

UNITED STATES DISTRICT COURT  
DISTRICT OF COLUMBIA

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BRIAN HALL )  
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Catlett, VA 20119 )  
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LEWIS RANDALL )  
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JOHN J. KRAUS )  
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)  
and )  
)  
RICHARD K. ARMEY )  
915 Dove Creek road )  
Bartonville, TX 76226 )  
)  
Plaintiffs )  
)  
v. )  
)  
MICHAEL LEAVITT, SECRETARY of )  
the UNITED STATES DEPARTMENT )  
OF HEALTH AND HUMAN SERVICES )  
615F Hubert H. Humphrey Building )  
200 Independence Avenue, S.W. )  
Washington, DC 20201 )  
)  
and )  
)  
MICHAEL J. ASTRUE, COMMISSIONER of )  
the SOCIAL SECURITY ADMINISTRATION )  
6401 Security Boulevard )  
Baltimore, MD 21235-7703 )  
)  
Defendants. )

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CIVIL ACTION  
NO. 1:08-cv-01715-RMC

DECLARATION OF  
GABRIELLE M. KOTOSKI

NOW COMES GABRIELLE M. KOTOSKI, and for her Declaration states as follows:

1. My name is GABRIELLE M. KOTOSKI; I am a Registered Nurse and President of Medical Communications Management Group, a professional group of independent associate consultants who provide analytical, educational and consulting services for health care providers and payers to achieve appropriate coding and payment for health care services. I am a health care reimbursement specialist, and am recognized nationally for my expertise in claims analysis, coding and billing for purposes of Medicare. My curriculum vitae is attached hereto and is incorporated herein as though set out at length verbatim. I reside at 4819 Summerlin Road, Albuquerque, New Mexico, 87114.
2. Having served as a professional in the field of claims analysis, coding and billing for Medicare for many years, it is my considered opinion that medical services/benefits under Medicare are inferior to medical services/benefits individuals are willing to pay for themselves. Individuals who have health insurance benefits superior to, or substantially better than, Medicare or have significant savings that they are willing to use for medical care should be free to make that choice. Simply speaking, Medicare promises coverage for almost everything, but it does not deliver that coverage to its beneficiaries. It has to limit access to and ration care to control its massive, growing costs.
4. The Medicare program is fiscally insolvent. In calendar year 2008, Medicare's Hospital Insurance ("HI") Trust Fund was expected to pay out more in hospital benefits and other expenditures than it received in taxes and other dedicated revenues. The Medicare Trustees have estimated that the Federal Hospital Insurance Trust Fund will be **insolvent** by 2019.<sup>1</sup>

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<sup>1</sup> *Status of the Social Security and Medicare Programs, A Summary of the 2008 Annual Reports* (Online). Social Security

5. As a consequence, Medicare constantly struggles to avoid accelerating its expected insolvency. Thus, like any other government-run program, Medicare functions through the use of force: controls, threats, limitations on physician and patient freedom, and often draconian penalties for innocent mistakes. Through internal medical coverage policies, claim denials for lack of medical necessity and other mechanisms, Medicare limits its costs by limiting the medical care beneficiaries can get and the options they have.
  
7. Physicians are the initial source of virtually all medical evaluations and are the decision-makers regarding diagnostic and treatment options. With ever increasing knowledge of the items and services for which Medicare will not pay, I have observed that physicians have become increasingly hesitant to offer some or all of them to their Medicare patients. Hence, beneficiaries who otherwise might be interested in at least hearing about all options open to them for diagnostics and treatment might never learn about some of them. Compared to the medical items and services that people who are willing to pay for themselves could be offered or would receive, those offered by Medicare are tragically inferior.
  
8. When physicians are aware that patients a) want to know all diagnostic and treatment options available to them, b) want to make their own choices about their medical care based on the risk/benefit analysis and their ability to pay for a particular treatment (e.g., their insurance will pay for the care and/or the patients are willing to pay either alone or to supplement their insurance), the physician is free to practice medicine and work in *exclusive* partnership with his patient, offering all he/she determines to be best for the patient and unhampered by Medicare. That is how medical care, ethically and morally,

should be provided.

