CAUSE NO. 2022-66491 / Court: 127

JHALEN DEMMING and BROOKLYONN PORGUE *Plaintiffs,*	§	**IN THE DISTRICT COURT OF**
V.	§	**HARRIS COUNTY, TEXAS**
ROAD MONSTER EXPRESS, LLC D/B/A HUSAM HASANI and HUSAM HUSANI *Defendant.*	§	**_____JUDICIAL DISTRICT**

CONTROVERTING AFFIDAVIT OF NADINE L. GONZALEZ, CPC, CRC

BEFORE ME, the undersigned authority, on this day personally appeared NADINE L. GONZALEZ, known to me to be the person whose name is subscribed hereto, who, being by me duly sworn, stated as follows:

"My name is NADINE L GONZALEZ. and I am over the age of eighteen years and am of sound mind. I have never been convicted of a felony or crime of moral turpitude and am otherwise competent to make this affidavit.

I am a healthcare compliance and revenue coding and billing consultant in the State of Texas. I received a Certificate in Documentation Coding from St. Philips College in 2007. My curriculum included courses in human anatomy & physiology, pathophysiology, pharmacology, advanced medical terminology, ICD diagnostic/procedural and CPT coding, healthcare statistics, and legal and ethical aspects of healthcare. My *curriculum vitae* is attached hereto and incorporated herein for all intents and purposes.

I have been a Certified Professional Coder (CPC) for thirteen years and a Certified Risk Adjustment Coder (CRC) for four years. Both certificates come from the American Academy of Professional Coders (AAPC). To maintain my CPC and CRC certification, I must complete forty

hours of continuing education every two years. The AAPC is the world's largest credentialing organization for the business of healthcare, with more than 190,000 members worldwide who work in medical coding, medical billing, medical auditing, clinical documentation improvement, healthcare compliance, revenue cycle management, and practice management. AAPC is nationally recognized by the Center for Medicaid and Medicare Services (CMS) to provide acceptable expertise in coding and claims processing.

Having been a Certified Professional Coder for thirteen years and a Certified Risk Adjustment Coder for four years, I am knowledgeable about medical terminology, disease processes, and pharmacology, and I am highly skilled in classifying medical data from patient records and assigning numeric codes for each diagnosis and procedure. I also possess expertise in:

- Current Procedural Terminology (CPT®), developed by the American Medical Association (AMA), which is a code set to bill services performed by physicians and other qualified healthcare providers in the office or facility setting (e.g., outpatient or inpatient hospital);
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD10-CM), which is a system used by physicians; and
- Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare and Medicaid (CMS) for the same reasons that the AMA developed CPT, which is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

For over twenty years, I have been involved in medical coding and billing for numerous medical practices. In each position I was responsible for designing, implementing, directing, reviewing, and overseeing processes for coding, billing, pricing, and collections. Among other

things, my duties throughout my career have included responding to subpoenas, completing billing affidavits and attesting to the reasonableness of various services and charges.

I am currently employed with Juris Medicus as a Medical Billing and Coding Specialist. My duties include reviewing and analyzing physician and healthcare professional medical billing records and/or facility medical billing records to determine if the charged amount is usual, customary, and reasonable (UCR) based on cost comparisons in the geographic area and determine the anticipated reimbursement rate. I perform my UCR review by evaluating data from industry standard resources such as Optum 360 Fee Analyzer, Find-A-Code, Context4 Healthcare, Novitas-Solutions JH (Texas) Jurisdiction and the Centers for Medicare and Medicaid Services (CMS) by the applicable geographic region. I also provide medical billing expert witness testimony in writing, at deposition, and/or trial as needed.

Most recently, I worked for the University of Texas Health San Antonio (UTHSA) as a Senior Compliance Auditor in the Institutional Compliance and Privacy Office. Part of my duties included coordinating compliance and maintaining current knowledge of applicable federal, state, and local regulations in the use of operational systems for documentation and workflow process for a large medical practice in a healthcare teaching institution; performed workplan risk assessments for various departments and business/clinical operations to evaluate compliance and mitigate risk, informing leadership of risk assessment findings, and advising and assisting in developing a timely corrective action plan; and promoting and maintaining policies and procedures and facilitate education on policies and procedures as required. I also performed quarterly retrospective audits to evaluate coding, billing, and documentation to ensure compliance with the UTHSA Faculty Practice Plan and state and federal regulatory guidelines.

Based on my many years of experience as a healthcare educator, and a consultant, including over thirteen years as a Certified Professional Coder and four years as a Certified Risk Adjustment Coder, as well as my training and education, I am very familiar with all aspects of

medical coding, medical billing, and various payor reimbursement methodologies. Based on this experience, I am also familiar with the typical contractual amounts allowed and amounts paid to providers for professional services in relation to the Medicare, Medicaid and various commercial payers allowable amounts. Most third-party payor claim adjudication policies and their contractual allowed amounts are based on the Medicare fee schedule for the designated service geographic region plus a small negotiated agreed percentage above these Medicare allowed amounts. Further, it is standard practice in my field to consider and rely on such contractually allowed amounts when determining whether a medical bill is usual, reasonable, and customary for the time, date, and location of service.

My twenty plus years of demonstrated professional expertise in medical coding and billing, as well as my knowledge of reimbursement strategies, and my mandated continuous coding training qualify me as an expert with regards to understanding medical documentation and medical billing practices. I have over 27 years of experience in healthcare, including 21 years reviewing medical bills and coding, during which I further developed a fluency in medical documentation and medical billing practices. For many years and on a regular basis, I have performed billing and coding reviews involving the same or similar medical services provided to the plaintiff in this case. In my best estimate, over the course of my career I have reviewed tens of thousands of medical records and billing, which translates to hundreds of thousands of medical billing codes.

A. <u>Summary</u>

I have reviewed the Affidavit of Mireya Trevino, Custodian of Records from North Houston Imaging Center, LTD., dated 07/06/2022, reflecting total charges in the amount of $11,265.00 for services rendered to Plaintiff Jhalen Demming, on 01/20/2022 through 02/11/2022 in Houston, Texas, 77008. Based on my experience, education and training as set

forth above, I am familiar with the usual, reasonable, and customary billing charges and reimbursements in Houston, Texas, 77008 where the medical services were provided.

