

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

Billing Compliance Programs: A Matter of Thorough Audits and Follow-Up

As every medical practitioner knows, billing is a complex function that is rife with nuance. "It's part art, part science," says Michael W. Carbrey, MHA, a health care consultant based in Celebration, Fla. But because the task is also governed by concrete Medicare regulations, your management of insurance claims should be guided by more than professional instinct. An overall billing compliance program, like the more targeted coding compliance plan, is essential to the financial health of your medical practice.

A comprehensive billing compliance program evaluates every aspect of billing. Specifically, a designated compliance officer should conduct audit reviews at least twice a year. (See the audit checklist on page 7.) An

effective appraisal includes an assessment of a random sample of charts, along with all associated documentation, claims, explanations of benefits, and payment stubs. Approximately 20 charts should be examined for each physician, with the reviews focusing on whether all services are well documented and properly support the patient's diagnostic code.

The physicians and staff should then examine the findings and devise mechanisms for correcting any problems that have been identified. Some practices use software that includes edits that will correct a claim before it is filed, though rejections are still likely to occur—these systems don't do away with the need for a billing compliance program.

Start by tracking a trio of common problems

Three areas cause the majority of billing errors: claims fail to demonstrate that services were medically necessary, the provided services were not covered, or patient information is incorrect. "You should therefore begin by determining how many denials fall into these categories," says Carbrey. "Keep a denial log, and make a graph of the reasons for denials." This way, you can determine the points at which your billing process needs improvement. "If most denials are because of

non-necessity, then it's the coding that requires attention," he points out. "If you find the problem is consistently with the tax identification number, determine why that is occurring."

An essential skill is the ability to match the procedure with the diagnosis code. "Doctors often get stuck on this point," observes Carbrey. He gives the example of a patient with a history of gastrointestinal disorder. "A colonoscopy on that basis alone is not medically necessary and a claim for it would be denied," he notes. "To collect the optimal revenue and to prevent over-coding, a coding compliance plan is needed."

Much of the problem will also likely begin before the patient even sees the doctor. "Ninety percent of denials begin at the front desk, because of such things as a wrong patient address, an incorrect social security number, expired insurance, or failure to obtain preauthorization or note a change in the patient's insurance," says John W. McDaniel, president and CEO of Physician Management Group, Inc., located in New Orleans, La. One way to avoid the problem in the first place is to make a copy of the patient's insurance card and have the patient fill out a new patient information sheet at every visit.

Once errors are identified in the audit, denied claims should be re-filed

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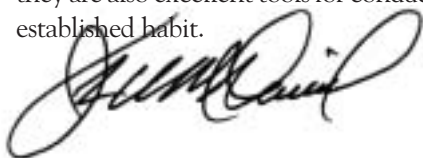
Compliance As a Way of Life

On March 4, 2003, President Bush put forth his proposed outline for the modernization of the Medicare program. The blueprint promises senior citizens better benefits and more options for how these benefits will be delivered. If the US Congress responds favorably to the framework, patients will be able to select a traditional Medicare plan; Enhanced Medicare, in which patients choose from among health care plans similar to those offered members of Congress; or a plan called Medicare Advantage, in which beneficiaries join a "low-cost and high-coverage managed care plan, like those already available under Medicare."

Each arrangement entails some form of prescription drug coverage. Seniors who opt for Enhanced Medicare would have the freedom to "choose any doctor or any hospital they want for the treatment and care they need." This plan, the most liberal, could cost more, though the White House says that people enrolled in "an average priced plan" would pay a premium for the medical segment of coverage equal to that of Part B Medicare. Note that Enhanced Medicare would be administered by a new Medicare Center for Beneficiary Choices. (For more details, go to www.whitehouse.gov/news/releases/2003/03/20030304-1.html.)