9. In an effort to reduce out-of-control inpatient hospital costs, Medicare replaced its former cost-based payment with Diagnosis Related Groups (“DRGs”) in 1983. Under this scheme, Medicare pays a flat rate for virtually all items and services provided by the hospital during the patient’s hospital admission based on the patient’s principal diagnosis upon discharge. Each DRG is assigned an average Length of Stay (“LOS”) and relative weight which is used to determine the payment the hospital will receive. With few exceptions, the hospital receives no additional payment if the patient stays longer than the LOS even if additional complications develop during the stay that were not recognized upon admission. On the other hand, if the patient is discharged earlier, the hospital retains the difference.
10. I have observed that DRGs are hazardous to Medicare patients. Hospitals are incentivized to a) discharge the patient as early as possible and b) to cut costs by always providing the cheapest alternative for everything from supplies to nursing care. It follows that hospitals *are not* incentivized to provide optimal care for as long as the patient needs it and until the patient is fully ready for discharge. Not infrequently, patients who are seriously ill can be discharged to a lower level of care setting or even to home despite the fact that they require a level of care available only in the acute care hospital.
11. For example, a recent case in the Midwest, the facts of which I am personally aware, involved a seriously ill diabetic Medicare patient one day removed from a long intensive care stay, still in kidney failure, unable to eat, still on antibiotics for a life-threatening systemic/septic infection, where the case manager approached the spouse to discuss discharging the patient *to home* within two (2) days. Physicians on the case did not

intervene to prevent this appalling decision and were absent from the case for days, seemingly oblivious to the situation, I believe, possibly because of hospital pressure to get rid of “this case.” Had not the spouse expressed outrage and taken action to prevent the discharge, the patient might have died.<sup>2</sup>

12. In another recent case, about which I am also personally aware, a Medicare patient, this time in the Southwest, with a serious digestive condition and lymphoma had been in the hospital two (2) weeks, some days in excess of the average length of stay (LOS). No preparations for discharge had taken place (training in tube feeding, etc.) when the spouse was asked to look at four (4) nursing homes in the area as soon as possible because discharge was imminent. Surprised, he carefully checked each one out, but came to the conclusion that none was acceptable or even safe. With continued pressure from the hospital to move the patient to a nursing home, he informed the hospital he intended to ask for a second opinion—from the state’s largest law firm. The hospital backed down.<sup>3</sup>
13. From my experience observing the Medicare payment system, the foregoing cases are neither unique nor rare, but in both cases the patients are surviving today because a dedicated spouse was successful in persuading the hospital to incur additional costs for which it would not be paid. The lives of Medicare patients living alone without such a spouse or other loved one to intervene are at far greater risk.
14. In both of the foregoing cases, the beneficiaries would have been financially able to pay for additional days in the hospital, having prudently saved and invested over the years. However, they and all other Medicare beneficiaries are prohibited from doing so *because the government prohibits private contracting with providers under 42 USC § 1395a(b)*.

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<sup>2</sup> Personal communication, September 2008.

<sup>3</sup> Personal communication, October, 2008.

Hospitals are not allowed to charge the beneficiary directly for any covered service (save the deductible), but must submit all charges to Medicare for reimbursement, regardless of the length of stay or cost. Hence, Medicare policies and procedures are unquestionably a threat to the lives of Medicare patients.

15. Contrast the above situation to individuals not on Medicare who have excellent insurance benefits and/or who are willing to pay for care themselves. Freed from being subject to a system like Medicare, these people are free from the threat to their lives imposed by the high-risk DRG payment system.
16. Medicare accomplishes its cost-cutting efforts through multiple mechanisms. Each contributes to making Medicare an inferior and, in some cases, an unsafe product for beneficiaries. Those cost-cutting saving mechanisms are:
  - The Medicare-physician fee schedule;
  - Onerous regulations and physician documentation and billing requirements as well as threats of audit and prosecution for fraud and abuse of the Medicare program for mistakes; and
  - Medicare coverage policies that have never been directly disclosed to Medicare beneficiaries and “medical necessity” claim denials.
17. Access to care can be determined by whether (a) physicians, such as primary care physicians or certain specialists, are available in a patient’s community; b) physicians are accepting Medicare patients; c) certain diagnostic or therapeutic procedures are available or, more importantly, have been offered to the patient; or c) individualized treatment is available or provided to the patient.
18. Through legislation and internal coverage policies written to limit costs and drastically reduce utilization of services, Medicare adversely and seriously affects every aspect of

