WWW.PUGETSOUNDADJUSTERS.ORG May 2021 Vol. 10 No. 9

PSAA
Puget Sound Adjusters Association

~ Our Mission ~

"A professional organization dedicated to the ongoing education of the claims community. Providing an arena for member interaction and the sharing of resources."

Next Zoom Meeting: May 21, 2021
See below for details and also on page 2

Join Others Via Zoom Friday, May 21

RSVP to info@pugetsoundadjusters.org

PSAA is hosting another joint Zoom meeting this month. Please mark your calendar for **Friday, May 21, 2021, at 1:00pm.**

Meeting Presentation

By Roger Howson, Claims Dispute Resolution, PSAA Past President & Education Chair

At the risk of igniting volumes of vitriol over pandemic politics, the PSAA meeting on Friday, May 21st has empanelled adjusters (both independent and public) and contractors to discuss the phenomenon of escalating repair costs due to the pandemic, and the insurance industry's many challenges in accounting, accommodating, and managing those cost increases.

We are hearing from policyholders, adjusters, and contractors complaining about the unprecedented increase in material and labor costs, subcontractor quotes, and prolonged delays due to disruptions in the global supply chain.

This is a new problem that may not be all that new, but it is different. The insurance industry is used to material and labor cost increases after catastrophic events. The wildfires of California, Oregon, and parts of Washington are a recent example. Supply and demand drive the economic model. Catastrophe adjusters contend with a combustible combination of legitimate price increases, wanton price gouging, and outright fraud... whether wildfires, hurricanes, tornadoes, windstorms, snowstorms, or freezes.

However, the Coronavirus is a global disruption the world has not seen on this scale in one hundred years.

- Brandi's husband Matt is a longshore mechanic at the Port of Tacoma, and he says there is now a worldwide shortage of shipping containers, some ports are unable to offload ships due to localized pandemic restrictions, and other ports lack enough qualified personnel to accomplish the dangerous work of loading and unloading container ships. In other words, products, materials, and component parts are held up for any number of reasons.
- Auto manufacturers have tens of thousands of vehicles fully assembled and ready for delivery except for the critical absence of the computer chips that enable those vehicles to function. Taiwan produces all the silicon chips that power the operating systems for the world's entire auto industry, and the challenge of the Coronavirus has set them back many months.
- The Starbucks in Ballard (and elsewhere) posts a sign that they have no pastries and some other food products "due to disruptions in the global supply chain". For their customers' convenience they helpfully list other bakeries and doughnut shops nearby, but some of them are also out. My daughter Hannah cannot even find the cans of Starbucks Double-Shot anywhere.

(Continued on page 3)

PSAA Golf Tournament
June 18, 2021
Northshore Golf Club

Mark your calendar!
More info available at our website!

2020-21 PSAA OFFICERS

PO Box 58083, Tukwila, WA 98138

Joel Mattes.....President
Frontier Adjusters
425/757-7318, jmattes@frontieradjusters.com

Nicole Porter.....Vice President
Grange Insurance
206/753-4357, nicole.porter@grange.com

Sherry Moore.....Secretary
Crawford & Co.
206/348-3262, sherry_moore@us.crawco.com

Lizzy Adkins.....Treasurer
Crawford & Co.
253/376-8085, lizzy.adkins@us.crawco.com

Keely Abbas.....Vendor Partner
Crawford & Co.
406/439-6932, keely_abbas@us.crawco.com

Bianca Mollo.....Vendor Partner
ATI Restoration
206/620-4281, bianca.mollo@atirestoration.com

Roger Howson.....Editor & Education Chair
Claims Dispute Resolution
206/979-0659, rhowson@icdrinc.com

Deanna Boras.....Immediate Past President
Frontier Adjusters

PSAA 2020-21 Committee Liaisons

Holiday Party: Joel Mattes, Chair
jmattes@frontieradjusters.com

Bowling: Keely Abbas, Co-Chair
keely_abbas@us.crawco.com
Bianca Mollo, Co-Chair
blianca.mollo@atirestoration.com

Symposium: Nicole Porter, Chair
nicole.porter@grange.com

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Website: Barb Tyler, Liaison
npassist@msn.com

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Next Meeting…

Meeting Date: **May 21, 2021**

Time: **1:00pm**

Location: **Zoom Meeting**
Join us from your own location!

