



***CMS Chiropractic Demonstration Compliance Education
 Medical Necessity, Documentation and Fraud and Abuse Prevention***



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The Medicare Demystified Practical and Most Comprehensive Action Seminar

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Medicare Correct Coding For Chiropractors
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[Click Here for Instructions](#)

Instructions
(As Easy As 1-2-3)

1. On main page, select ONE **CPT** code, 98940, 98941 or 98942, for your chiropractic manipulative technique (CMT); (click here for Medicare official policy)
2. Select **ICD-9 Subluxation** code for appropriate and correspondent CMT, please note that each body region and correspondent subluxation ICD-9 are color-coded for visual efficiency;
3. Then select correspondent **ICD-9 Symptom** code from short-term, moderate term or long-term treatment or complicating conditions, by clicking the correspondent box, then matching each **ICD-9 subluxation** code in **Column B** with **ICD-9 symptom** code in **Column A**. Please use color match to greatly improve coding efficiency, such as yellow represents neck region, 739.0 and 739.1. That's it.
4. Then enter your CPT and ICD-9 codes into appropriate box on your HCFA-1500 Form by following instructions on Main Page and Sample Pages.
5. For accuracy, each action and coding procedure have immediate links to Medicare Official Policy-Medicare Bulletin, Jan. 2001, Wisconsin Physicians Service.

ICD-9-CM Official Guidelines for Coding and Reporting

Effective April 1, 2005

Narrative changes appear in bold text

The guidelines have been updated to include the V Code Table

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U. S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. **Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals.** A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. **The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.**

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

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240.1.3 - Necessity for Treatment

(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

B3-2251.3

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.

Most spinal joint problems fall into the following categories:

- Acute subluxation-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, *or arrest of progression*, of the patient's condition.
- Chronic subluxation-A patient's condition is considered chronic when it is not expected to *significantly improve or be resolved with further treatment* (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, *without expectation of additional objective clinical improvements*, further manipulative treatment is considered maintenance therapy and is not covered.

*For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review.*

A - Maintenance Therapy

*Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, **or maintain or prevent deterioration of a chronic condition**. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the*

instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.

B – Contraindications

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart. The following are **relative contraindications** to dynamic thrust:

- Articular hyper mobility and circumstances where the stability of the joint is uncertain;
- Severe demineralization of bone;
- Benign bone tumors (spine);
- Bleeding disorders and anticoagulant therapy; and
- Radiculopathy with progressive neurological signs.

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis;
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
- A significant major artery aneurysm near the proposed manipulation.

240.1.5 - Treatment Parameters

(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

B3-2251.5

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

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Medlearn Matters Number: MM3449
Revised

Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063

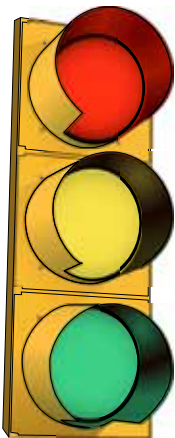


Note: This article is a full replacement for the article released on September 8 to clarify certain language regarding denials.

Provider Types Affected

Chiropractors.

Provider Action Needed



STOP – Impact to You

Chiropractors have been submitting a very high rate of incorrect claims to Medicare. Medicare only pays for chiropractic services for active/corrective treatment (those using HCPCS codes 98940, 98941, or 98942). Claims for medically necessary services rendered on or after October 1, 2004 must contain the Acute Treatment (AT) modifier to reflect such services provided, or the claim will be denied.

CAUTION – What You Need to Know

This article completely replaces MM3063 on the same subject. On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every claim that uses HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not considered medically reasonable or necessary under Medicare.

GO – What You Need to Do

Ensure that your billing staff is aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of active/corrective treatment. Additionally, your billing staff should be aware of any LCDs for these services in your area that might limit circumstances under which active/corrective chiropractic can be paid.

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What Doctors Need to Know about the
ADVANCE BENEFICIARY NOTICE (ABN)



Helping Physicians and Providers Navigate Medicare

CENTERS FOR MEDICARE & MEDICAID SERVICES

THE ADVANCE BENEFICIARY NOTICE

An Advance Beneficiary Notice (ABN) is a written notice which a physician or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary before he or she receives specified items or services that otherwise might be paid for by Medicare that Medicare probably will not pay for them for that particular beneficiary on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

ABN Decision Tree #1

Standard Decisions

Will Medicare deny payment for this service (or item)?

