipt mail.
- **Code review**: HCFA and UB92 bills evaluated & compared to documentation of services rendered / billed.
- **Physician performs** a CPT code evaluation / report of indicated and non-indicated procedures (billing).
- **Physician prepares** a report on medical necessity,reasonableness and relatedness of care rendered.

Review of Diagnostic Procedures:

- Was the procedure billed actually performed (must have "raw data")?
- Was the procedure performed, and/or performed properly utilizing the appropriate protocols?
- Was the procedure interpreted correctly?

Before you can determine if the diagnostic procedure was *medically necessary* you must determine if the procedure was actually performed, performed properly and interpreted correctly.

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MEDICAL FILE CONSULTANTS, INC.

PRESENTATION / TRAINING OUTLINE

"Identifying and Patterning Suspect Medical Claims"

There is a small group of fraudulent providers who are abusing medical practices. Unfortunately, that represents a big portion of the money being spent today.

Every policyholder pays the price for unnecessary treatment and tests, as well as abusive, over-utilized and fraudulent billing practices.

Fraud in medical claims has reached epidemic proportions. This is especially true in areas of diagnostic testing. Not only has diagnostic testing become an arena of entrepreneurs with little or no medical background, it has also become a significant source of income to treating physicians through various "kickback schemes".

This presentation will encompass the following:

- The technical aspects and proper protocols of diagnostic testing.
- How providers use the coding system to their financial advantage.
- Why reviewing diagnostic tests and procedures can be cost effective and stop the churning of the file.
- How reviewing diagnostic tests and procedures can drastically cut cost in your organization.
- How the investigation and review of suspect files can benefit the claimant/patient.
- The warning signs from coding and billing practices that can alert the adjuster or SIU to potential misuse.
- How certain providers are intentionally and consistently cheating the health care system and why more providers are participating.
- What insurers are doing to successfully combat the problem.

You will be shown examples of:

- Advertisements designed for "Financial Gain" with no mention of patient benefit.
- How documentation can be obtained for review and how that information can be used in the event of future litigation.
- Billing for tests and procedures that have never been performed.
- Submitting exaggerated, false-positive findings, and interpretations of tests to be used to extend further unnecessary and excessive care.
- Billing for tests, procedures, and treatment not causally related.
- **PATTERNING THE ABUSE.**

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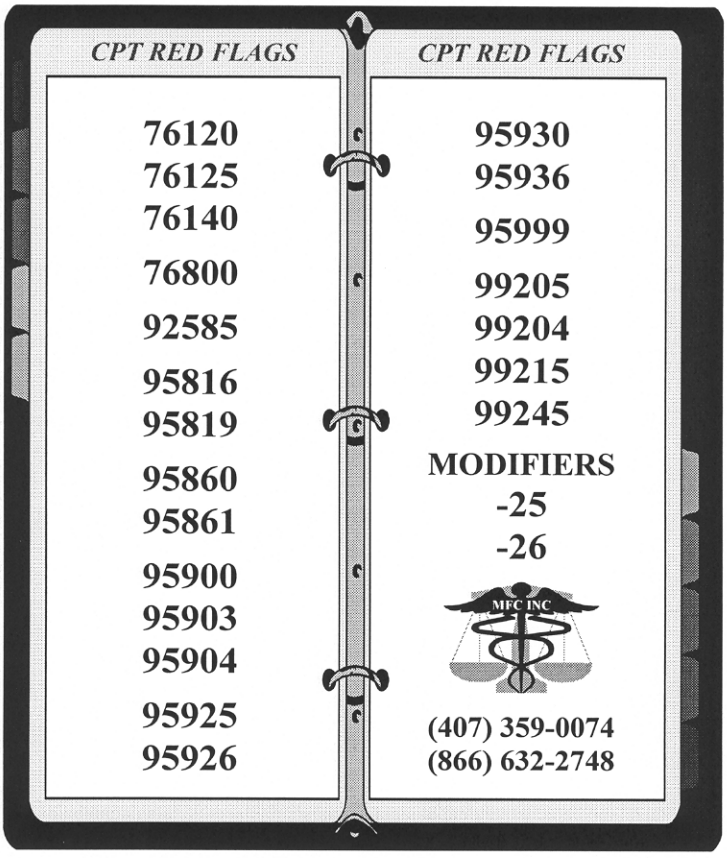

The above listed CPT™ Codes represent procedures that are valid **when** utilized according to the descriptions and principles of the AMA (Principles of CPT™ Coding & A Physician's Guide to Compliance) as well as the accepted standards of care governed by the physicians licensing chapters.