Presentation: See front page

Sponsored by: To sponsor contact Keely Abbas

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(Continued from front page)

- My brothers are builders who are turning in to their customers $30,000+ change orders for the increased cost of a lumber package. These change orders are not for an increase in quantity or quality, this is just a price increase from one week to the next. This is a bitter pill to swallow because there is no added value accompanying the added cash outlay.

Savvy restoration contractors are currently including in their service agreements boilerplate caveats that they (the contractor) are NOT accountable for sudden cost increases or construction delays. Policyholders complain that these cost increases and delays are not THEIR fault, but adjusters are pushing back on agreed cost of repairs and the expiration of additional living expense coverages. Adjusters are complaining that reconstruction challenges should not entitle policyholders and their contractors to a blank check. While the restoration contractors blame the consequential cost increases on the prolonged adjustment process and the inability of their customers to make decisions.

This is a problem no one wants to own. Everyone needs to work together to minimize the damage.

Contractors deserve to earn a reasonable profit, policyholders should be indemnified for their loss without having to incur costs that exceed their deductible, and adjusters must request payment authority with a quantifiable certainty ("repairs will cost whatever they will cost, and reconstruction will take as long as it takes" is NOT an acceptable reserve).

We will figure it out. We always do.

Replacement cost violated all theories of indemnity. Asbestos was an expensive hazardous material, then it was toxic mold. The courts redefined "collapse" as a covered peril, so construction defect claims became a multi-billion-dollar debacle. Electric vehicles are uninsurable because they are too expensive to repair. The sharing economy is confounding insurable interest and liability exposure.

It is always something. Been there. Done that. Got the hat. Got the tee-shirt.

Rumors of the insurance industry's demise are overstated. Speaking of unfounded rumors of a demise, PSAA is as resilient as asbestos and toxic mold. We are NOT going away! Check in with us on Friday, May 21st at 1:00pm. Be prepared to participate. We want to hear what you have to say. ❖

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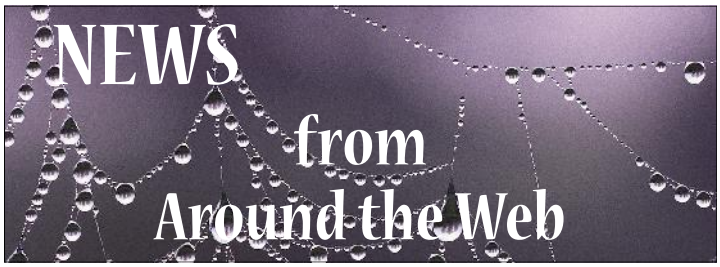

How Auto Insurers, Consumers Rode the Bumpy Year of Pandemic

Reprinted from www.insurancejournal.com

The U.S. auto insurance market experienced market disruption due to pandemic-related shopping volatility, an uptick in dangerous driving, policy renewal delays and fewer claims.

But by the end of 2020, shopping volumes closed 5.3% higher than in 2019 and net policy renewals increased after some bumpy periods.

The U.S. Auto Insurance Trends Report from LexisNexis Risk Solutions looks at how consumer behavior and carrier business practices tied to the auto insurance policy lifecycle diverged in 2020 from typical patterns largely due to the influence of Covid-19.

According to the report, auto insurance shopping data fluctuations were turbulent throughout 2020. However, year over year, 2020 shopping volumes closed 5.3% higher than 2019 with an annual year-end shop rate of 41%.

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Cyclical policy renewal patterns for many consumers were interrupted by the pandemic with new business policies written down 12.6% in April 2020 and 10.4% year over year. Even so, this unusual activity still prompted an overall net increase for 2020, bringing market retention to 83%.