1. "No, I do not expect Medicare to deny payment." →	<p>Do <u>not</u> give any ABN. <u>Do</u> submit a claim to Medicare.</p> <ul style="list-style-type: none"> • If Medicare pays: You may collect charges from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient. • If Medicare denies payment for medical necessity, you may: <ol style="list-style-type: none"> A. Provide additional documentation of medical necessity so Medicare will pay. (This may happen even before the initial determination is made for the claim, during "claims development.") [If Medicare agrees, Medicare pays because the service is covered.] B. Appeal on the basis that the service should be covered. [If Medicare agrees, Medicare pays as covered.] C. Appeal on the basis that you did not know and could not reasonably have been expected to know that Medicare would not pay. [If Medicare agrees, then Medicare will pay (for assigned claims) under the Limitation On Liability provision, AS IF the service were covered.] • If Medicare denies payment on the basis of a statutory exclusion or failure to meet technical coverage requirements under the program benefits sections of the law: You may collect full charges from the patient. <p style="text-align: center;">[End #1 & #2]</p>
2. "I don't know. I never know what Medicare will deny." →	

3. "Yes, I have a genuine reason to expect that Medicare will deny payment, based on other Medicare denials, LMRPs, local standards of medical practice, etc.." Then, ask this question: "On what basis do I expect that Medicare will deny payment?"

MEDICAL NECESSITY
Denial as "not reasonable and necessary."

- DMEPOS denials – prohibited telephone solicitation; no supplier number; payment denied in advance – also are handled in the same way as "medical necessity" denials.

Do give an ABN (either a General Use form ABN-G or laboratory test form ABN-L). If the patient receives the services or items you must always submit a claim to Medicare (it is called a "demand bill").

- If you do not submit a claim, timely, you violate the mandatory claims submission provision, which can result in sanctions.

When you have submitted a claim: ↓

- **If Medicare pays:** Collect payment from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient.
- **If Medicare denies payment:** You may collect full charges from the patient.

EXCLUSIONS & TECHNICAL DENIALS
All other exclusions from Medicare benefits; and failure to meet technical coverage requirements under the program benefits sections of the law.

Do not give an ABN (neither the General Use form ABN-G nor laboratory test form ABN-L).

You do not need to submit a claim unless the patient demands it.

If you do not submit a claim, you may collect full charges from the patient.

If you submitted a claim: ↓

[End # 3]

ADVANCE

ABN Decision Tree #2

EMTALA

Premise: You see a patient in a setting in which, and in circumstances to which, EMTALA provisions apply.
Has a Medical Screening Examination [MSE] by a qualified individual been completed?

No.		Yes.	
1. Do not give an ABN. 2. If you do not complete an MSE, no ABN may be given.	1. Do not give an ABN. 2. First, complete an MSE. 3. Stabilize the patient. 4. Then give an ABN, but only if appropriate. (see Decision Tree #1).	Is the patient stabilized?	
		No.	Yes
		1. Stabilize the patient. 2. Give an ABN, but only if appropriate (see Decision Tree #1).	1. Give an ABN, but only if appropriate (see Decision Tree #1).

Do not routinely give ABNs to all emergency department patients who are Medicare beneficiaries.

Even after a patient has received an MSE and is stabilized, do not give the patient an ABN unless you have a genuine reason to expect Medicare to deny payment for the services, per the directions in Decision Tree #1. Giving routine ABN notices is a prohibited practice.

EXCLUSIONS FROM MEDICARE BENEFITS

Medicare does **not** pay for **all** health care costs for a beneficiary. Medicare **only** pays for **covered** benefits. Listed below, for your information, is a general summary of some exclusions from Medicare benefits.