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MEDICAL FILE CONSULTANTS, INC.

Request for Services

Phone 407.359.0074 ☎ Fax 407.365.6536 ☎ Toll Free 866.MFC.2748

Request Date: _____ **Date of injury/illness:** _____ **Date of Birth:** _____

Claimant: _____ **Insured:** _____

Claim#: _____ **Policy#:** _____

Adjuster: _____ **Company:** _____

Ph#: _____ **Fax#:** _____ **E-mail:** _____

Address: _____

Attorney: _____ **Phone #:** _____ **Fax #:** _____

Address: _____

Type of Claim: PIP____ BI____ WC____ UM____ Liab____ Med. Pay____ Other___

Type of Service Requested

_____ **File Management ***
[Chronologically organize, tab & examine file. Prepare summary of findings and return with indexed file].

_____ **Physician Code / Peer Review ***
[Physician of same license reviews prepared file, provides a "code evaluation" ***and*** report on the medical necessity, reasonableness and relatedness of care rendered].

_____ **Diagnostic Peer Review**
[Physician of same license reviews "raw data" regarding protocol and interpretation of diagnostic procedures].

_____ **BI / 3rd Party File Review ***
[Includes **File Management** above "plus" Physician and/or Diagnostic Peer Review (address demand when applicable).]

_____ **IME** (Independent Medical Examination). Specialty: _____

* Price may vary depending on the size and type of file.

Would you like MEDICAL FILE CONSULTANTS, INC. to: (must have signed patient's authorization when required). ***There is no additional charge for this service.***

1	Request Medical Records	Yes	No
2	Request Diagnostic "Raw Data"	Yes	No

Mail or fax claimant information to: MEDICAL FILE CONSULTANTS, INC.
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Fax: (407) 365 – 6536

MEDICAL FILE CONSULTANTS, INC ®

-26 modifier

Professional Component

According to the AMA – Medicine Guidelines and The Chiropractic Standard for Coding and Reimbursement:

"**Modifier '-26'** is used when, certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number. "

When procedures are billed utilizing separate professional and technical components, a global code is not applicable for that procedure. The technical portion is identified by a ' -TC' (Technical Component).

For example:
The radiologist performed a series of x-rays of the spine in his/her office and billed the carrier for the technical component. The Chiropractic physician billed for the professional component, which is the interpretation and management plan for the patient, using the modifier -26 appended to the CPT code for the specific service performed.

Code: 72052-26 (physician's office) 72052-TC (facility)

Note: UNBUNDLING
"There are two types of unbundling: the first is unintentional, which results from a misunderstanding of coding and second is intentional, when this technique is used by providers to manipulate coding in order to maximize payment. Unbundling is essentially the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code.
Example: Fragmenting one service into component parts and coding each component part as if it were a separate service.

Code: 72052-TC and 72052-26 are billed from the same provider at the same address.

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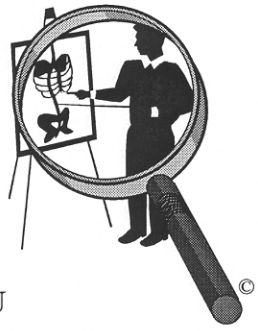
SIU



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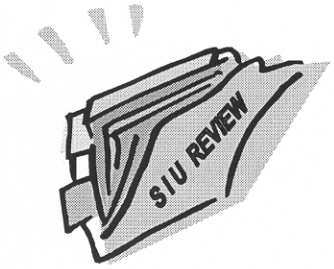
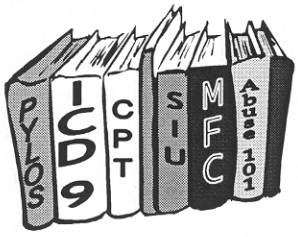
The* SIU Review *process can be completed on a single file or a group of files (special projects - selected for comparisons and patterning).



The entire file is reviewed, tabbed and highlighted.

- Inconsistencies and inappropriate billing are reported and patterned (explanation of CPT & ICD-9 codes billed).
- Questionable diagnostic procedures and protocols are identified.