Other findings from the LexisNexis Risk Solutions report:

- Empty roadways gave rise to dangerous driving behavior with a noted increase in high-speed instances first observed in mid-March 2020. That trends held at 10% higher than 2019 figures for the remainder of the year.
- New generational data illustrated an increase of Driving Under the Influence (DUI) violations among younger drivers – particularly those in the Generation Z age segment, with an approximate 50% increase in recorded violations in March and April of 2020.
- Collision claims decreased, but severity rose, much like the reduction in total miles driven, the volume of collisions and subsequent claims dropped considerably. Collision severity saw a 3.7% year-over-year increase in 2020. ❖

Research Questions Accuracy of Smartphone Alcohol Breath Testers

Reprinted from www.insurancejournal.com

Alcohol breath testing devices that pair with smartphones are marketed as safety tools for general use, but their accuracy is highly variable, a new laboratory study shows.

According to the report from the Research Society on Alcoholism, while some of these widely-available devices potentially help people avoid driving while impaired, others may mislead users into thinking falsely that they are fit to drive.

The study in Alcoholism: Clinical & Experimental Research compared the accuracy of six devices with that of two validated alcohol-consumption tests including a police-grade handheld device. Researchers worked with 20 moderate drinkers aged 21–39, testing their breath alcohol concentration (BrAC) several times after giving them doses of alcohol and then testing their blood alcohol concentration (BAC), which is the the most accurate way of measuring alcohol consumption.

The participants' peak blood alcohol concentration ranged from 0.06% to 0.14%. All the breath-testing devices, including the police-grade device, underestimated BAC, consistent with previous research — in this study by a mean of more than 0.01%.

The accuracy of smartphone-paired devices varied widely. The most accurate — the BACtrack Mobile Pro and the police-grade device — underestimated BAC by no more than 0.02%.

Other devices yielded wider margins. Drinkmate and DRIVESAFE Evoc generated average estimates of 0.04% below peak BAC; BACtrack Vio and Floome differed significantly from the police-grade device at certain points in the study.

The devices also varied in detecting driving-limit thresholds. BACtrack Mobile Pro and Alcohoot were the most sensitive, while Drinkmate and DRIVESAFE failed to detect BAC limit thresholds of 0.08% more than half the time.

The researchers concluded that such devices are potentially useful for remotely monitoring alcohol consumption and may help reduce risky driving behavior. The BACtrack Mobile Pro, for example, was

suitable for personal, clinical, and research use. Other devices, however, dangerously underestimated BAC and frequently failed to detect risky breath-alcohol levels, they concluded.

The researchers recommend closer government regulation of such devices and research into their effects on users' decisions to drive.

Since the study was conducted, Drinkmate has been discontinued and some models have been updated.

Alcohol-impaired driving kills 29 people a day and costs $121 billion a year in the U.S, according to the research society. ❖

Insurers Expected to Expand Use of Drones to Survey Damage With Rule Change
By Jim Sams
Reprinted from www.insurancejournal.com

New Federal Aviation Administration (FAA) rules are expected to clear the way for expanded commercial use of drones, which are increasingly being used by insurers to assess property damage.

The updated Operations Over People rules, which took effect on April 21, allow certified commercial drone pilots to fly over people and moving vehicles while in transit and at night, subject to certain conditions. Drones must weigh less than 250 grams (0.55 pounds) and cannot contain rotating parts that can lacerate human skin.

The rules allow heavier drones to fly over people and vehicles if the operator can demonstrate to the FAA that their drones conform with performance standards, demonstrating that they have mitigated the risk of harming people if they fall. The agency said it intends to release performance standards in the next nine to 12 months.

State Farm got a jump on the new rules when the FAA in late 2020 issued a waiver allowing the insurance carrier to fly its drones over roadways. State Farm spokesman Dave Phillips said the company has been using drones since 2015, primarily to assess damage after catastrophes and for roof inspections.