If Congress passes the relevant legislation in 2003, the new menu will be available beginning January 1, 2006. Help with prescription drug costs, however, would start as early as 2004. While it's too soon to predict how this will all shake out, you won't be scrapping your compliance programs any time soon. On the contrary, they will likely become even more essential. For example, a billing compliance program helps you bring in the money you've earned. We discuss the components of an effective system in this issue and address some of your specific billing quandaries. Health care policy is on the agenda as well. Specifically, we take a look at financial arrangements between physicians and ambulatory care centers, an issue of great interest to the American government.

All in all, compliance issues and the programs needed to keep them in check are vital to medical practice. While such systems can help you avoid penalties, they are also excellent tools for conducting a strong business. Make them a well-established habit.



John W. McDaniel
Editor-in-Chief
Toll-free phone: 1-800-764-2633
E-mail: jmcdaniel@premierhealthcare.com

Randall D. Ayers, MD
Clinic for Rheumatic Diseases
Tuscaloosa, Ala.

Michael W. Carbrey
Health Care Consultant
Celebration, Fla.

Robert J. Chugden, MD
West Jefferson Emergency
Physicians Group
Marrero, La.

Charles E. Colitre
President
Med Management Group, Inc.
Akron, Ohio

Randy J. Gershwin, MD
Medical Director
Deaconess Medical Group
Evansville, Ind.

Sara S. Grostick, MA, RHIA
Director and Associate Professor
Health Information
Management Program,
University of Alabama at Birmingham
Birmingham, Ala.

D. Scott Jones, CHC
Vice President, Risk Management
InLight Risk Management
Oklahoma City, Okla.

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis, Minn.

Thomas Loughrey, MBA, CCS-P
Chairman and CEO
Economedix, LLC
Orange, Calif.

Rhonda Lynn Picou,
RN, MSN, CPC
Vice President, Physician Compliance
Physician Management Group
New Orleans, La.

Editor

Cynthia Starr, MS, RPh
Phone: 201/652-6181
E-mail: cstarr@premierhealthcare.com

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
Phone: 888/457-8800
Fax: 973/682-9077
E-mail: publisher@premierhealthcare.com

This newsletter is published by Premier
Healthcare Resource, Inc., Morristown, NJ.

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Does Physician Ownership of ASCs Affect Cost of Surgeries?

The Office of the Inspector General (OIG) of the US Department of Health and Human Services (HHS) plans to analyze financial arrangements between physicians and ambulatory surgical centers (ASCs). In its 2003 General Work Plan, the agency stated its intention to determine whether physician ownership in ASCs affects utilization and the cost of outpatient surgeries. A study “will evaluate whether a relationship exists between physician investments and the number of certain surgical procedures performed in comparison to national norms.”

Does that mean there is a problem with ASCs? Not necessarily, says Ben St. John, spokesman for the OIG in Washington. “We typically do studies of various services to the Medicare beneficiary community to see whether or not they’re efficient and effective—and to see whether there is a spike in the cost for particular services,” he explains.

Tom Loughrey, MBA, CCS-P, CEO of Economedix, a physician training and consulting company in Pittsburgh, Pa., says more and more surgery is being done in ASCs with physician ownership. “What the OIG wants to know is whether there’s an increased amount of surgery being done because of physician ownership in ambulatory surgical centers,” he says. “That needs to be studied as no one really knows the answer. My feeling is that there is probably some likelihood of it.”

Loughrey adds, however, that there may be some gray areas with ASC surgeries. “What’s unnecessary and what’s necessary sometimes isn’t so obvious,” he points out. “And it’s in those cases that legitimate questions can be drawn. Should a surgery have been done? Should it have been outpatient? Should it have been inpatient? Was the facility where the surgery was performed the best one it could have been done in, given equipment, staffing, and the like?

There are a lot of parameters to investigate there.”

A long-standing concern

The issue of “self-referral” has a long history. In 1989, the US Congress enacted a law prohibiting physicians from referring patients to a clinical laboratory with which he or she—or an immediate family member—has a financial relationship. This law was spearheaded by Rep. Pete Stark (D, Calif.), and is thus often referred to as the “Stark Amendment.”