In summary, it is my opinion, which I hold to a reasonable degree of professional probability, that the charges in the Affidavit in the amount of $11,265.00, exceeded what would be considered the usual, customary, and reasonable ("UCR") amounts for the services provided, the dates of service, and for the geographic region where the records indicate that the services were rendered by **$1,758.26**. I am not offering an opinion as to the necessity of the services reflected in the Affidavit. Rather, my opinions are directed specifically to the comparison of the UCR to the charges billed for those services.

B. Methodology

As part of my UCR analysis and billing and coding review, I first review the medical documentation and medical billing. I compare the billing/coding with the medical documentation to determine if the coding was proper. Uniform coding systems (such as CPT ("Current Procedural Terminology"), HCPCS ("Healthcare Common Procedure Coding System") and ICD ("International Classification of Diseases" coding systems) are used for medical, surgical, and diagnostic services. These uniform systems were developed and published by the American Medical Association and are standardized throughout the country.

This step—identifying the services by their industry standard code—is necessary because the databases of medical charges aggregate charge data according to these industry standard codes. In other words, this step ensures all of the coding and billing provided in the review is correct and supported by the medical documentation. If, in my analysis, I determine that the coding was not properly applied in some fashion, I will note the same. Otherwise, if I determine the appropriate codes were used, my analysis will focus on a comparison of the charges on the billing records with the UCR for the geographic area and date when the services were provided.

To determine UCR charges in my analysis, the resources "Find-A-Code" by innoviHealth and "Context 4 Healthcare" were consulted and referenced. These databases provide medical cost data that is used nationally by insurance companies, medical practices, and hospitals to determine reasonable treatment charges. It is standard and accepted practice in the medical community to rely upon these and other similar databases and resources to set fee schedules, determine the reasonableness of charges, and to evaluate the UCR. In order to correctly utilize the Context 4 and Find-A-Code databases, the user must be proficient in the use of medical coding, including the use of modifiers and when bundling may be appropriate, billing interpretation, and the different medical fee schedules in order to properly and accurate analyze and interpret the data. Because of my background, experience, and training, I am proficient in these skills and completely adept at utilizing the databases and interpreting their data.

i. Find-A-Code Database

Find-A-Code by innoviHealth, is also an online tool for medical coding and billing. Find-A-Code is commonly used within the healthcare payer industry for the purpose of establishing benchmarks by which to filter submitted charges. It has a simple search engine function that can be used to search for the appropriate code to assign to a medical diagnosis or procedure, and that provides the complete definition of the major code sets (CPT, HCPCS, ICD, etc.).

In addition to this and other helpful resources, Find-A-Code also provides UCR data, which is gathered from the U.S. Department of Veterans Administration (the "VA"). The VA's methodology for computing UCR is set forth in 38 C.F.R. § 17.101. The VA's UCR methodology is "designed to replicate, insofar as possible, the 80th percentile of community charges, adjusted to the market areas in which the VA Facilities are located." *See* 74 Fed. Reg. 32820. In general, the VA establishes national reasonable charges which are then adjusted

locally by each VA medical center based on their Geographical Adjustment Factor (GAF). The GAF is a weighted average of the geographic practice cost indexes (GPCIs)--that is, data is collected from each physician or facility payment area and the ratio of area costs to national costs is applied to improve the accuracy of payments to providers in various areas of the country by accounting for the differences in prices for certain expenses (such as clinical and administrative staff salaries, benefits, rent, malpractice insurance and other defined costs). The VA's UCR, as reported by Find-A-Code, represents the geographically adjusted charges at the 80th percentile. In other words, and as mentioned, this means that 80% of the providers in that geographical region charged less than or equal to this UCR amount for the same service or procedure. As also mentioned, use of the 80th percentile for UCR analysis is standard and customary in my industry.

The Find-A-Code tool also provides the Medicare allowable for each service or procedure. While this information is publicly available online at various governmental websites,[1] the Find-A-Code database imports this data and reports it in the search results (appropriate for the date and location of service). Medical professionals and hospital facilities are often contracted with Medicare, insurance companies, or other payers. The medical professional and/or hospital facility may show their standard fees on submitted claims and bills, but they will only be reimbursed the amounts specified in the contracts. It is accepted and standard practice in my industry to consider Medicare allowable rates because they are widely referenced in setting fee schedules, provide a measure of anticipated reimbursement or payment for a service or procedure, and overall, they bear on the question of the reasonableness of the billed amount, regardless of whether the patient has such benefits or the provider has such negotiated rates.

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[1] *See, e.g.*, ww.novitas-solutions.com/webcenter/portal/MedicareJH/FeeLookup; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo.

In a study of data from 2010 to 2017, based upon data from the Kaiser Family Foundation, a nonprofit organization, that serves as a nonpartisan source of facts, analysis and journalism for policymakers, the media, the health policy community and the public, focusing on national health issues, it was found that, on average, private insurers paid 264% of Medicare for outpatient hospital facility services and 189% of Medicare for inpatient hospital facility services, for an overall average of nearly double of Medicare rates for all hospital facility services (199%). For physician professional medical/physician services, private insurance paid 143% of Medicare rates, on average. [2] Accordingly, for purposes of this Counter-Affidavit, I used these average percentages of Medicare to determine the anticipated reimbursement rates for the professional medical services and procedures billed to the plaintiff in this case. However, my opinions about UCR were made without regard for the anticipated reimbursement, and only in comparison to UCR data.

C. Basis for the disputed charges

For my analysis and opinions set forth in this counter-affidavit, I use an average of the UCR data from Find-A-Code. Attached hereto as **Exhibit A** is a worksheet that details my analysis and supports my opinions as stated below. The spreadsheet identifies (a) the medical code for the service provided, (b) the date of service, (c) the provider's charge, (d) the units (if applicable), (e), the UCR obtained from Find-A-Code, (f) the amount each charge exceeds the average UCR (if applicable), and (g) the total amount the provider's charges exceed the average UCR. As mentioned, the worksheet also reflects 143% of Medicare was used to represent the anticipated reimbursement for professional medical/physician services.