He said FAA rules that prohibit flying over roadways decreased efficiency.

"We would have to land it and literally pick it up and carry it across the street," he said. "It just wasn't making any sense."

State Farm persuaded the FAA to issue a rules waiver after working with Virginia Tech to demonstrate that drones will not crash through windshields at normal traffic speeds. Researchers flew a small, parachute-

equipped drone into a salvaged automobile windshield at varying speeds. No damage was done until the speed of the vehicle reached 67 mph.

"The slim margin between a virtually pristine windshield and a destroyed one drew a clear boundary around low-risk scenarios," State Farm said in a press release. "The data showed that as long as potential relative impact speeds never exceeded 62 mph, flights over moving vehicles presented minimal risk."

No waiver will be required for the smallest drones under the updated rules that took effect last week, but operators of drones than weigh more than 250 grams will have to wait for the FAA to develop performance measures and then demonstrate that their drones are safe.

"So realistically, there will be some period of time before operators will really be able to leverage the rule," Eleanor Nelsen, director of communications for Virginia Tech's Institute for Critical Technology and Applied Science, said in an email.

"More broadly, though, our perspective is that having a quantitative understanding of an operation's potential risks is always valuable for determining how to conduct that operation as safely as possible," she said. "Building a safety case for a particular waiver was the original motivation for the research, but to us, the most significant outcome of it are new test methods for rigorously evaluating impact risk."

The FAA rules allow operators to fly over people and roads but only incidentally while in transit. Sustained flight over a road is not allowed. Similarly, sustained flight over congregations of people is not allowed unless specific conditions are met, including a remote identification device that sends an electronic signal, similar to an aircraft transponder.

The FAA website shows that Chubb Insurance and Auto-Owners Insurance have also obtained rule waivers, both to allow nighttime drone operations. ❖

Cracking Telemedicine Codes: Deciphering the Signals of Fraud

By Tami Rockholt, RN, BSN and Michael Fossey, MS, CPMA
Reprinted from www.insurancefraud.org

Telemedicine continues its rapid rise as a widely used emergency pandemic healthcare response. While initially a largely stop-gap measure to help home-bound patients receive medical treatment and diagnosis, much of telemedicine likely will remain a permanent and mainstream fixture in healthcare long after the U.S. emerges from its pandemic lockdown.

Billions of dollars of video and telephone scams are almost certain to follow, now and well into the future. We know this because billion-dollar telemedicine schemes already happened before the pandemic. Equally, so have smaller telemed schemes that we have seen in our own coding analysis work for insurance companies.

Expect schemes of all dollar sizes to proliferate in healthcare, workers' compensation and auto injury treatments — wherever medical treatment is prominent and offers high-profit reimbursement potential. While health insurers have rapidly expanded telemed fraud training, many automobile and workers' compensation insurers must accelerate their anti-fraud learning curves and training.

Billing codes: golden gateway to fraud

Abuse of telemedicine billing codes is the fraudster's golden gateway to stealing insurance money. Knowing the codes and recognizing the fraud signals form the focus of this article.

Mastering telemedicine codes should be an urgent fraud-fighting priority. Insurers must know the telemed codes well — and how scammers can effectively abuse them for financial gain. Fraudsters are rapidly gaining telemed coding skill sets and knowledge themselves. They will continue testing insurer defenses. Insurers must gain the upper hand now by knowing telemedicine codes and coding fraud tactics better than the scammers themselves.

We at Rockholt and Associates know the telemedicine and traditional CPT medical codes intimately. We expose thousands of suspect medical bills for insurers across all lines every year. We also give seminars (including telehealth training), and testify as coding experts at insurance-fraud trials.

From that observational standpoint and our nearly 50 years of combined coding experience, we know that telemedicine codes already are, and will continue to be, widely abused for attempted financial

gain long after the pandemic subsides. The dollar losses to insurers are potentially significant. Many patients are receiving potentially dangerous sub-standard medicine in the process.