In 1995, Congress extended the law to prohibit physicians from referring patients to 10 other categories of health care services if the physician or his or her immediate family members have a financial relationship with the service provider. Those 10 categories include physical therapy services, purveyors of durable medical equipment and supplies, and outpatient and inpatient hospital services.

Michael W. Carbrey, MHA, a health care consultant based in Celebration, Fla., says ASCs are different from other facilities listed in the self-referral law, thus providing something often called a “safe harbor” for physicians. “The problem is that a surgery center is an extension of the doctor’s workplace,” he says. “It’s not like he’s sending the patient someplace to get something done—he has

to go do it there. I don’t see that the ownership of a surgery center should be anywhere remotely related to a diagnostic center, a home health agency, or a freestanding laboratory.”

For example, Carbrey recalls that lithotripsy was excluded from the self-referral legislation because the physician must perform the procedure at a lithotripsy center affiliated with the hospital where he or she practices. “The question in this instance was whether or not a physician may send someone to a place that he or she owns to do a procedure? And the answer is yes, particularly if you’re doing the procedure,” he concludes.

Watch and wait

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, Tenn., reports that the organization is “actively monitoring” the OIG’s proposed study. “We have no cause for alarm at this stage of the study,” he says. “We clearly advocate the values of physician ownership in ambulatory surgery centers. We see no evidence that would indicate a need to readdress this safe harbor.”

Recent advisory opinions provide some guidance on the issue of potential fraud and self-referrals (see oig.hhs.gov/fraud/advisoryopinions.html). One opinion concerns an ASC jointly

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owned by a group of physicians and a hospital. The OIG notes that there is a “substantial likelihood of cross-specialty referrals.” Group physicians for whom the ASC is not an extension of their office practice would profit from referrals to the ASC or to their partners who do practice at the ASC.

Thus, the OIG states, the arrangement “poses the same risks [for fraud and abuse] as an ASC owned directly by surgeons and primary care physicians in the community.” The OIG ruled that “the proposed arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the OIG could potentially impose administrative sanctions” on the ASC.

In another advisory opinion, a free-standing orthopedic ASC is indirectly owned by a physician group practice through a wholly owned holding company. A hospital wants to acquire ownership interest in the ASC. The advisory opinion states that the arrangement “could potentially generate prohibited remuneration under the anti-kickback statute if the requisite intent to induce or reward referrals were present,” if, for example, physicians employed by the hospital made referrals directly to the ASC. However, the OIG advised that it would not impose administrative sanctions on the hospital, group holding company, or ASC in connection with the proposed arrangement.

The bottom line for physicians is that they should watch for the OIG study to come out, possibly as early as this fall, according to St. John. In the meantime, says Loughrey, “Physicians always have to be practicing good medicine. If you’re rendering needed care, you’re doing your job.”

Reported and written by Theresa Waldron, in Marietta, Ga. More information on the OIG Work Plan is on our Web site (see page 8).

OIG: Hospital Outpatient Departments Have Higher Rates Than ASCs

Making reimbursement rates uniform between ambulatory surgical centers (ASCs) and hospital outpatient departments could save Medicare \$1 billion annually, according to a report recently released by the Office of the Inspector General (OIG) for the US Department of Health and Human Services. (To obtain a copy of the report, titled *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers*, go to the OIG’s Web site: oig.hhs.gov/oei/reports/oei-05-00-00340.pdf.) The report states that Medicare reimbursement rates for hospitals are higher than rates for ASCs for many of the same outpatient services, and that the rates vary by as much as 200%.

HHS Inspector General Janet Rehnquist observes that, “In the absence of a compelling reason for a payment differential, the amount Medicare pays for a procedure should be based on the service and not the setting.” The OIG study evaluated 453 procedure codes for outpatient services performed either in a hospital outpatient department or an ASC. Those 453 codes accounted for 95% of the volume of services billed in 1999 under one of the 2,500 procedure codes for services that can be performed in an ASC.