access to care. Regarding item (a) for example, I am aware that many physicians have already retired or are in the process of retiring because of Medicare's continuous and growing demands and intrusions in their delivery of care and their billing processes. For many, the National Provider ID requirement was the last straw because it enables government to more closely monitor all future physician behavior and prescribing, forcing compliance with government dictates and enabling punitive action. The loss of experience and knowledge these retired or retiring physicians possess is a loss not only for beneficiaries, but for entire communities because fewer physicians are left behind to serve the same size population. In this regard, Medicare and government intrusion affects every American citizen.

20. Too, physicians increasingly cannot afford to treat Medicare beneficiaries. The fees that Medicare pays physicians are among the lowest in the nation with the exception of fees paid by State Medicaid (Medical Assistance) programs. As an example, Medicare's fee for a total knee arthroplasty for which the surgeon's charge may be \$6,000.00 is approximately \$1,193.00, a shockingly low fee for the extensive work and expertise required for this procedure. Or, consider a breast needle biopsy performed by a radiologist using ultrasound guidance. The physician's fee might be \$1,500 *but Medicare's allowable would only be \$107.38*. This procedure requires at least three quarters of an hour's time plus effort, including prior training and experience, that requires locating the mass in the image and then insertion of a needle to precisely capture the biopsy sample.
21. Almost every year, Congress reduces physician fees in an attempt to reduce Medicare costs, only to eliminate part or all of the reduction after outrage, threats of leaving the program, and outright begging from physicians.

22. “Participating” physicians contractually agree to accept Medicare’s “allowed amount,” the published fee, as payment in full for their services. “Non-participating” physicians, by law, cannot charge a Medicare patient more than 115% of 95% of the allowed amount (known as the “limiting charge”) for their services. *Under the law, neither category of physician is allowed to accept more from the patient than these charges. Even if offered by a patient willing to do so, the physician must refuse to accept any payment above the amount established by Medicare.*
23. Low payments and threats of impending reductions from Medicare are a deterrent to physicians seeing Medicare patients. Physicians whose Medicare caseload may be as high as 30%, must see more patients each day to generate the income they need to operate their practice profitably and support themselves. Physicians who can reduce the number of Medicare patients and replace them with a smaller number of higher-paying, private-pay patients will do so because they can, therefore, render a higher level of care to their patients. I have observed that more physicians are making this choice and are closing their practices to new Medicare patients. There are many primary care physicians in my own community, City of Albuquerque, New Mexico, but only four (4) of them are accepting new Medicare patients. Of those four, two (2) are not far from retirement and the other two (2) are new in practice. As further evidence, the American Academy of Family Physicians has published vivid testimonials from doctors in sixteen (16) states that amply demonstrate the scope of this problem. See <http://www.aafp.org/online/en/home/policy/federal/legislation-endorsements-and-letters-to-congress/sgrtestimonials.html>
25. Physicians are also opting out of Medicare altogether. Agreeing not to bill Medicare for two (2) years under 42 USC § 1395a(b), these opt-out physicians have spoken out and

written elatedly about their release from Medicare claims and pressures. Medicare beneficiaries can be treated by opt-out physicians, but neither the doctor nor the patient can bill Medicare for the service. The beneficiary must pay out-of-pocket for the physician's service.

26. Now contrast the above to a patient who would be free to contract with the provider and be willing to pay for the services himself or whose insurance is superior to that offered by Medicare. The physician may agree to accept the insurer's payment as payment in full or, alternatively, agree to accept a premium from the patient or all of the payment from the patient. In such an arrangement, there is no coercion involved on either side. Each person trades with the other to mutual advantage. And, access to care for the patient is a non-issue.
27. As discussed earlier, physicians are limiting their availability to Medicare beneficiaries by closing their practices to new Medicare patients because they cannot afford Medicare's low payments. But there are other reasons to close a practice to these patients. Medicare patients can pose a serious threat to a physician.
28. Always under the threat of audit, fraud or abuse investigations from Medicare or law enforcement, physicians who consent to treat Medicare patients must conform to a myriad of rules when billing their services. For example, they must document their services to meet the definition of each billing code they submit on a claim (including special, detailed documentation requirements for *every* visit), obey all rules for using the billing codes, select the correct diagnosis code for each diagnosis being treated and be certain the diagnosis code *matches* the billing code for logic and clinical relevance and meet Medicare's internal coverage policies. These are a daunting *additional* set of bureaucratic requirements to meet *while focusing on a far more valid and moral goal:*