In this article, we will explore how telemedicine codes can be misused for fraud, share insights on which specific codes are ripe for exploiting, and show practical steps insurers can take to better identify coding scams.

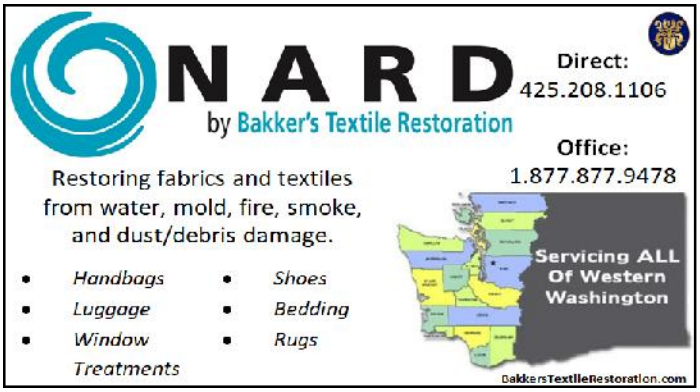
Telemedicine on the rise
Some brief trend background will reveal how ripe the environment is for telemedicine scams:

- The global market for telehealth is expected to grow from $41 billion in 2019 to $155 billion in 2027.
- Telemed visits have increased 23-fold during the pandemic.
- CMS added 144 reimbursable telemedicine services in 2020.
- The cost of running a telehealth business also is much less than for a brick-and-mortar operation, thus inviting more players.
- Medicare's temporary — and potentially permanent — relaxing of many telehealth rules further opens the field to scam artists.
- New telemedicine businesses are starting up continuously. Many are fly-by-night operators whose sole purpose is to exploit telemed codes for fraud. Existing fraud rings and individual providers also are beginning to incorporate telehealth into their schemes.

Expect wide range of coding scams
Numerous large-dollar telemedicine cases have already surfaced over the last two years. They illustrate the large potential to exploit telemedicine for significant profits.

• Some 24 suspects, including five telemedicine firms, allegedly launched schemes that stole $1.2 billion. Call centers in the Philippines and Latin America comprised an international telemarketing network that tricked hundreds of thousands of seniors. The call centers "up-sold" to the seniors to get them to accept numerous "free or low-cost" braces, regardless of medical need. Doctors gave cursory or no telemed phone exams to falsely prescribe the equipment.

• Some 86 suspects around the U.S. were federally charged with lodging more than $4.5 billion of false telemedicine claims before the pandemic6. Telemed execs allegedly paid doctors and nurses to order unneeded braces, diagnostic tests and pain medications. Doctors often had only brief telemed phone exams with patients. DME firms, genetic testing labs and pharmacies gave illegal kickbacks and



bribes for the orders, then made false Medicare claims.

Not all telemedicine schemes will be as large as these. Regardless, they all will be just as illegal. Insurers thus can expect a wide range of telemedicine schemes going forward. They may go from massive multinational operations to smaller schemes by individual medical providers, or groups of providers colluding to jointly exploit telemedicine codes. We will shortly discuss two of our own, smaller-dollar telemedicine coding cases that insurers are more likely to confront in day-to-day fraud fighting.

Relaxed rules, waiver open up telemed

While on the books for years, telemedicine codes are relatively new to wide usage. Medicare has widened their use through emergency waivers and relaxing of Medicare telemedicine rules to allow more usage during the pandemic. In the process, this has enabled telemedicine — and hence telemed codes — to rise from a niche specialty to a firm mainstream foothold throughout public and private medicine during the pandemic.

Importantly, many private insurers are following Medicare's liberalizing lead to broaden their own use of telemedicine codes. A better understanding of telemedicine codes and how their use is being dramatically expanded in private and taxpayer insurance programs will be helpful in better combating telemedicine schemes.