SUMMARY OF EXCLUSIONS*

- Personal comfort items.
- Routine physicals and most tests for screening.
- Most shots (vaccinations).
- Routine eye care, eyeglasses and examinations.
- Hearing aids and hearing examinations.
- Cosmetic surgery.
- Most outpatient prescription drugs.
- Dental care and dentures (in most cases).
- Orthopedic shoes and foot supports (orthotics).
- Routine foot care and flat foot care.
- Health care received outside of the USA.
- Services by immediate relatives.
- Services required as a result of war.
- Services under a physician's private contract.
- Services paid for by a governmental entity that is not Medicare.
- Services for which the patient has no legal obligation to pay.
- Home health services furnished under a plan of care, if the agency does not submit the claim.
- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility.
- Services of an assistant at surgery without prior approval from the peer review organization.
- Outpatient occupational and physical therapy services furnished incident to a physician's services.

*This is only a general summary of exclusions from Medicare Benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

BENEFICIARY NOTICE

Related Change Request #: N/A
Effective Date: N/A

Medlearn Matters Number: SE0441
Revised

“Incident to” Services

Note: This article was revised on November 1, 2004, to correct the spelling of physician assistants in the background section.

Provider Types Affected

All Medicare providers of professional services

Provider Action Needed

None. This article is for your information only. It clarifies when and how to bill for services “incident to” professional services.

Background

The intent of this article is to clarify “incident to” services billed by physicians and non-physician practitioners to carriers. “Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.

These services are billed as Part B services to your carrier as if you personally provided them, and are paid under the physician fee schedule.

Note: “Incident to” services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that “incident services” supervised by non-physician practitioners are reimbursed at 85% of the physician fee schedule. For clarity’s sake, this article will refer to “physician” services as inclusive of non-physician practitioners.

To qualify as “incident to,” services must be part of your patient’s normal course of treatment, during which a physician **personally performed an initial service** and remains **actively involved** in the course of treatment.

You do not have to be physically present in the patient’s treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service.

Disclaimer

The information contained in this article was current at the time of its development.
We encourage users of this article to review statutes, regulations and other interpretive materials for the most current information.

**1997 Documentation
Guidelines for Evaluation
and Management Services**

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1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- **the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.**
- **communication and continuity of care among physicians and other health care professionals involved in the patient's care;**
- **accurate and timely claims review and payment;**
- **appropriate utilization review and quality of care evaluations; and**
- **collection of data that may be useful for research and education.**

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- **the site of service;**
- **the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or**
- **that services provided have been accurately reported.**



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Request 1: Can I be punished with jail or fines for making innocent mistakes?

Response 1: Providers are not subject to civil or criminal penalties for innocent errors, mistakes, or even negligence. The Government's primary enforcement tool, the civil False Claims Act (FCA), covers only offenses that are committed with **actual knowledge** of the falsity of the claim, **reckless disregard** of the truth or falsity of the claim, or **deliberate ignorance** of the truth or falsity of the claim. The FCA simply does not cover mistakes, errors, or negligence. The other major civil remedy available to the Federal Government, the Civil Monetary Penalties Law, has exactly the same standard of proof. We are mindful of the difference between innocent errors and negligence (erroneous claims), on the one hand, and reckless or intentional conduct (fraudulent claims) on the other. When billing errors, honest mistakes, or negligence result in erroneous claims, the provider will be asked to return the funds erroneously claimed but without penalties. In other words, erroneous claims result only in the return of funds claimed in error. Nevertheless, inadvertent billing errors are a significant drain on the program and all parties need to work cooperatively to reduce them.

Request 2: Can you explain what local medical review policy is and how it works?

Response 2 : Local medical review policy is an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment. Local policies outline how contractors will review claims to ensure that they meet Medicare coverage requirements. HCFA requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with input from medical professionals (through advisory committees), and consistent with scientific evidence and clinical practice. They are developed by contractor medical directors.

The use of local medical review policy helps avoid situations in which claims are paid or denied without a full understanding of why. Local medical review policies can be found at www.lmrp.net.

Providers can also request decisions at the www.hcfa.gov/pubforms/transmit/AB00116.pdf.

Request 3: Why can't Medicare implement a "one-strike" policy, so that first time errors are dealt with through education?