Based upon my education, training, and experience, and using the methodology described above, my overall opinions regarding the medical charges in the Affidavit are presented in **Exhibit A and A1** and are detailed below:

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2 *See, e.g.*, https://www.kff.org/medicare/issu e-brief/how-much-more-than-medicare-do-private-insurers-pay-a-

- Based on my review of the records from 01/20/2022, the North Houston Imaging Center, LTD., billing affidavit listed imaging services with CPT codes 72141 (Magnetic resonance imaging; cervical without contrast) and 72148 (Magnetic resonance imaging, spinal canal and contents, lumbar; without contrast material) for a total amount billed of $4,800.00. To determine the UCR charge, I consulted Find-A-Code and Context4's geographical adjustment to Houston, Texas 77008. The average UCR charge for these services is $5,049.71 with an anticipated reimbursement of $609.70. The billed charge is **under UCR** by an average amount of **(-$249.71)** when compared to the UCR charge in the geographic region.
- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., billing affidavit listed injection services with CPT codes 62281 (Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic) and 62282 (Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)) for a total amount billed of $2,400.00. To determine the UCR charge, I consulted Find-A-Code and Context4's geographical adjustment to Houston, Texas 77008. The average UCR charge for these services is $3,686.77 with an anticipated reimbursement of $853.36. The billed charge is **under UCR** by an average amount of **(-$1,286.77)** when compared to the UCR charge in the geographic region.
- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., billing affidavit listed imaging services with CPT codes 71045 (Radiologic examination, chest; single view), 72040 (Radiologic examination, spine, cervical; 2 or 3 views) and 72100 (Radiologic examination, spine, lumbosacral; 2 or 3 views) for a total

amount billed of $600.00. To determine the UCR charge, I consulted Find-A-Code and Context4's geographical adjustment to Houston, Texas 77008. The average UCR charge for these services is $740.38 with an anticipated reimbursement of $159.60. The billed charge is **under UCR** by an average amount of **(-$140.38)** when compared to the UCR charge in the geographic region.

- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., listed additional services with CPT codes 72275 (Epidurography, radiological supervision and interpretation), 77002 (Fluoroscopic guidance for needle placement), and HCPCS codes J2001 (lidocaine hcl for intravenous infusion, 10 mg), J3360 (diazepam, up to 5 mg), J7042 (5% dextrose/normal saline (500 ml = 1 unit)), A4215 (Needle, sterile, any size, each), A4550 (Surgical Tray), for the total billed amount of $2,415.00. These services were disallowed. The use of fluoroscopic guidance, epidurography for needle placement, surgical supplies, needles, lidocaine, saline, and oral medication used during the course of an injection procedure, are all encompassed under the primary services (62281, 62282) and are not separately payable, therefore the total amount billed of $2,415.00 is high by $2,415.00.
- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., listed an additional service with CPT codes 62310 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic), for the total amount billed of $350.00. 62310 was disallowed as this service code was deleted from the CPT coding guidelines on 12/31/2016 and is no longer a billable service, therefore the total amount of $350.00 for 62310 is high by $350.00.

- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., listed an evaluation and management service with CPT codes 99354 (Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services), for the total amount billed of $500.00. 99354 was disallowed as coding guidelines state this service code is reported along with a primary evaluation and management service only (code sets 99202-99205 or 99212-99215). The documentation did not include an evaluation management in addition to the procedure on this same date of service, therefore the total amount of $500.00 for 99354 is high by $500.00.
- Based on my review of the records from 02/11/2022, the North Houston Imaging Center, LTD., billing affidavit listed HCPCS code J0702 (Betamethasone Acetate 3mg) , for a total amount billed of $200.00. To determine the UCR charge, I consulted Find-A-Code and Context4's geographical adjustment to Houston, Texas 77008. The average UCR charge for HCPCS code J0702 is $29.88 with an anticipated reimbursement of $9.68. The billed charge is high by an average amount of $170.12 when compared to the UCR charge in the geographic region.

D. Data

Attached hereto as **Exhibit A and A1** is a worksheet that I prepared that supports my opinions, as stated herein.

Case 12935
Exhibit A Jhlen Demming Affidavit for: North Houston Imaging Center Custodian: Mireya Trevino

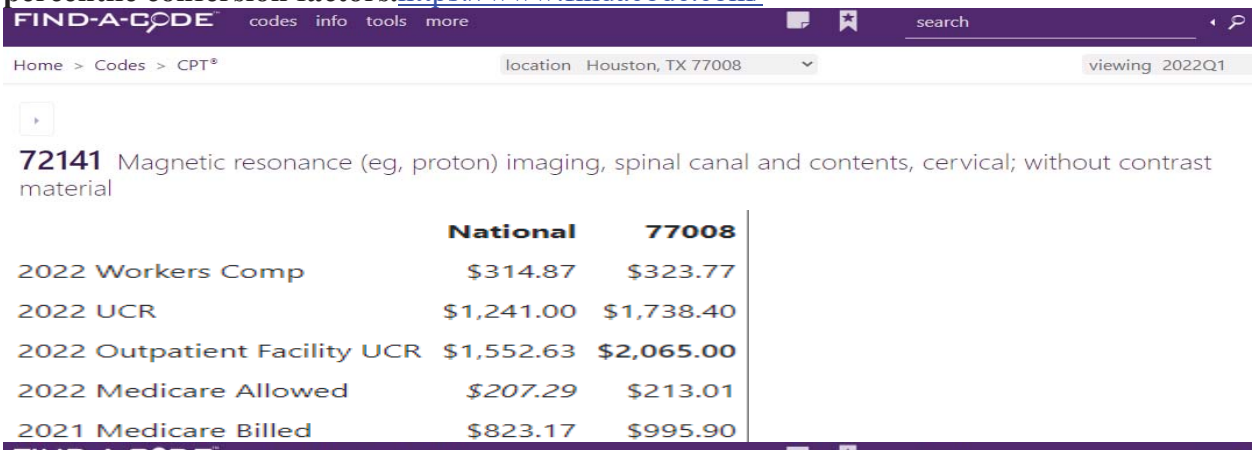
Location	Date of Service	CPT/HCPCS Code(s)	Description	Provider Charges	Find A Code 80th % URC	Context4 80th % URC	AVERAGE TOTAL UCR	Amount Over URC	2022 MCR GPCI Allowable	Anticipated ** 143% of MCR GPCI Allowable
Houston, TX 77008	1/20/2022	72141	Magnetic resonance imaging; cervical without contrast	$2,400.00	$1,738.40	$3,277.26	$2,507.83	($107.83)	$213.01	$304.60
	1/20/2022	72148	Magnetic resonance imaging, spinal canal and contents, lumbar; without contrast material	$2,400.00	$1,741.24	$3,342.52	$2,541.88	($141.88)	$213.36	$305.10
	2/11/2022	62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	$1,200.00	$1,674.55	$1,944.96	$1,809.76	($609.76)	$252.34	$360.85
	2/11/2022	72275	Epidurography, radiological supervision and interpretation	$800.00	$0.00	$0.00	$0.00	$800.00	$0.00	$0.00
	2/11/2022	62282	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	$1,200.00	$2,315.10	$1,438.91	$1,877.01	($677.01)	$344.41	$492.51
	2/11/2022	72275	Epidurography, radiological supervision and interpretation	$800.00	$0.00	$0.00	$0.00	$800.00	$0.00	$0.00
	2/11/2022	71045	Radiologic examination, chest; single view	$200.00	$207.70	$237.83	$222.77	($22.77)	$27.35	$39.11
	2/11/2022	72040	Radiologic examination, spine, cervical; 2 or 3 views	$200.00	$321.50	$176.86	$249.18	($49.18)	$41.95	$59.99
	2/11/2022	72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	$200.00	$324.35	$212.51	$268.43	($68.43)	$42.31	$60.50
	2/11/2022	77002	Fluoroscopic guidance for needle placement	$700.00	$0.00	$0.00	$0.00	$700.00	$0.00	$0.00
	2/11/2022	62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic (DELETED 12/31/2016)	$350.00	$0.00	$0.00	$0.00	$350.00	$0.00	$0.00
	2/11/2022	99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services	$500.00	$0.00	$0.00	$0.00	$500.00	$0.00	$0.00