Telemed codes: the basics

Telemedicine coding starts with the five-digit CPT Codes® — short for Current Procedural Terminology4. CPT Codes® are developed and updated annually by the American Medical Association and are used to accurately describe what medical procedures have been performed. They are also used by medical providers to bill insurers for healthcare, in telemedicine and traditional mainstream healthcare. They're also the tools that fraudsters widely exploit when submitting bogus medical bills.

Pre-pandemic telemedicine codes and services existed, but were allowed only in specific circumstances. CMS has relaxed many telemedicine rules and expanded the CPT Codes® for services available via telemedicine. CMS has posted a downloadable list of telehealth codes that includes the temporary codes in effect during the pandemic. We expect some of the added codes to become permanent and used even after the pandemic subsides.

The American Medical Association also offers a list that incorporates the CMS temporary codes into a comprehensive list of services allowed via tele-

health platforms. These are the codes that private insurers also must use, master, and astutely decipher the bills for fraud.

Here are the most-common telemedicine codes, and thus are likely to be used for fraudulent abuse and manipulation:

Telephone
CPT 99441 5-10 minutes of medical discussion
CPT 99442 11-20 minutes of medical discussion
CPT 99443 21-30 minutes of medical discussion

Video
CPT 99201 to 99205 New patient exams
CPT 99211 to 99215 Established patient exams
CPT 99241 to 99245 Consultation exams

Online (email or portal)
CPT 99421 5-10 minutes
CPT 99422 11-20 minutes
CPT 99423 21 or more minutes

Primary telemed modifiers
Telemedicine code modifiers are used to accurately bill treatments as telemedicine.

"95" code modifier. Traditional codes also can be used in telemedicine claims if the provider uses a temporary "95" code modifier to signal a real-time

interactive audio and video connection. Appending this modifier to an appropriate CPT code tags the service as telemedicine.

Place of service. 02 for all telemedicine services. On a temporary basis, CMS is allowing providers to bill telemedicine using place of service code 11 (in office) for greater reimbursement. In the long term, the 02 modifier will be required for all telemedicine charges.

GT modifier. Via interactive audio and video telecommunication systems. Use only when directed by a payer in lieu of modifier 95. Medicare stopped usage in 2017, though some providers still inaccurately use it.

Email and portal communications. These and telephone evaluations do not require the modifier 95 because by code definition they are distinguished as telehealth services.

Exploiting telemed rule changes

With so much insurance money at stake, fraudsters no doubt are rapidly familiarizing themselves with the telemed rule changes (and hence the codes). Without a doubt, they are developing strategies to exploit them for illicit profit. Here are several potential avenues:

In-person visits. Previously, telehealth services were limited to medical facilities such as physician's offices or hospitals. Recent changes have enabled Medicare to pay for telehealth services in all areas of the country in virtually any setting.."

During the pandemic, however, the temporary rule allows telemedicine services to be coded with the typical place of service code that would be used as if the visit was in-person. This allows a higher in-person reimbursement rate even though the service was done by phone or video. Even so, medical providers still should also include the omnipresent "95" code when billing to ensure it is flagged as a telemedicine visit.

Waiving copays. Other temporary waivers include reduction or waiver of cost-sharing for telehealth visits. The patient does not have to pay all or even part of their co-payment. This will be identified on the bill by the modifier "CS." It can be appended along with the modifier 95 where appropriate (i.e., some services do not require 95).

Expanding provider involvement. Recent rule changes have also widened the type of healthcare professionals who can provide telemedicine services. Providers such as nurse practitioners, clinical psychologists and licensed clinical social workers can legally provide telehealth to their patients. Some specialties are temporary, yet permanent changes may be coming. This

would allow long term continuing of tele-services previously unavailable.

New players entering telemed. Not surprisingly, the change in guidelines has triggered a large wave of new medical providers to offer the telemed services. A quick Google search of the terms "telehealth" and "telemedicine" will reveal a large and growing volume of companies (27 million results in 0.6 seconds) entering this business for profit. Some are legitimate, but a certain percentage likely will set up shop to steal insurance money.