Response 3: In fact, most errors are addressed administratively when they are first encountered, by collecting the overpayments in the specific cases or identifying claims and engaging in education. However, when the information suggests that the error has resulted in significant losses to the Medicare program, additional corrective action should be taken (for example, conducting a postpayment review to determine the

amount of overpayments made). We all are still accountable to the program, its beneficiaries, and the public to correct errors as we find them.

As an example, suppose that a computer program has caused a provider to submit claims in error for a period of time, and this is discovered through a contractor's review of a single claim. In light of the nature of the error, it would be appropriate not only to collect the overpayment on the one claim that brought the problem to light but, also, to conduct a postpayment review or a statistical sample to establish an accurate overpayment amount reflective of a total cost of the computer glitch to Medicare. On the other hand, if the problem seemed to be isolated and minimal, that additional step would not be necessary. Contractors are directed to use progressive corrective action commensurate with the nature of the error and impact on the program.

In August 2000, HCFA released more detailed guidance to contractors about how to determine which corrective actions should be employed under different circumstances. Copies of this contractor instruction can be downloaded in PDF format from www.hcfa.gov/pubforms/transmit/AB0072.pdf.

Request 4: I'm looking at my operations to make sure I am billing correctly. Sometimes I find that Medicare has overpaid me. What do I do?

Response 4: Certainly, you should repay any overpayments. Often, these can be handled administratively by contacting your intermediary or carrier. The intermediary or carrier may be able to offset against future payments or can deposit a check you provide them. If you believe fraud has been involved, you should alert the U.S. Department of Health and Human Services Office of Inspector General.

Request 5: How does HCFA make sure providers, physicians, and suppliers have input into Medicare rules and program decisions?

Response 5: HCFA uses a variety of mechanisms to receive feedback from its partners. At the local level, contractors use contractor advisory committees and interact often with local providers, physicians, and suppliers on a wide range of matters. HCFA regional offices meet regularly with state associations and partners and participate in conferences. HCFA has formally convened advisory committees, such as the Practicing Physicians Advisory Council, to provide input and advice and to react to HCFA policy and program decisions. Proposed rules are issued in the Federal Register and are subject to public comment.

Request 6: I heard that Medicare Integrity Program (MIP) contractors get bonuses for dollars received, isn't this another form of bounties?

Response 6: The MIP has a stable source of funding under HIPAA. It is not funded out of "savings" or monies recovered through program integrity efforts. All recovered monies are returned to the Medicare Trust Funds. Contractors do not receive bonuses for dollars they recover, nor are they paid on a bounty system.

Request 7: I understand HCFA is using different contractors to do program integrity activities. What is this all about?

Response 7: HCFA is using its MIP authority to create new types of contractors. One kind is called Program Safeguard Contractors (PSCs). A PSC can take on some, all, or any sub-set of the work associated with the following payment safeguard functions: medical review, cost report audit, data analysis, provider education, and



In the United States Court of Appeals For the Seventh Circuit

No. 95-3671

United States of America,

Plaintiff-Appellee,

v.

Thomas Bruce Vest, also known as T. Bruce Vest, doing business as Doctors Clinic,

Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Illinois, Benton Division. No. 93 CR 30053--J. Phil Gilbert, Chief Judge.

Argued December 13, 1996--Decided June 25, 1997

Before Cudahy, Ripple, and Kanne, Circuit Judges.

Kanne, Circuit Judge. Dr. Thomas Bruce Vest is, by all accounts, not your ordinary medical doctor. Vest is both an internist and a radiologist--an unusual combination in the field of medicine. Vest claims this combination allowed him to practice a new method of preventive medicine at his \$10 million, state-of-the-art Doctors Clinic in Alton, Illinois. The United States, however, claims that Vest used his position as an internist to order unnecessary medical tests conducted at his own clinic, thereby bilking patients, private insurance companies, and the government out of thousands of dollars. A jury convicted Vest on 33 counts of mail fraud under 18 U.S.C. sec. 1341. On appeal, Vest asserts numerous trial errors. We find that none of his arguments justify reversal, and we therefore affirm the judgment of the District Court.