	2/11/2022	J0702	Betamethasone Acetate 3mg	$200.00	$32.59	$27.17	$29.88	$170.12	$6.77	$9.68
	2/11/2022	J2001	lidocaine hcl for intravenous infusion, 10 mg	$10.00	$0.00	$0.00	$0.00	$10.00	$0.00	$0.00
	2/11/2022	J3360	diazepam, up to 5 mg	$10.00	$0.00	$0.00	$0.00	$10.00	$0.00	$0.00
	2/11/2022	J7042	5% dextrose/normal saline (500 ml = 1 unit)	$10.00	$0.00	$0.00	$0.00	$10.00	$0.00	$0.00
	2/11/2022	A4215	Needle, sterile, any size, each	$10.00	$0.00	$0.00	$0.00	$10.00	$0.00	$0.00
	2/11/2022	A4550	Surgical Tray	$75.00	$0.00	$0.00	$0.00	$75.00	$0.00	$0.00
			TOTALS	$11,265.00	$8,355.43	$10,658.02	$9,506.74	$1,758.26	$1,141.50	$1,632.35

* All Usual Reasonable and Customary (URC) fees are calculated using the 80th percentile of the Find-A-Code/Context4 Healthcare and the appropriate Geographic Adjustment Factor.	** Anticipated fee based on date of service and adjusted to 143% of MCR allowable for the service location (Geographic Practice Cost Index-GPCI).

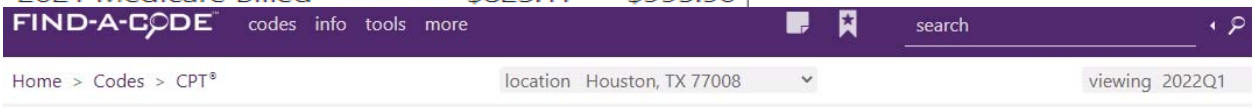
Exhibit A1
Resource(s)

Find-A-Code is an online database of medical billing codes and information. People use Find-A-Code to assign codes to medical diagnoses and procedures to be reimbursed by insurance companies and Medicare (Medicare Administrative Contractor (MAC), Novitas Solutions Part B, Region JH (Region JH includes Texas) fee schedule). Find-A-Code's online libraries included extensive information for all major code sets (ICD-10, CPT, HCPCS, DRG, NDC, and more) along with a wealth of supplemental information such as newsletters and manuals i.e. AHA Coding Clinics, CPT Assistant and Medicare Manuals. All of this information is indexted, searchable, and organized for quick access and extensive cross-reference. **The "100 % pricing" reflects the Geographically-adjusted or national un-adjusted charges *and* the 80th percentile confersion factors.**https://www.findacode.com/



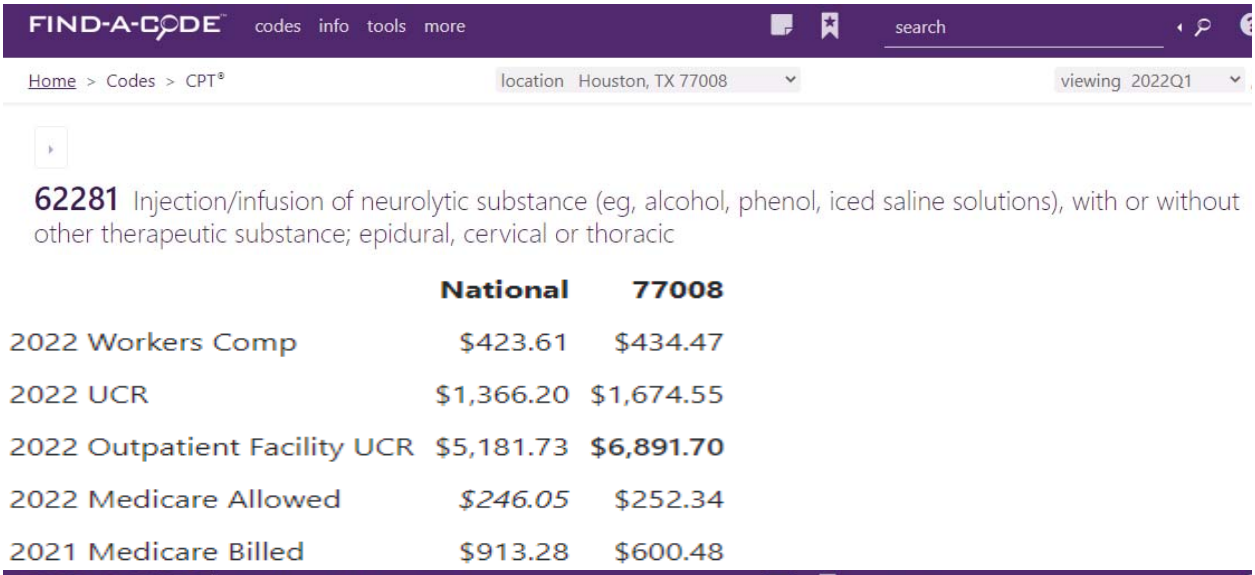
72141 Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