For 279 of the codes, Medicare reimbursed more for a hospital outpatient department than for the same service provided by an ASC. For the 145 remaining codes, Medicare reimbursed an ASC more than a hospital outpatient department. The range of difference for all codes was \$3.18 to \$1,383.18, with 16 procedure codes differing by more than 200%.

For example, the report notes that there could be a \$330 million annual savings in eye procedures by equalizing at the lower end of the reimbursement for cataract surgery requiring the implantation of an intraocular lens. Medicare pays hospital outpatient departments about \$1,333 for that procedure; ASCs receive \$949.

The OIG recommends that the Centers for Medicare and Medicaid Services (CMS) “seek authority from Congress to set reimbursement rates that are consistent across sites and reflect only the costs that are necessary for the efficient delivery of needed health services.”

In addition, the OIG report indicates that additional savings could be achieved if ASCs were no longer reimbursed for procedure codes that meet federal criteria for removal from the ASC list of covered procedures. The OIG states that 72 of the codes should be deleted by CMS and payment made only if the services are provided in either a hospital outpatient department or a physician’s office instead of an ASC. Under that arrangement, Medicare would save an estimated \$8 million annually for procedures performed in a hospital outpatient department and as much as \$14 million if they were performed in physicians’ offices.

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, Tenn., is concerned about the OIG’s suggestion to move payment for services to the lowest available rate. “It’s a financial recommendation and has no basis in thoughtful health policy considerations,” he comments.

Dual Billing Systems: Does It Matter Which Method We Use?

Q: *I oversee the billing for two centers that provide patients with mental health and substance abuse services. They share the same owner, but each has its own computerized procedure for attaching ICD-9-CM codes to claims. One center assigns a primary diagnosis code to the patient at the start of treatment. This is inserted in subsequent claims. If the code changes during therapy, it is updated. The other center assigns a diagnosis code each day a service is rendered, and this is entered on the claim. Do both practices comply with requirements set out by the Centers for Medicare and Medicaid Services (CMS)?*

A: “Government guidelines tend to describe the expected result without mandating how you achieve it,” says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. You can use either method to tie a patient’s diagnosis to the service rendered as long as all codes are consistently bolstered with accurate documentation for each date of service.

To that end, the CMS 1995 Documentation Guidelines for Evaluation & Management Services recommend you include the reason for the encounter, along with relevant history, physical examination findings, and prior diagnostic test results; your clinical impression or diagnosis; a plan for care; and the date and identity of the observer. (Two sets of guidelines are available at cms.hhs.gov/medlearn/emdoc.asp, and either can be used.) Additional elements should be documented as

well, such as your rationale for ordering diagnostic tests, health-risk factors, treatment alterations, and revised diagnoses.

In short, your records should make it easy for you to verify the site of service, the medical necessity of your services, and your having precisely noted the care delivered. Otherwise, you can assemble your claims in whatever way is most convenient. However, Picou believes that while predetermined diagnosis coding helps keep billing consistent, accuracy can be diminished when codes are not updated to reflect changes. “If a patient comes in with another issue during the course of treatment, this is often not reported correctly,” she observes. “You can evaluate whether this is a problem by performing an audit of services to see whether the documentation matches the billing.”

Q: *I prepare claims for a urologist who says that as a specialist, he can charge for a new patient visit when a patient he has seen before comes back a year later with an entirely different complaint, thus requiring a new history and diagnosis. Is this correct?*

A: No, this is an established patient encounter. A new patient, according to CPT terminology, has not obtained professional services from any of the physicians practicing the same specialty within the same practice during the past three years. But if your employer has been asked by another physician to consult on the care of a patient who has been treated in his urology practice in recent years, he can bill for a consultation, whether that patient has a new problem or a

preexisting disorder. In fact, if the patient’s primary care physician requests input on multiple occasions and each of these requests is documented in the medical record, the pertinent office consultation code can be used repeatedly.