*that of assessing and treating a patient.*

29. Innocent errors can result in monetary sanctions or even criminal prosecution. A serious Medicare and/or FBI audit of claims and documentation can literally destroy a physician's practice, his financial security and his life. It is no wonder that opt-out physicians or others who no longer see new Medicare patients are relieved.
30. Few Medicare beneficiaries have any idea of the extent of these requirements and the additional pressures they exert on each physician who chooses to treat them. Further, few know how such a threatening environment serves to limit their access to physician care.
31. Again, for patients who would be free to contract with each physician, no such regulations and corresponding threats would apply. Except to the extent that insurers would, upon their request, need to be able to see medical record evidence that the services were rendered, the physician and patient would be free to work together without the threat of those onerous requirements. In these cases, access to care for the patient is simply a factor of physician availability and patient choice of services based on his/her desires and financial ability to pay for them.
32. To understand these Medicare methods to ration care, it is important to understand several key concepts. First, Medicare's formal "non-covered" services are virtually identical to those that are not covered by most health insurers. They are specifically stated in the Medicare Act. An example is cosmetic surgery. Next, one must grasp the distinction between Medicare's "formal" *covered* benefits, as stated in the Medicare Act, and its internal medical coverage policies. The coverage policies are subsets of the formal "covered" benefits.
33. The chief methods of "training" physicians to willingly select diagnostic or treatment

alternatives Medicare will pay for and to withhold options they won't pay for are comprised of "medical necessity" claim denials and the medical coverage policies upon which the denials are based. The sad result is that beneficiaries now have limited choices of diagnostics and treatments, and individualized therapy/management is no longer available or is strictly limited.

34. "Medical necessity" is a Medicare term based on a provision in the Medicare Act (Title XVIII of the SSA)<sup>4</sup> which states that no Medicare payment shall be made for "items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Unfortunately, "medical necessity" *has never been defined* by any government agency or official. Therefore, there are no objective measures to determine what it means; each bureaucrat or contractor<sup>5</sup> can, and often does, define it subjectively to suit his or her or the agencies' objectives.
36. In 1989, the Health Care Financing Administration ("HCFA"), predecessor agency to the current Center for Medicare & Medicaid Services ("CMS"), proposed a rule defining it, but the rule was never finalized. "So, in practice, the Medicare bureaucracy and its contractors often deny payment for medical services...even if the services are formally 'covered' by Medicare. Based on a Heritage Foundation study (Heritage *Backgrounder* No. 1295) and HCFA statistics, nineteen percent (19%) of all denied claims were denied because of "medical necessity." If one excludes those medical services which are denied because of "statutory exclusion," that number rises to forty-five percent (45%). Medicare contractors have denied payment for preoperative electrocardiograms,

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<sup>4</sup> Social Security Act §1862(a)(1)(A).

<sup>5</sup> Contractors are private organizations that contract with the Centers for Medicare and Medicaid Services to process Medicare claims. Examples are Blue Cross Blue Shield plans, Cigna, Trailblazer Health.

treatment of precancerous skin lesions, and even the use of anesthesia in certain cases.”<sup>6</sup>