	National	77008
2022 Workers Comp	$314.87	$323.77
2022 UCR	$1,241.00	$1,738.40
2022 Outpatient Facility UCR	$1,552.63	**$2,065.00**
2022 Medicare Allowed	*$207.29*	$213.01
2021 Medicare Billed	$823.17	$995.90



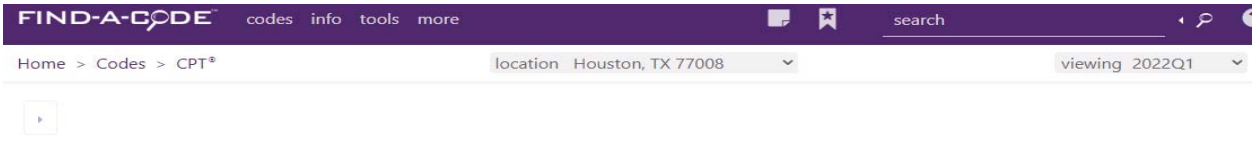
72148 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material

	National	77008
2022 Workers Comp	$315.38	$324.29
2022 UCR	$1,243.03	$1,741.24
2022 Outpatient Facility UCR	$1,552.63	**$2,065.00**
2022 Medicare Allowed	*$207.64*	$213.36
2021 Medicare Billed	$856.69	$1,077.20



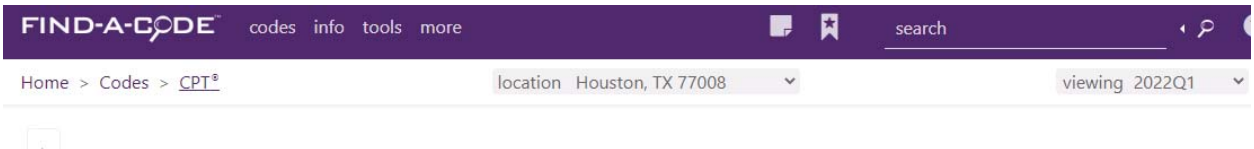
62281 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic

	National	77008
2022 Workers Comp	$423.61	$434.47
2022 UCR	$1,366.20	$1,674.55
2022 Outpatient Facility UCR	$5,181.73	**$6,891.70**
2022 Medicare Allowed	*$246.05*	$252.34
2021 Medicare Billed	$913.28	$600.48



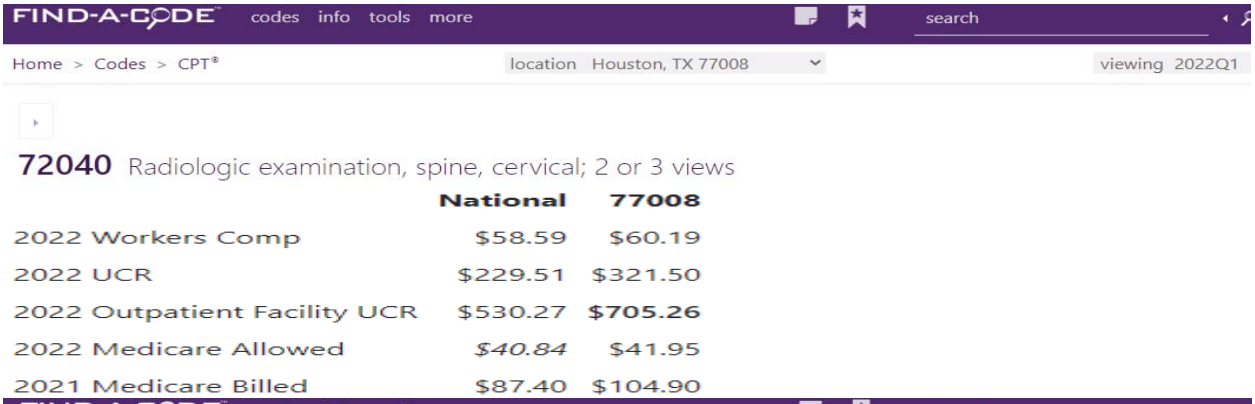
62282 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)

	National	77008
2022 Workers Comp	$577.70	$593.27
2022 UCR	$1,888.79	$2,315.10
2022 Outpatient Facility UCR	$5,181.73	**$6,891.70**
2022 Medicare Allowed	$335.33	$344.41
2021 Medicare Billed	$591.66	*$0.00*