Q: *We’ve been submitting CPT code 94762 in combination with an evaluation and management (E&M) code when billing for overnight pulse oximetry monitoring, and the claims are being denied. The patient is seen in the office, wears the apparatus all night, and drops it off at the desk the next day. A staff member then downloads the report for the physician’s review. Should we bill for the E&M code on the first day and the test on the second day instead of using the first day as the date of service for both?*

A: Preparation of the patient is inherent to testing and can’t be billed as a separate E&M service. Billing for routine preprocedural work is considered unbundling. In addition, all services should be billed on the day they were carried out—you can indicate start and end dates on the CMS-1500 form. However, if the patient is evaluated for a complaint on the same day the test is initiated, you have two independent services that qualify for reimbursement. Attach the modifier “-25” to the appropriate E&M code to indicate that an additional distinct service was provided by the same physician on the same day.

Editor’s note: Readers of The Physician’s Compliance Alert are invited to visit our Web site (see page 8) and submit their questions. Members of our Advisory Board will offer their expert opinions in response.

when appropriate. “If possible, try to obtain the correct information from the patient, and re-file the claim. It adds a time-consuming step to the process, but it’s well worth the effort,” says McDaniel. As part of the compliance program, decide whether the denied claims can be filed again using a different code. “But you must be able to support whatever diagnosis is used,” warns Carbrey. “If you can’t prove it, don’t do it.”

Keeping tabs on other important details

Along with these three common problem areas, there are a number of other elements to examine in your audits. Be sure, for example, to examine all claims and documents to determine that unbundling did not occur. To do this, check the codes in the *National Correct Coding Initiative Edits Manual*. This lists the CPT and HCPCS codes that are not paid when billed by the same physician for the same patient on the same date of service. For example, you can’t charge for separate elements of a procedure when a global procedure code exists. (To learn more, go to www.cms.hhs.gov/medlearn/ncci.asp.)

Reviews should also include the practice’s daily and weekly charges in order to be certain that all practice charges have been submitted on a timely basis. If the reason for denials is that the claims are not timely, determine where bottlenecks in the system are occurring and devise ways to eliminate them, Carbrey suggests.

Also, look at your practice’s procedures for billing consultations. Ensure that requirements are met and the consulting physician’s findings are documented in the medical record and have been communicated to the referring physician. Remember when you are coding that once the consulting physician assumes management

for one or all of the patient’s conditions, the billing codes for consultation should not be used. Instead, the standard evaluation and management codes should be used.

This is a matter of confusion in some practices. Basically, consultation and new patient codes have the exact same requirements, even though consultations pay a higher reimbursement rate. To be coded as a consultation, however, a written or verbal request from a health care provider for a consultation is required. If the patient returns to the care of the referring physician after being seen for the consult, the visit was a consultation. If the consulting doctor continues to treat the patient in subsequent visits, these visits are coded as established patient visits. In addition, if the patient or family requests the consultation, then the visit is an office visit or a confirmatory consultation and should be coded as such. A visit is a consultation only when it is requested by a physician.

Every internal encounter form should also be checked in a comprehensive audit, to be certain that it contains a clear diagnosis. All diagnoses must be listed on the form. In addition, each chart reviewed in the audit should have a clinical and clerical audit trail. This means that every charge should be evident from the clinical record and each clerical transaction should include all of the supporting documentation.

An audit should also include a review to see that all necessary waivers are in place and in the patient’s chart for noncovered services or those that are not medically necessary. Keep in mind that waivers are also needed if screening laboratory tests are performed.

One source of confusion may be advance beneficiary notice (ABN) forms. ABNs must be provided to

beneficiaries before items or services are provided whenever Medicare is likely to deny payment for them. If Medicare does decline to pay for a service and the patient did not sign an ABN, the provider is not permitted to bill the patient for that service.

“First, be sure your practice is using ABNs, especially for Medicare,” urges McDaniel. “We recommend that ABNs be used for non-Medicare patients as well.” Then, ensure that ABNs are being used correctly. “Pull out the top 20 services for your practice, such as complete blood counts and lipid tests, and the reimbursement polices for these services. Follow this up by seeing if the codes used most often for those services are payable,” says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for the aforementioned Physician Management Group, Inc.