37. A “coverage determination” is a written policy that either originates in CMS offices in Baltimore as a national policy (“NCDs”) or at any contractor office at the local level as a local policy (“LCDs”). These policies specify the condition or circumstances under which an item or service will or will not be reimbursed (covered). *They state the conditions under which an item or service will be deemed to be “medically necessary.” They are of crucial importance.*
38. On the national level, CMS periodically publishes National Coverage Decisions which must be observed by all its contractors<sup>7</sup>. Relatively small in number, the policies commonly focus and interpret the formal covered benefits provided under the Medicare program.
39. At the local level, Medicare contractors develop LCDs for those items and services that are not addressed by the NCDs. The number of policies is large and growing larger. Because of their number, these policies are *chiefly responsible for claims being denied for lack of “medical necessity.”* Disturbingly, these policies can and do vary from region to region with one contractor allowing payment and another denying it. For example, in a DHHS Office of Inspector General Report: “Medicare Payments for Surgical Debridement Services in 2004,” twelve (12) of seventeen (17) carriers [contractors] “had at least one LCD that addressed surgical debridement services. The remaining five (5) carriers did not...” The report goes on to detail the variances in policy coverage among the twelve (12) carriers and noted that one (1) carrier had an

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<sup>6</sup> Moffit, R. *AAPS News* (Online) <http://www.aapsonline.org/newsletters/jan00.htm> [06 Dec 2008]

<sup>7</sup> Contractors for Medicare Part A are called Fiscal Intermediaries and for Part B, Carriers. They have now largely become legacy Contractors under the umbrella of new, regional Medicare Administrative Contractors [MACs] mandated by the law that established Medicare Administrative Reform. Among other duties, Contractors process over \$700 million in health care claims each business day.

LCD that “was significantly different from the other eleven (11) carriers’ LCDs. For additional details, see the Report, page 11.<sup>8</sup>

40. One LCD currently in force for the use of biologic wound products (skin substitutes that are used to temporarily cover chronic or burn wounds) states that any use not indicated by the Federal Food and Drug Administration (“FDA”) product literature is not considered reasonable and necessary and is therefore not covered by Medicare. Hence, any use other than that stated in the FDA-approved product literature is not covered. Such is blatant rationing of care. For decades, physicians have legally made off-label use of substances, materials, and drugs that they determine, on an individual basis, would be effective for a specific patient. Many, many patients have been and currently are the beneficiaries of off-label use and prescribing. Medicare, though, will not allow seniors to be among those beneficiaries.
41. Another current LCD allows the use of the drug Leukine (“GM-CSF”) for its FDA indications only. The indications are generally limited to treatment of neutropenia and support for bone marrow transplants. However, numerous noted studies and current accepted therapy have shown it to be effective alone or in combination with other drugs against advanced and otherwise untreatable prostate cancer. The drug is very expensive, over four thousand dollars (\$4,000.00) per month. Based on the LCD, Medicare would not cover this individualized treatment for prostate cancer regardless of the fact that the prostate cancer might be arrested in a durable remission or held in check by the therapy.
42. Both of the foregoing therapies, among many others, would be denied as not “medically necessary” if provided for other than the indications listed in the policies.
43. A Medicare denial for lack of “medical necessity” typically cannot be billed to the

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<sup>8</sup> *Medicare Payments for Surgical Debridement Services in 2004* (Online). Department of Health and Human Services, Office of Inspector General. <http://www.oig.hhs.gov/oei/reports/oei-02-05-00390.pdf> [10 Dec 2008]

patient *unless* a) the provider *accepts assignment*<sup>9</sup> on the claim *and* b) the patient has signed an Advance Beneficiary Notice (“ABN”) agreeing to pay for the service if Medicare denies it as not “medically necessary” or the patient has refused to sign the ABN.<sup>10</sup> Providers who *do not accept assignment* cannot bill a patient who has refused to sign an ABN in these circumstances.

44. But providers often do not know when such a denial will occur, typically learning of it only after the fact. Once the denial has occurred a few times, the provider may establish a policy to have the patient sign an ABN. Alternatively, if other “medically necessary” treatment options are sanctioned by a coverage policy, the provider may not even mention the “medically unnecessary” treatment option to the patient.
45. But what if the denied treatment is one that the physician thinks might have been better for the patient? In elective situations, the patient may or may not be informed of the better option. The physician’s integrity, risk tolerance and willingness to risk a financial loss determine whether or not the patient is informed. In an emergency situation, the determinants are the same but can be complicated by the availability of the diagnostic or therapeutic option selected.
46. On the other hand, what if the patient is told about the better treatment option and wants it? An ABN, *correctly executed*, must be submitted for the item or service *every time* it is provided. An exception applies for a series of treatments. Each time the series is to be repeated, another ABN is required. However, too many ABNs will likely cause Medicare to threaten the physician with sanctions for “systematically” performing care that is not “medically necessary.”