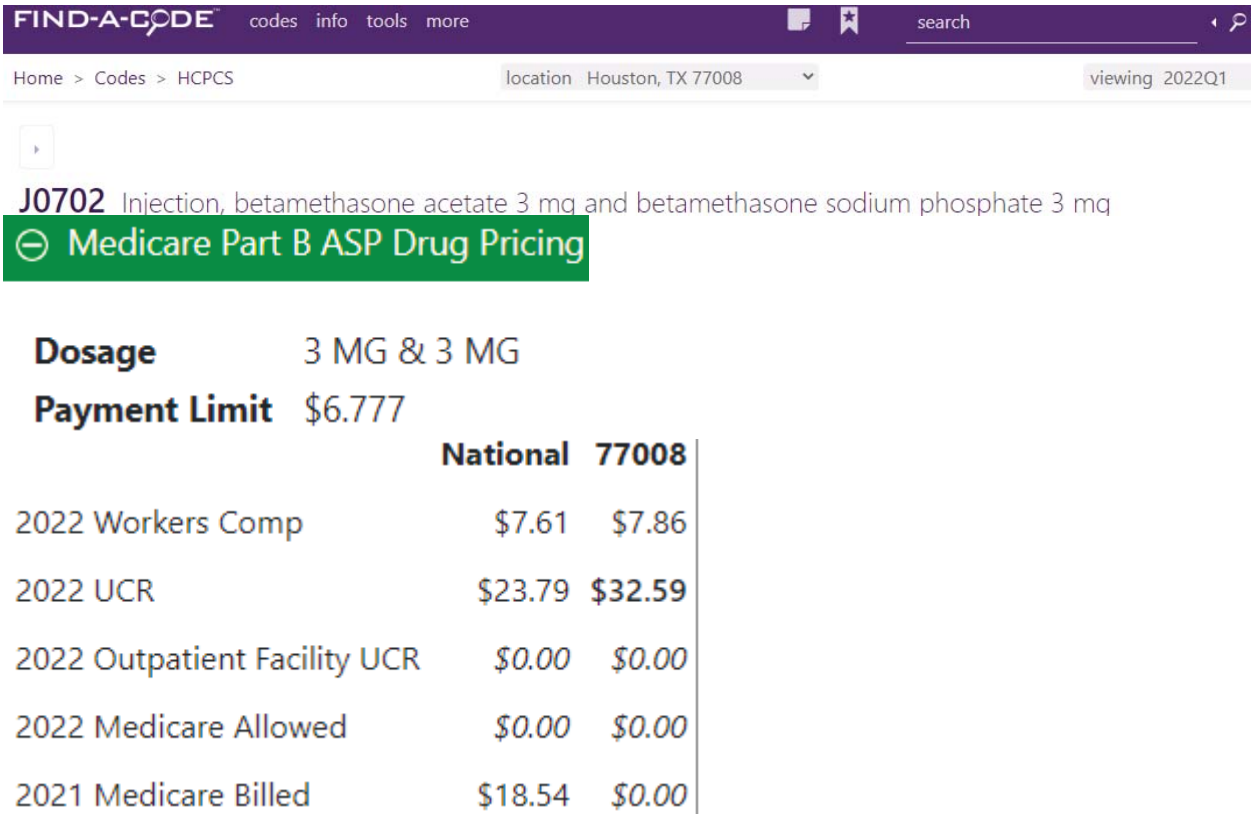


71045 Radiologic examination, chest; single view

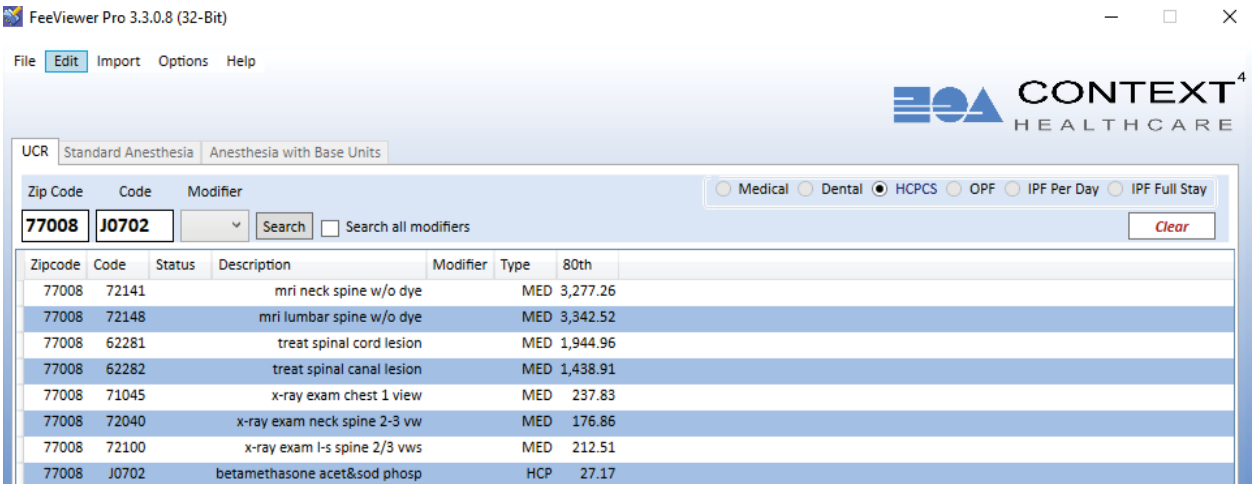
	National	77008
2022 Workers Comp	$38.21	$39.22
2022 UCR	$148.27	$207.70
2022 Outpatient Facility UCR	$530.27	**$705.26**
2022 Medicare Allowed	*$26.65*	$27.35
2021 Medicare Billed	$45.63	$68.29


FIND-A-CODE codes info tools more search
Home > Codes > CPT®
location Houston, TX 77008
viewing 2022Q1
72040 Radiologic examination, spine, cervical; 2 or 3 views
National 77008
2022 Workers Comp $58.59 $60.19
2022 UCR $229.51 $321.50
2022 Outpatient Facility UCR $530.27 $705.26
2022 Medicare Allowed $40.84 $41.95
2021 Medicare Billed $87.40 $104.90


FIND-A-CODE codes info tools more search
Home > Codes > CPT®
location Houston, TX 77008
viewing 2022Q1
72100 Radiologic examination, spine, lumbosacral; 2 or 3 views
National 77008
2022 Workers Comp $59.10 $60.72
2022 UCR $231.55 $324.35
2022 Outpatient Facility UCR $745.75 $991.85
2022 Medicare Allowed $41.18 $42.31
2021 Medicare Billed $91.06 $116.10


FIND-A-CODE codes info tools more search
Home > Codes > HCPCS
location Houston, TX 77008
viewing 2022Q1
J0702 Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg
Medicare Part B ASP Drug Pricing
Dosage 3 MG & 3 MG
Payment Limit $6.777
National 77008
2022 Workers Comp $7.61 $7.86
2022 UCR $23.79 $32.59
2022 Outpatient Facility UCR $0.00 $0.00
2022 Medicare Allowed $0.00 $0.00
2021 Medicare Billed $18.54 $0.00

Context4 Healthcare – The UCR fee data is arrayed in percentiles from the 25th through the 95th. It is also divided by more than 340 geo-zip regions around the country to allow for the regional differences in healthcare costs. UCR fee data is updated semi-annually. This methodology ensures that the UCR fee products represent current provider charges from around the country.



