

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

Government Seeks to Shrink Payments for Medically Unnecessary Services

Documenting Medicare claims for medical necessity can be a challenge. Yet, practices had better be prepared to pay even closer attention to medical necessity in their claims or face the consequences. Once again, the US government is seeking to reduce payments for ineligible claims, which were estimated at more than \$13.3 billion in 2002, according to *Improper Fiscal Year 2002 Medicare Fee-for-Service Payments*, a report from the Office of Inspector General (OIG), US Department of Health and Human Services. That amount represented 6.3% of the total \$212.7 billion in processed fee-for-service payments reported by the Centers for Medicare and Medicaid Services (CMS) last year.

Medically unnecessary services were

the largest category of improper payments in 2002, as they were in 2001, 2000, and 1998 (see table, page 6). Such services accounted for 57% of incorrect claims last year—a significant increase from 2001—and cost Medicare an estimated \$7.6 billion. Documentation errors also swallowed a significant percentage of the funds paid out in error in 2002—and in many previous years. The OIG says these two categories are “pervasive problems” and recommends that the CMS increase efforts to ensure that medical records support billed services—and that improper payments are recovered. You should therefore strive to be as accurate and thorough as possible when documenting medical necessity. The task is time-consuming, but it is also imperative.

“The regulations will only get tighter in the future, and practices will lose money if they don’t comply,” says Sara S. Grostick, MA, RHIA, associate professor and director of the health information management program at the University of Alabama at Birmingham.

Changes ahead

Denied claims are already very costly for practices in terms of lost revenue and staff productivity. But judging from the recommendations of the OIG report, rejections are likely to become

even more common. This particular report calls for stricter oversight and interventions to reduce overpayments.

In addition, the report states that the OIG will no longer publish the improper payments report. Instead, the CMS will publish a national error rate developed through Comprehensive Error Rate Testing and the Hospital Payment Monitoring Program. Baselines will be established to measure each contractor’s correct processing and claims payment. The results will allow CMS to identify billing anomalies and to develop “corrective action plans” that include provider education.

A further sign of the stricter control to come is a recent change from the CMS in documentation requirements for providers who order laboratory services. When more information is needed to settle a claim, the CMS will first go to the laboratory for the information. If the laboratory can’t provide the necessary details, the CMS will then request them from the ordering doctor. If after 45 days the documentation is still not provided, the service will be denied. If the laboratory doesn’t give the ordering doctor’s name, the claim is automatically denied. “The ordering doctor’s name must be provided even if the ordering doctor is the one who performed the test,” says Thomas Loughrey, chairman and

(Continued on page 6)

CONTENTS

Editorial

Speaking of Errors.....2

Strategy

Strictly Confidential:
Does Your Practice
Have a Privacy Officer?3

Questions From Readers

How Does Reporting
More Than One Diagnosis
Affect My Payment?5

Speaking of Errors

A lot of work can be generated by a simple typographical error. In November 2001, the Centers for Medicare and Medicaid Services (CMS) stated its intention to include ICD-9-CM codes 401.0 through 401.9 in its list of covered diagnoses for lipid testing. However, when the national coverage determination (NCD) for lipid testing was published, the dash between these two codes was inadvertently replaced by a comma. As a result, the NCD says it covers lipid testing for patients with malignant essential hypertension (401.0) and unspecified essential hypertension (401.9), but not for those with benign essential hypertension (401.1). On April 9, 2003, the CMS opened a formal NCD request that described this problem on its Web site (www.cms.hhs.gov/ncdr/tracking-sheet.asp?id=94) and called for public comments. A resolution is expected by July 9 of this year.

Seemingly small clerical errors can cost you much time, too—not to mention money. Specifically, incomplete documentation or use of the wrong codes can limit your reimbursement. While physicians have made tremendous progress in the area of coding compliance over the last several years, physicians have not made much progress when it comes to supporting the medical necessity of their services. The confirmation is found in *Improper Fiscal Year 2002 Medicare Fee-for-Service Payments*, a report from the Office of Inspector General for the US Department of Health and Human Services. As you'll learn in this month's cover story, more than one half of all claims paid in error involve medically unnecessary services; at least the claims don't appear to prove that the care given was essential. We tell you how to avoid this recurring problem.

Also in this issue, we discuss a new staff position for your practice—the privacy officer mandated by the Health Insurance Portability and Accountability Act's privacy rule. You'll learn what is expected of the employee charged with these responsibilities. Depending on the size of your practice, you may be able to add the job to your current compliance officer's duties. In addition, you'll also find out how to code three very different clinical encounters that have confounded readers of this publication.

It may sometimes seem that federal regulations are overwhelming and the methods needed to comply with them convoluted. While regular review and modification of the compliance programs you've developed may not seem like exhilarating work, the tasks are designed to help ensure financial success—as well as peace of mind.



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

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Strictly Confidential: Does Your Practice Have a Privacy Officer?

Now that the Health Insurance Portability and Accountability Act's (HIPAA) regulations regarding patient privacy have gone into effect, physician practices must have a privacy officer who is responsible for overseeing the integrity of public health information (PHI). Practices that don't comply with the new rules face fines of up to \$250,000—and in severe cases, even imprisonment for individual violators of the regulation.