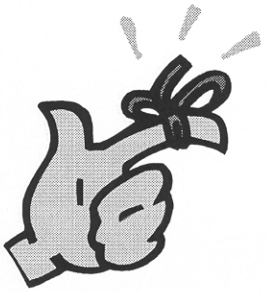


Investigative techniques, consultation and research are provided to aid the SIU agent with recommendations:

- For clinic inspections.
- Additional material and or information that should be obtained from the provider(s).
- Questions to ask in EUO's.
- Type of peer and/or diagnostic review (if any) that should be performed.

Preparation of file(s) for:

- Deposition.
- Trial.
- Referral to Department of Insurance Fraud and/or State's regulatory agency (when requested).



REMEMBER – You must be a registered SIU agent (insurer designated employee) pursuant to State Laws and Regulations to obtain this review.

THE STATUS OF ALL AGENTS WILL BE VERIFIED WITH THE DEPARTMENT OF INSURANCE

SIU Review, inc.®

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"Identifying and Flagging Suspect Diagnostic Testing"

- ***The lack of an adequate history and examination by a doctor ordering or performing the diagnostic tests:*** The examination must include the areas, which would document the necessity for the tests, to be performed. Examples would include performance of EMG and nerve conduction studies without the claimant having had a full neurologic examination of motor, sensory or reflex function. It might also include visual evoked potentials (VEP) without the doctor having first performed visual acuity testing. Another example might be performance of a Brainstem auditory evoked response (BAER) without the doctors having first evaluated cranial nerve functions or determined the thresholds of hearing. Also one must identify if the patient/claimant is on pain medication (i.e., Lortab, Vicodin, Lorcet, etc.) when these procedures were performed as they could alter the results.

- ***A large number of diagnostic tests ordered at once:*** Diagnostic tests are to be done to **confirm** suspected diagnosis. Therefore, the diagnostic test should be ordered within areas of symptoms and possible findings on examination. It is not appropriate to order numerous diagnostic tests to look at the entire body without any correlation to the history and examination or the localized areas of suspected involvement.

- ***Unbundling of services:*** History and examination which includes a charge for the history and examination as well as additional charges for muscle testing, range of motion testing, cognitive testing, aphasia testing, and interpretation. All of these additional services should be included within the fee for the doctor's history and examination. They are not justified as separate bills.

- ***Additional charges for interpretation of diagnostic tests:*** These should be included within the fees for the diagnostic tests when no modifier (TC) is added to the CPT code to indicate that this procedure is just being billed for the technical component. This would then reduce the fee of this procedure. Any additional bill from the interpreting provider should have a 26 modifier by the same CPT code to indicate only the interpretation of same. The total cost of both bills should equal the UCR of that specific GLOBAL CPT code.

- ***Problems in timing of procedures:*** This would include the performance of some tests too early (needle EMG performed, less than three weeks post injury), as well as long intervals between the order of the diagnostic tests and the performance of the tests (sometime this interval will be several weeks to many months). There is a significant cause to question the medical necessity of a diagnostic procedure when it is performed but not interpreted until weeks or months later. Another issue of timing is one in which electrodiagnostic tests are scheduled and/or performed with a long interval of time between the comprehensive neurological history and examination. EMG and nerve conduction studies (as well as somatosensory evoked potentials - SSEP's) are extensions of the neurological examination. There should be evidence of an updated thorough neurological examination not too long before the performance of the EMG and nerve conduction study or somatosensory evoked potential.

- ***Word-processed letters of necessity:*** Often printed years prior are form letters stating the need and medical necessity of the diagnostic testing/procedure to be performed and not referring or relating to the patient/claimant in question. Generic letters of necessity are not adequate, and certainly do not deal with a specific claimant's problems or reasons for testing.

- ***Diagnostic procedures billed with a CPT code ending with 99 (i.e. 95999, 76499, etc.):*** This indicates that the procedure performed is unlisted and many audit systems do not identify this resulting in a payment without inquiring about the procedure. When questioned or investigated, a typical response is "computer generated billing errors".