E. Reservation to Supplement

I reserve the right to supplement these opinions, should additional information be made available to me in the future.

Further affiant sayeth not."

Nadine Gonzalez

Signed by: Nadine Gonzalez
Date & Time: May 12, 2023 11:46:47 CDT

NADINE L. GONZALEZ

SUBSCRIBED AND SWORN TO BEFORE ME, by the said NADINE L. GONZALEZ for the purposes herein expressed, on this the 12th day of May 2023.

VERONICA MACHADO HOWSDEN
Notary ID #133426327
My Commission Expires
November 2, 2025

This remote online notarization involved the use of audio/visual communication technology

Notary Public, State of Texas

Nadine L. Gonzalez, CPC, CRC

8711 Heath Circle Drive
San Antonio, Texas 78250
210-831-5309
ngonzalez@jurismedicus.net

SKILLS:

Comprehensive knowledge of coding and reimbursement methodologies; specializing in Pediatrics, Psychiatry, Neurology, and Anesthesiology CPT, ICD-10-CM and HCPCS.

Comprehensive knowledge and experience regarding Medicare and Medicaid, commercial payers' fraud, and abuse, billing processes, understanding explanation of benefits (EOB) language and extensive knowledge in the provider's and payer's contractual obligations.

Extensive knowledge of regulatory state and federal requirements pertaining to documentation and coding guidelines for physician services.

Comprehensive knowledge of and familiarity with determining usual, customary, and reasonable (UCR) fees for medical services.

EDUCATION:

2007 Certificate in Documentation Coding – St. Philips College

2008 Certified Professional Coder (CPC) – AAPC

2018 Certified Risk Adjustment Coder (CRC) - AAPC

EXPERIENCE:

Medical Billing and Coding Specialist
Juris Medicus, LLC
August 2020 – present

- Review and evaluate physician and facility medical billing records to determine if the charged amounts are usual, customary, and reasonable (UCR) based on cost comparisons in the geographic area and to determine the anticipated reimbursement rate.
- Perform UCR review by evaluating resources such as Optum 360 Fee Analyzer, Find-A-Code, Context4 Healthcare, Novitas-Solutions JH (Texas) Jurisdiction, and the Centers for Medicare and Medicaid (CMS).
- Knowledge of all state and federal guidelines for multispecialty coding and billing as it pertains to CPT, ICD-10-CM, ICD-10-PCS, MS-DRG and HCPCS codes reviewed for counter.
- Compose written reports as applicable based on the UCR data and my findings.

Senior Compliance Auditor
UT Health San Antonio, Institutional Compliance and Privacy Office
January 2016— August 2020

- Coordinated compliance and maintained current knowledge of applicable federal, state, and local regulations in the use of operational systems for documentation and workflow process for a large medical practice in a healthcare teaching institution.

- Performed workplan risk assessments for various departments and business/clinical operations to evaluate compliance and mitigate risk, inform leadership of risk assessment findings, and advise and assist in developing a timely corrective action plan.
- Promoted and maintained policies and procedures and facilitate education on policies and procedures as required.

Senior Compliance Specialist
Institutional Compliance and Privacy Office
May 2014—January 2016

- Provided "Basic Evaluation and Management" documentation education and training for all newly hired providers, coders and residents for outpatient and inpatient services for my assigned departments – Pediatrics, Neurology, Department of Medicine, Department of Psychiatry, and the Department of Anesthesiology.
- Performed quarterly retrospective documentation coding and billing audits of outpatient and inpatient services and diagnosis code selection for physicians and mid-levels and coders alike.
- Audit findings were compiled using federal and state payer documentation coding guidelines and shared with the individual provider or coder and their perspective department leadership.
- Reconciled any and all services (E/M and procedures) that were either over or under-coded using the federal and state payer fee schedules and conferred with the Revenue cycle team to begin the process of refunding the payers and/or resubmitting corrected claims for additional monies owed to UTHSA. Reviewed Medicare and Medicaid calculations of anesthesia payments and allowables.
- Perform prospective coding reviews of un-cleared providers to identify educational opportunities and verify coding competency and compliance.

Medical Records Administrative Specialist
PASBA Dept. of the ARMY
February 2010—May 2014

- Performed and planned audits of outpatient encounters to quantify coding agreement between the providers' medical documentation and the final CPT and ICD-9 selection coded and the billing information brought forth in the reporting database.
- Coordinated monthly written mediation and necessary training of the audit findings with the Military Treatment Facilities (MTFs) and their coding coaches, to ensure efficient and effective use of their coding resources
- Actively participated in a staff assistance team with the MTF administration and leadership officer as a coding consultant and trainer, developing new policies and/or procedures relevant to technical and regulatory issues to follow suit with federal coding and documentation guidelines.

Coder and Trainer
Healthcare Resolution Services
July 2008—February 2010

- Coded and audited in four specialty clinics – Cardiology, Gastroenterology, Endocrinology and Diabetes Excellence Clinic at the required 95% facility coding accuracy within the 72-hour turn-around to meet the facility's required billing and revenue standards.
- Provided education to the clinic providers (Staff, fellows, physician assistance, nurses, etc.) on the correct E/M leveling and ICD-9 CM and CPT code selection based on the documentation.

- Finalized all coding and training reports to leadership and presented findings during our weekly coding/auditing meeting and train the clinic providers on better documentation practices.

Coder
Gonzaba Medical Group NW
October 2006—July 2008

- Coded and audited all outpatient services documented and ordered or performed in the clinic by the physicians and mid-level providers of a large primary care clinic that included an Urgent Care/Afterhours clinic, Well Woman Clinic, the Cardiovascular Clinic, and the Podiatry Clinic such as evaluation and management services, lab services, radiology services, minor procedures, and diagnosis code selections.