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<sup>9</sup> “Accepts assignment” means the provider agrees, on the claim, to accept Medicare’s allowed amount for the item or service as payment in full.

<sup>10</sup> WPS [Wisconsin Physicians Service] Medicare Part B Claims “Waiver of Liability” (Online) [http://www.wpsmedicare.com/part\\_b/business/waiver\\_liability.shtml](http://www.wpsmedicare.com/part_b/business/waiver_liability.shtml) [06 Dec 2008].

47. Patients cannot contract separately with the provider to eliminate the ABN requirement that stands as a barrier to entry to obtaining the treatment both the physician and patient desire.
48. Medicare's coverage policies and "medical necessity" denials ration medical care for Medicare beneficiaries, making Medicare an inferior program at best.
49. For an individual who would be free to contract with the provider and be willing to pay for the services himself/herself or whose insurance is superior to Medicare's, there would be no such restrictions. The physician may agree to accept the insurer's payment as payment in full or agree to accept part or all of the payment from the patient. Access to care and rationing is not a concern.
50. Unquestionably, medical services/benefits under Medicare are inferior to medical services/benefits individuals are willing to pay for themselves. Individuals who have health insurance benefits superior to, or substantially better than, Medicare, or have significant savings that they are willing to use for medical care should be free to make that choice. To force an individual to take Medicare benefits that he/she does not want or need is morally wrong on its face. But to additionally penalize him/her tens of thousands of dollars by taking his/her Social Security if he does not take those benefits is outrageous. It forces him/her into a second tier, government-controlled health care program and he/she is then forced to accept the limitations imposed by the government. He/she no longer has freedom to choose the care he/she alone desires and wishes to pay for.

I declare under penalty of perjury that the foregoing is true and correct.

12/29/2008  
Dated

/s/ Gabrielle M. Kotoski  
GABRIELLE M. KOTOSKI

/s/ Frank M. Northam  
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## MEDICAL COMMUNICATIONS MANAGEMENT GROUP

### **CURRICULUM VITAE**

**GABRIELLE M. KOTOSKI, RN** is president of Medical Communications Management Group, a professional group of independent associate consultants providing analytical, educational and consulting services for health care providers and payers to achieve appropriate coding and payment for health care services. She and her associates have worked with payer, legal, physician, facility, and corporate clients throughout the mainland United States, Hawaii, and Guam, including large multi-specialty clinics and university faculty groups as well as medical/surgical specialty associations, commercial insurers, IPAs, managed care plans, and the Blues. She is a healthcare reimbursement specialist, recognized nationally for her expertise in claims analysis, coding and billing for optimal, appropriate payment.

Ms. Kotoski is the author of a number of publications, among them "*CPT Coding Made Easy: A Technical Guide*" (1989-2005, Aspen Publishers & MCMG Multimedia Publishers), an annually updated clinical coding and billing reference for physician, outpatient hospital and ambulatory surgical center reporting. Its thousands of pages were available in print for 11 years and then converted to electronic media only. In addition to authoring several other books—*Coding Answers for Optimal Physician Payment* and *Physician Documentation for Reimbursement (co-author)*—Ms. Kotoski authored and annually updates (2000-2008) the American Burn Association's *Coding and Reimbursement Primer*, which is distributed to all burn surgeons and burn centers in the U.S and member/burn centers in Canada. Ms. Kotoski has served as Consulting Editor for Aspen Publishers, Inc., a member of the worldwide Wolters Kluwer group and has authored numerous, peer-reviewed clinical coding articles that have been published in the American Medical Association's official coding publication, *CPT Assistant*, since 1996.

Using her expertise in Medicare, federal regulations, and information sources, she was principal consultant for an international firm in the design, development, and continuous updating of a web based & CD-ROM library containing over 290,000 pages of all Medicare, Medicaid, CHAMPUS, and CMS related regulatory documents.