UNDERSTAND THE METHOD BEHIND THE MADNESS OF HEALTHCARE FRAUD

COMMONLY ABUSED ICD-9 CODES

337.( )	Disorders of the Autonomic Nervous System
350.( ) thru 359.	Disorders of Peripheral Nervous System
353.( )	Nerve Root and Plexus Disorders
354.( )	Mononeuritis of Upper Limbs
355.( )	Mononeuritis of Lower Limbs
324.( )	Dentofacial Anomalies including Malocclusion
710.( ) thru 739.	Disorders of the Musculoskeletal System and Connective Tissue
740.( ) thru 759.	Congenital Anomalies
780.( ) thru 799.	Unspecified Symptoms, signs and ill defined conditions
830.( ) thru 839.	Dislocations
840.( ) thru 848.	Sprain/Strains of Joints & Adjacent Muscles
850.( )	Concussion
920.( ) thru 924.	Contusion with Intact Skin Surfaces
950.( ) thru 957.	Injury to Nerves

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COMMONLY USED MODIFIERS

	-22	Unusual Procedural Services
see note →	**-25**	Separately Identifiable E&M Service
	-26	Professional Component
	-32	Mandated Services
	-51	Multiple Procedures
	-52	Reduced Service
	-59	Distinct Procedural Service
	-76	Repeat Procedure by Same Physician
	-77	Repeat Procedure by Another Physician
	-90	Reference (Outside) Laboratory
	-99	Multiple Modifiers / Unlisted Procedure
	-LT	Left Side
	-RT	Right Side
	-TC	Technical Component

Modifier - 90 (aka - TC) is a technical component
Modifier - 26 (aka - PC) is a professional component.

The global value (RVU total) is for the technical and professional components together and no modifier is appended.

-25 modifier

"Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service"

<u>According to the AMA – Medicine Guidelines - and The Chiropractic Standard for Coding and Reimbursement:</u>

"**Modifier '-25'** is used when, on the day of a procedure, the patient's condition requires a separate E/M service over and beyond the established routine course of care. E/M modifier -25 is used whether the patient is new or established and when there is one or more diagnosis. The physician's note must clearly indicate that the service provided was above and beyond the usual."

"The physician may need to indicate that on the day a procedure or service identified by a CPT code is performed, the patient's condition required a <u>significant, separately identifiable E/M service above and beyond the other service</u> promised or beyond the usual care associated with the procedure that is performed."

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"Problem CPT Codes"
&
"Identifying and Flagging Suspect Diagnostic Testing"

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DebPacha@aol.com.
SIU Review, inc.®
"Call for your Corporate Presentation Today"

Audience:
Adjusters
Claims Management
SIU
Counsel
Corporate Management
Training with "hands on" medical file investigation and appropriate patterning process procedures are also available.
***References Upon Request**

UNDERSTAND THE METHOD BEHIND THE MADNESS OF HEALTHCARE FRAUD

SIU Review,

Request for Services

Phone 407.359.0074 * Fax 407.365.6536 * Toll Free 866.632.2SIU

Claimant: _____ **Insured:** _____

Claim #: _____ **Policy #:** _____

Adjuster: _____ **Phone #:** _____ **Ext:** _____

Company: _____ **E-mail #:** _____

Address: _____

Phone #: _____ **Fax #:** _____

Attorney: _____ **Phone #:** _____

Type of Claim: PIP___ BI___ WC___ UM___ Liab___ Med. Pay___ Other ___

SIU Review, inc® will provide all the following with a Request for Service:

1. **Special Medical Investigative Report -** Inconsistencies and inappropriate billing reported; additional information from provider(s) that should be obtained; type of peer and/or diagnostic review (if any) that should be performed.
2. **Identification of Abusive Pattern(s)** - Explanation of CPT & ICD-9 codes billed; analysis of CPT codes billed by dates of service; pattern ICD-9 & CPT codes.
3. **Utilization Tools** - Questionable diagnostic procedures & protocols identified; identification of abusive or potentially fraudulent activity within all areas of file.
4. **Investigative Techniques and Consultation** - Suggestions for clinic inspections; questions to ask in EUO's; etc.
5. **Referral to Department of Insurance Fraud -** When requested, will forward completed file to DIF and/or business & professional regulatory agency.

Total Cost: $495.00 * **

* Special Projects containing numerous files can utilize the **PYLOS** program to visually demonstrate and report **PATTERNING**. The cost of this is determined by # of files received.

** Price may vary depending on the size of the file.

I allow SIU Review, inc to review, pattern and document findings on the above referenced file.

Signature _____

Mail file(s) to: SIU Review, inc® PO Box 623128
Oviedo, Florida 32762-3128