Hidden fraud clues in billing codes
Although telemedicine patient appointments do not have in-person contact, the documentation should still be similar as an in-patient visit (without the physical exam). The services should be identifiable as telemedicine through the coding and related documentation.

While there are many ways dishonest providers can exploit telemedicine coding, here are several clues to watch for:

New patients — no audits. Typically, patients must be established to receive and their insurers be billed for telemedicine visits. New-patient evaluations are temporarily allowed, however, via telemedicine. Importantly, however, CMS says there will be no audits to ensure a previous relationship existed for Medicare telemed claims.

This is another open door to fraud. Dishonest providers may falsely bill large numbers of new clients as pre-existing ones. Of equal concern is whether private insurers will follow this no-audit lead. They should maintain a detailed regimen of anti-fraud audits for new patients.

Audio-video documenting. A code that indicates the service was performed via audio/video communication (as opposed to a telephone visit, i.e. 99441) should be documented. For example, the documentation should include what video platform was used such as Facetime, Skype or Zoom. The specific amount of time spent also must be documented if the provider bills by time. If billing by medical decision-making, the documentation should include the appropriate history, assessment and treatment plan according to the code level (i.e., a review of systems is required for certain levels).

Traditional scams. Also watch for suspicious telemedicine billing patterns for areas of medicine that traditionally attract fraud due to high profit potential. This includes back braces and other medical equipment; compound medicines; drug tests and

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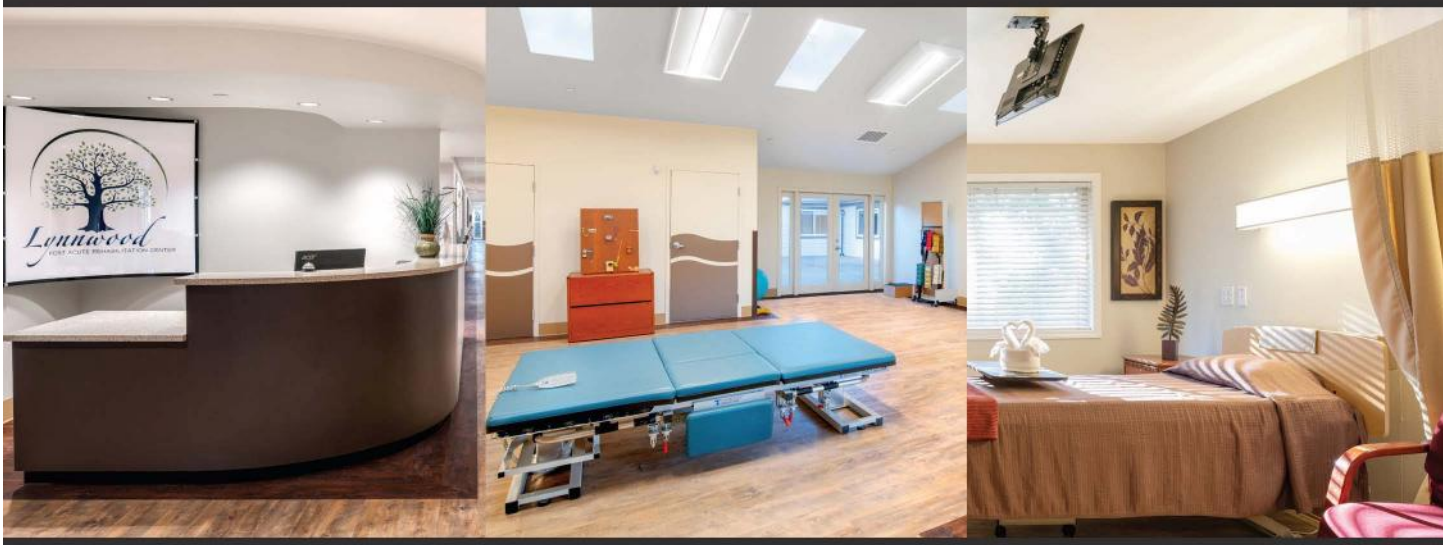

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rehab; DNA testing; dispensing medications; and overlapping providers. These treatments drive up the costs and can be an enticing source for fraudsters.