Ms. Kotoski has worked extensively with clients, providing them with the clinical knowledge and reporting skills necessary for legitimate, accurate claim payment to achieve optimum savings. She has trained physicians and facility coding staff in key techniques for analysis of documentation to identify billable services and with physicians to document all those services. Using her expertise in health care reporting, she has worked with third party payers to identify and eliminate potentially fraudulent billing practices while accurately and appropriately adjudicating claims payment for all billed services. Ms. Kotoski has also served as expert consultant in various types of litigation including, but not limited to, Qui Tam, fraud and abuse, patent infringement, and defamation.

During the past thirty years, she has worked for and consulted with a number of reimbursement entities, including Blue Cross Blue Shield plans, commercial insurers, and managed care plans. During that period, she developed a clinical training program for a Blue Shield plan, was medical policy development analyst, administered utilization review and performed medical claims review. Over a two-year period, she also continued her clinical nursing experience in the operating theatre. Prior to and following the establishment of Medical Communications Management Group, she taught extensively throughout the nation, providing CPT/HCPCS/ICD-9 coding seminars for physician groups, facilities, payers and other health care organizations.



## MEDICAL COMMUNICATIONS MANAGEMENT GROUP

### **Gabrielle M. Kotoski, RN PUBLICATIONS**

#### **Books**

Kotoski, GM. *CPT Coding Made Easy: A Technical Guide*. Gaithersburg: Aspen Publishers, 1991-2000 (Print). Converted to CD-ROM & web database product, MCMG Multimedia Publishers, 2001-2005.

Kotoski, GM. *CPT Coding Made Easy: A Technical Guide*. Chicago: PMMC, 1989-1991.

Kotoski, GM. *Coding Answers for Optimal Physician Payment*. Gaithersburg: Aspen Publishers, 1994.

Kotoski, GM, Stegman, MS. *Physician Documentation for Reimbursement*. Gaithersburg: Aspen Publishers, 1994.

Kotoski, GM, Granucci, S., Seigal, BA. *The Claims Examiner Manual: Coding & Payment Guidelines*. Albuquerque: MCMG, 1992-1999.

#### **Journals, Other**

Kotoski, GM. "Surgery's black hole: Is it consuming your practice?" *American College of Surgeons Bulletin* 79 (1993) 34-36.

#### **Articles: CPT Assistant,<sup>11</sup> American Medical Association 1996-2005**

Coding TIPS: Transjugular Intrahepatic Portosystemic Shunt. (10/96)

Anesthesia: Coding for Procedural Services (2/97)

Sentinel Node Biopsy (7/99)

Arteriovenous Fistulae for Hemodialysis: Treatment of Complications (2/97)

Lymphoscintigraphy for Sentinel Node Biopsy (12/99)

Consultations—Answers to Perplexing Questions (8/01)

Cryosurgical Ablation of the Prostate (9/02)

Radiofrequency Ablation of Liver Tumors (10/02)

Nails (12/02)

Laparoscopic Nissen Fundoplication (12/02)

Evaluation and Management: Time as Controlling Factor (10/03)

Trabeculectomy (7/03)

Implantation Glaucoma Drainage Device: Aqueous Shunt , Part I (8/03)

Implantation Glaucoma Drainage Device: Aqueous Shunt , Part II (9/03)

Time-Based E/M Services (10/03)

Combined Cataract Extraction and Glaucoma Surgery (11/03)

Skin Biopsy Guidelines (10/04)

Modifier 25 Part I (11/04)

Modifier 25 Part II (12/04)

Wrist Arthroplasty (12/04)

Coding Communication: Allergen Immunotherapy (2/05)

Breast Reconstruction (8/05)

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<sup>11</sup> Official coding publication of the American Medical Association. By federal regulation, CPT Assistant is the official coding guideline reference for the CMS (Center for Medicare Services) Hospital Outpatient Prospective Payment System (HOPPS).



## MEDICAL COMMUNICATIONS MANAGEMENT GROUP

### **Private Publications**

*Coding and Reimbursement Primer*, specialty-specific private publication of the American Burn Association, Chicago, Illinois. Updated annually to be current with all coding and regulatory requirements. 2000-present.

Billing, coding and reimbursement manuals. Basic, advanced, and specialty-specific for multiple organizations in confidential and/or work-for-hire publications.