It’s also important to ensure that modifiers are used correctly. These allow physicians to communicate with automatic processing systems and can increase or decrease payment for a specific service, depending on the modifier used.

Also, check credit balances and patient refunds to be sure they have been made on a timely basis. If the practice owes money to Medicare or to a Medicare patient, the refund must be given within 60 days of notification that the refund is due. The use of credit balances instead of refunds is not allowed and is a major area of investigation by the Office of the Inspector General (OIG) for the US Department of Health and Human Services, says McDaniel. “Most of the refunds are small, and many practices decide to simply credit the patient’s account, but the US government mandates that the practice refunds the amount that is due,” he notes.

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"Incident-to billing is another hot button, and the important thing here is to educate staff members on compliance with rules on incident-to billing and to document those training efforts," emphasizes McDaniel. "It's important to be able to prove you made a good effort in the event of a problem," he adds. Incident-to claims are used for services or supplies that are furnished as an integral, although incidental, part of the physician's professional services in the course of diagnosis or treatment of an injury or illness. They are provided by nonphysician practitioners who can perform any services permitted by the laws in their state and bill for those services using their own identification number. Reimbursement for services billed this way is 85% of the physician fee schedule in most states. Incident-to claims are filed in the same manner as when the doctor provides the service, and such claims pay 100% of the doctor's fee. Because abuse of incident-to billing is thought to be extensive, it is included in the OIG's 2003 Work Plan. Correct use of incident-to billing is therefore particularly critical.

There are three requirements to remember for incident-to billing. First, nonphysician providers who provide the services must be allowed to do so under the laws of their state. Second, the physician must supervise the nonphysician practitioner and be immediately available and on the premises. Finally, the service must be initiated and followed up by the physician. A new patient visit or a visit by an existing patient for a new medical problem cannot be billed as an incident-to service, explains Picou, because the physician must first see and evaluate the patient. This requirement also calls for the physician to stay involved in the patient's care during follow-up, she concludes.

A thorough billing audit also

Billing Audit Checklist

A billing compliance audit should ensure the following:

- Each chart includes evidence of medical necessity, all associated documentation, claims, explanations of benefits, and payment stubs.
- Unbundling did not occur.
- Consulting physician's findings are documented in the medical record and have been communicated to the referring physician.
- Each encounter contains a clear diagnosis, and all diagnoses are listed in the internal encounter form.
- Each chart reviewed has a clinical and a clerical audit trail.
- An educational program is in place for all staff members responsible for posting charges and payments.
- The number of claims resubmitted for review or appeal is examined, and the reasons for the denial are compiled.
- All charges have been submitted on a timely basis.
- All necessary waivers are in place and in the patient's chart if you are providing noncovered services, services that are not medically necessary, or screening laboratory testing.
- All modifiers are used appropriately.
- Patient refunds have been made within 60 days.
- Services provided by nonphysician providers meet the requirements for incident-to billing.
- Documents such as encounter forms and superbills use codes that are complete, current, and appropriate.

includes a review of internal documents such as encounter forms and superbills to determine that codes are complete, current, and appropriate. This is best done by reviewing the practice's CPT-4 frequency report. Approximately 80% of the practice's volume will be contained within 20% of the available codes for that specialty, McDaniel says.

The education connection

Finally, the information gathered in each audit is only useful if it leads to effective changes in billing. An ongoing educational program should therefore be in place for all staff members responsible for posting charges and payments. "Doctors should look at the results of the audits closely," says McDaniel. "For one thing, they

should want to know the dollar impact of the problems that are uncovered. For another, the issue may come down to something as simple as educating one person."

Whatever the problems in your billing system, a comprehensive billing compliance program will not only help uncover them, but it will also often suggest fixes to address them. "Many doctors rely on their staff people to ensure billing compliance, but it's the doctor who signs the claim and who is responsible for it," sums up Carbrey. Careful audits will go far to eliminate billing problems today as well as down the road.

Reported and written by Deborah Epstein, in West Milford, NJ. More information on these issues is available on our Web site (see page 8).

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May 2003

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