Medical Billing Specialist/Coder
LoneStar Cancer & Blood Disorder
February 2005—October 2006

- Performed charge entry and coding of patient chemotherapy services, injections, lab, and evaluation and management services.
- Verified any health insurance eligibility and benefits for any new and established patients.
- Obtained referrals and pre-authorizations from the health insurance for all chemotherapy related treatments, injections, inpatient hospital stays and/or diagnostic testing.
- Counseled patients on benefit level for all out-of-pocket costs for their treatment. Collected and posted all monies received to the patients' accounts.
- Daily prepared, reviewed, and transmitted all claims electronically or by mail if required.
- Researched and appealed denied claims from Medicare and Medicaid, commercial payers.
- Assisted patients with insurance questions on claims, out of pocket fees, and pre-authorization status and the application process to obtain financial assistance from a non-profit organization, Patient Advocate System.
- Set-up collections accounting on accounts 90 days and older found delinquent.

Billing Co-Ordinator
PharMerica Pharmacy
April 2004—February 2005

- Billing coordinator for a national long-term care pharmacy overseeing 14 facilities with Medicare and Medicaid census and payor source information for the accurate billing and coding for the medications dispensed daily.
- Completed all billing and prior authorizations for payments of the dispensed medications from Medicare, Medicaid, as well as from commercial health insurance.
- Performed a monthly audit of diagnosis coding assigned to all high dollar dispensed prescription medication paid through Medicaid.
- Processed electronic claims daily, corrected all denials in the adjudication process of claims paid by the private payers and contracted insurances to ensure maximum reimbursement for the medications dispensed.
- Coordinated with our adjudication department for follow-up collections and appeals letters.

Medical Insurance Billing and Coding Clerk
Office of Dr. Rohit Kapoor
August 2002—April 2004

- Medical insurance billing and coding clerk for a high-volume oncologist/hematologist office.
- Performed charge entry and coding review of (over 400 individual line items daily) of patient chemotherapy services, injections, lab services, and evaluation and management services.
- Coded all professional medical hospital inpatient services.
- Verified all health plan(s) insurance eligibility and benefits for any new and established patients.
- Obtained referrals and pre-authorizations from the health insurance for all chemotherapy related treatments, injections, and/or diagnostic testing.
- Performed financial counseling for our patients on their out-of-pocket costs for their treatment.
- Prepared, reviewed, and transmitted/ processed all insurance electronic or paper claims daily.
- Posted all out of pocket monies collected to the patients' accounts.
- Maintained the Medicare and Medicaid aging report to a 60-day limit.
- Researched and appealed denied claims from Medicare and Medicaid, commercial payers.

Business Office Representative
Gonzaba Medical Group - Main Office
October 2001—June 2002

- Performed coding, billing and charge entry review of physician and mid-level evaluation and management services, procedures and diagnosis codes documented in the patient record.
- Verified any health plan insurance eligibility and benefits for any new and established patients.
- Performed insurance pre-authorization and financial counseling with our patients on their out-of-pocket costs for their treatment.
- Prepared, reviewed, and transmitted electronic claims daily.
- Researched and appealed primary and secondary denied claims from Medicare and Medicaid, commercial payers' EOB.
- Reconciled our commercial payers aging report to verify collection of our contracted rates.

Medical Insurance Billing Clerk
Alamogordo Clinic, Ltd.
August 2000—August 2001

- Prepared, coded, and reviewed all billing of outpatient evaluation and management services and diagnosis code selection. Transmitted electronic claims daily. Including paper claims to non-contracted insurance payers, workmen's comp claims as well as claims to secondary and tertiary insurance companies for the primary co-insurance balances.
- Reconciled all insurance denials indicated in the explanation of benefits (EOB) in the adjudication process and resubmitted claims with requested medical documentation to ensure maximum reimbursement. Checked status of any pending claim payments, or unpaid claims. Posted EOB insurance payments and payer adjustments. Verified the health insurance eligibility and benefits for any new and established patients.
- Counseled patients on benefit level for all out-of-pocket costs for their treatment. Collected and posted all monies received to the patients' accounts.
- Worked the front office "Walk-in Clinic" by entering new patient information, verifying all insurance benefits for new and established patients.

Senior Medical Secretary (Temp)
Texas Tech Health Science Center - Dept. of OB/GYN
March 1998—July 1998

- Senior Medical Secretary for two OB/GYN specialists in a large teaching facility. Verified the health insurance eligibility and benefits for new and established patients. Obtained referrals and pre-authorizations from the health insurance for all surgical procedures and/or diagnostic testing.
- Coordinated with patients on their out-of-pocket costs for their medical appointment copays surgical procedure payment responsibilities.
- Transcribed office notes and written correspondence associated with consultation services performed by our OB/GYN providers. Kept and updated the doctor's agendas and travel schedules.

Front Office and Insurance Clerk
Cardiology Care Consultants
March 1996—June 1997

- Verified the health insurance eligibility and benefits for any new and established patients. Obtained referrals and pre-authorizations for all in-office procedures and/or diagnostic testing.
- Coordinated with our patients on their out-of-pocket costs for their treatment as well as their medical appointment copay and/or deductible responsibilities. Assisted patients with any insurance questions on their claims, out of pocket fees, and pre-authorization status. Posted daily charges and payments using Medical Management Plus software.

Switchboard Operator
El Paso Heart Clinic
March 1994—February 1996

- Duties consisted of documenting and relaying all messages to the doctors from our patients, other physician offices, pharmacies, and drug representatives. Set and scheduled patient appointments in the clinic, set patient diagnostic appointments, treatment facilities, and inpatient admissions. Clerked in the afterhours clinic. Handled incoming insurance questions regarding Medicare and Medicaid for patients. Completed all home health agency paperwork for our patients.

Administrative Assistant
Laster & Miller Advertising
June 1989—December 1993

- Administrative duties included report writing, answering client emails, copying, and faxing, and covered reception area. Arranged travel and account meetings for executives. Invoicing clients and posting and reconciling payments. Planned and coordinated the Agency's company events and activities.

OTHER:

American Academy of Professional Coders (AAPC) member

Microsoft Word, Excel, and PowerPoint

MD Audit software; Epic EMR software; MediSoft EMR software; Sunrise Clinic EMR software

Bilingual – English/Spanish

Video Meeting

Video ID: yaYLOsASk4, Recording URL: https://ds4u.cc/yaYLOsASk4, Passcode: 2344