Miscode phone visits. Possible enticement for fraud may be found with telephone visits coded as more-profitable audio-video visits using the regular emergency medicine code set (99201-99245). Telephone visit charges are typically $45. Video and in-person sessions can be charged from $85 up to $300. Thus scammers may try to bill phone calls as video or in-person sessions using the related codes, yielding an extra $2,000 to $4,000 per provider, per day.

Recent insurer telemed cases

Here are two recent telemedicine cases whose coding we analyzed and discovered significant fraud. They illustrate the day-to-day telemed cases that auto and workers' compensation insurers, especially, are likely to face long after the pandemic subsides.

Drug-testing scam. A case from one of our Auto Insurance clients helps illustrate how telemed scams can be structured on a smaller though still-costly scale. We started out to evaluate potentially fraudulent drug tests. As we dug into the records, the case expanded to include expensive compound medications, inflated claims, unbundling and duplicate billings. And then, telehealth suddenly appeared in the billing data:

- A physician assistant was given a list of patients to call. The calls were made, perfunctory patient exams were done and overbilled. These were "cold calls" initiated by the provider. There were no prior appointments and the patient did not request the service.
- Per CMS and other payers, other than for educating patients about telehealth services, all telemedicine services must be initiated by the patient, not the provider.

The normal widespread patterns of fraud can and do appear on the telehealth front. Upcoding, unbundling, and duplicating services can be easily done via file telephone or video patient consults — they do not require in-person contact.

Personal injury scam. However, some services require in-person contact, and can be a clue for detecting inappropriate billing. For instance, in a recent personal-injury case from another Auto Insurance client, a doctor cloned the medical record from one visit to the next, changing only a few lines. This is an indicator of potential fraud in itself. After the pandemic started, the doctor continued using the same cloned evaluations:

- The fraud pattern was detected because the exam findings remained largely the same, and included comments like: "bowel tones in all four quadrants" and "breath sounds clear to auscultation." These findings require in-person contact and would be impossible during a telephone or video interaction.
- These exams were billed using regular CPT code 99214 — indicating a patient exam. The suspects included the "95" telemedicine modifier for real-time phone or video interactions. Yet there was no indication that the provider used a video or phone connection.

Workers' comp scam. In a case that predates the pandemic, a physician billed telemedicine codes when the only phone contact took place when office staff called patients to remind them about upcoming appointments.

Anti-fraud action steps

Insurers can stay ahead of oncoming telemedicine fraud by taking common-sense action steps:

- Stay current with telemedicine training. Make sure your claim handlers, investigators and ven-

dors can fully recognize suspicious telehealth charges.

- Look for new medical providers and check their licenses and credentials. Do an online search to see if the provider is soliciting new patients.
- Carefully screen high-level evaluation and management codes (ending in 4 or 5) performed in a telehealth setting. These high level codes are most often used while examining patients with complex or high risk injury or disease. They are difficult to perform in a telemedicine encounter.
- Watch for misrepresenting of virtual services. Make sure charges for real-time video interactions are not billed for exams performed by telephone.
- Scrutinize new-patient visits for new or unusual diagnoses that don't fit the claim. Also watch for suddenly increased frequency of services.
- Keep current on the temporary rules and waivers, and watch for changes in allowable telehealth codes.

Conclusion

The bad news is, with the rapid expansion of telemedicine due to the pandemic, the fraudsters are rushing to take advantage of opportunity.

The good news is, insurers can stay ahead of the game and protect their premium payers by intensively training their front-line troops to recognize and evaluate telemedicine claims for potential fraud. Once suspicious claims are identified, tried-and-true tools, like credential verification, can be used to head off trouble. ❖

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