I. History

Dr. Vest began conceptualizing his Doctors Clinic back in 1977. Vest envisioned up to 12 doctors working as limited partners at a state-of-the-art diagnostic and treatment center. The clinic was completed in 1985, but Vest was unsuccessful in getting other doctors to invest in the partnership. Vest therefore had only his own primary-care patients and patients referred by outside doctors to finance the clinic's considerable operating expenses. With its MR scanner, CT scanner, two surgical suites, emergency room, medical laboratory, and other sophisticated diagnostic equipment, the clinic had operating expenses ranging between \$150,000 and \$250,000 per month. Vest advertised heavily to generate walk-in patients, but by 1991, Vest was forced to declare bankruptcy.

In 1993, a federal grand jury indicted Vest on numerous counts of mail fraud. The true bill alleged that Vest had engaged in a scheme to defraud by falsifying medical records and ordering unnecessary medical procedures since 1985. Each count in the indictment referred to a particular patient whom Vest had treated.

At trial, the Government offered three general categories of evidence against Vest. First, the Government offered economic evidence suggesting that one could not legitimately run a clinic like Vest's without more referring doctors. A radiologist and professor of medical economics at Washington University in St. Louis, for example, testified that Vest never had enough referring physicians to make the clinic economically viable. The expert also testified that he had never known another radiologist to practice primary care and make self-referrals for testing. An insurance company employee also testified that Vest, when questioned about excessive billing, angrily responded, "You're damn right I'm going to use this equipment. It's expensive and I have to pay for it somehow."

Second, the Government presented 36 patients who testified that during their visits to the Doctors Clinic, they did not report many of the symptoms and past conditions that Vest recorded on their medical records. On cross-examination, defense counsel used the patients' pre-visit and post-visit medical records to impeach the patients' recollections. If, for example, a patient denied that she reported dizziness to Vest, defense counsel was allowed to cross-examine the witness with medical records showing that the patient reported dizziness either before or after visiting the Doctors Clinic. Third, the Government presented four medical doctors who testified that many of the tests Vest ordered were medically unnecessary. The first expert was a board-certified radiologist who testified regarding all 36 patients and the procedures Vest performed on them. The other three experts--who were board-certified in surgery and quality assurance utilization review, internal medicine, and rheumatology and internal medicine, respectively-- each testified regarding approximately one-third of the patients. The jury therefore heard expert testimony on each count from two Government medical experts. Unlike the cross-examination of the patients, the District Court prohibited Vest from using the patients' pre-visit and post-visit medical records during the cross-examination of the Government experts. Two of the Government experts also testified that Vest's testing did not follow the normal "sequencing" of medical tests, which doctors use to prevent unnecessary testing.

Vest offered three medical experts of his own, including his son who is an orthopedic surgeon and a cousin who is a diagnostic radiologist. The third expert was a board-certified psychiatrist and neurologist. These experts testified that the tests Vest ordered were medically necessary based on Vest's records and that, on most occasions, the tests were necessary even without the allegedly- false symptoms that Vest recorded. Vest himself also testified and denied that he ordered any inappropriate tests. Vest also stated that he accurately recorded the patients' symptoms, thus rebutting the patients' contrary assertions.

After a 55-day trial, a jury convicted Vest on 34 counts and acquitted him on two counts. The District Court later granted Vest's motion for judgment of acquittal on one of the counts. The District Court sentenced Vest to two years in prison and ordered him to pay fines and restitution totaling over \$65,000.

II. Analysis

A. Limitation on Defendant's Use of Patient Medical Records

Vest first contends that the District Court abused its discretion when it limited the use of the patients' pre-visit and post-visit medical records. Although the District Court allowed Vest to cross-examine the patients with their pre-visit and post-visit medical records, the District Court did not allow Vest to cross-examine the Government's medical experts with the records. Vest argues that such evidence was vital to showing his innocence.

Whether this evidence was relevant and should have been admitted depends, of course, on what facts are "of consequence to the determination of the action." See Fed. R. Evid. 401. To prove its counts of mail fraud, the Government had to prove that Vest had 1) devised or intended to devise a "scheme or artifice to defraud," and 2) placed something in the mails "for the purpose of executing such scheme or artifice." 18 U.S.C. sec. 1341. Crucial to the Government's case, therefore, was proving that Vest intended to defraud when he ordered the



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