But who should be in charge of privacy? Practices may already have a corporate compliance officer (CCO) as recommended by the Office of Inspector General for the US Department of Health and Human Services (HHS). By definition, the CCO's tasks usually include collecting PHI and distributing it through medical records, billing systems, and claims submissions, according to D. Scott Jones, CHC, vice president, risk management for InLight Risk Management in Oklahoma City, Okla. "The HIPAA information security officer—or privacy officer—is more finely focused on the protection of health information," he adds.

Practice size matters

The privacy officer in a small medical practice could be the office manager who has other non-privacy-related duties, according to the HHS. Or as noted, the additional duties could be taken on by the existing CCO. In many physician practices, this person may already shoulder responsibilities that are relevant to privacy while making certain that all coding and billing procedures are in order.

"The information security officer may rely on the services of outside security experts, to ensure that practice's computer system is safe from unauthorized access," Jones observes. Electronic security is an issue that

most information technology companies have already dealt with on behalf of their clients.

Sara S. Grostick, MA, RHIA, associate professor and director of the health information management program at the University of Alabama in Birmingham, agrees that the compliance officer and privacy officer could be the same person in a small practice. "I do think that many MDs could combine these duties into one person—someone to look at compliance, primarily documentation, coding, and billing—and security issues," she says.

However, bigger health care organizations will likely require a different system. "In large organizations, these roles may need to be differentiated to allow for proper management of both sets of duties," Jones stresses. "In complex organizations, the information security officer is often a high-ranking member of the information services department, but he or she should have sufficient operational knowledge of the organization to be able to analyze where data enters and leaves the organization and where it is at risk."

Other issues would also need to be handled differently in sizable locations. For example, in a small practice, the training requirement may be met by providing each new member of the workplace with a copy of the practice's privacy policies and documenting that new members have

reviewed the policies. In contrast, when many employees need to be educated at one time, training could be accomplished with live presentations, videos, or interactive software.

Developing a job description

The final modifications to the HIPAA privacy rule do not specifically explain what the person in charge of medical privacy and security issues should do. "The HIPAA rules are very general about the job duties for the compliance officer," says Grostick.

"The rule does not give precise things you must do or not do," says HHS spokesman Bill Pierce. "There are an infinite number of possible situations. What it does do is say you have to take reasonable measures to protect people's privacy." (See "Administrative Requirements for The HIPAA Privacy Rule," on the following page.) In short, he says, practical implementation of the new rule requires "simple common sense."

For example, sign-in sheets are acceptable, but the reason for the patient's visit should not be on the sheet. When patients' charts are placed outside patient care rooms, have the charts face the wall or door instead of facing outward. Also, computer screens should not face the public.

Jones says the duties of the privacy officer should include the following:

- To analyze facilities to ensure

(Continued on page 4)

adequate protection of medical records for both on- and off-site storage; other PHI such as billing data; and equipment that may transmit data, such as faxes, computers, and Intranet systems.

- To provide training to staff people to ensure that they are well aware of information privacy issues.
- To develop privacy notices that are sent or provided to patients and business partners.
- To develop or manage contract clauses that specifically protect health information that is shared with business partners.
- To review and develop systems (password protection, encryption, firewalls in computer systems) to ensure safety of electronically transmitted health information.
- To manage privacy and inadvertent disclosure incidents.

Don't be afraid to seek help when needed. A number of Web sites provide helpful background information. Start with the Centers for Medicare and Medicaid Services (www.cms.hhs.gov/hipaa/), the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), or the HHS (aspe.os.dhhs.gov/admsimp). Grostick reports that practices may want to contact the director of the health information management (HIM) department at their local hospital for practical guidance. "They need to work closely with HIM department personnel because they can help them," she notes. "Many of them consult part-time. The cost of an HIM consultant might not be as much as a full-time person within the practice. Many HIM professionals believe that assisting physicians will probably help them in their hospital department operations."

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

Administrative Requirements for The HIPAA Privacy Rule

According to the Office of Civil Rights, covered entities for the new HIPAA rules range from the smallest provider to the largest multi-state health plan. Each covered entity must meet the following general requirements under the new rules:

- It must develop and implement written privacy policies and procedures that are consistent with the privacy rule.
- It must designate a privacy official who is responsible for developing and implementing privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing information on its privacy practices.
- It must train all workforce members on its privacy policies and procedures as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the privacy rule.
- It must mitigate, to the extent possible, any harmful effect caused by use or disclosure of protected health information by its workforce or its business associates.
- It must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the privacy rule and to limit its incidental use and disclosure related to otherwise permitted or required use or disclosure. (For example, documents containing protected health information should be shredded before they are discarded.)
- It must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the privacy rule, and they must explain those procedures in its privacy practices notice. It is important that covered entities identify to whom individuals can submit complaints at the facility, and that individuals can submit complaints to the secretary of the US Department of Health and Human Services (HHS).
- It may not retaliate against a person for exercising rights provided by the privacy rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the privacy rule. Covered entities may not require an individual to waive any right under the privacy rule as a condition for obtaining treatment, payment, enrollment, or benefits eligibility.
- It must preserve all documentation required by the privacy rule—such as the practice's privacy policies and procedures and disposition of complaints—for six years after the date they were created or after they were last effective, whichever is later.

Source: "Summary of the HIPAA Privacy Rule," 2003, Office of Civil Rights, Washington, DC. Available at: <http://www.hhs.gov/ocr/privacysummary.pdf>.

How Does Reporting More Than One Diagnosis Affect My Payment?

Q: Sometimes a patient who makes an appointment to discuss one problem mentions another during the office visit. Or, a patient with a chronic illness will be seen for a different acute ailment. In these situations, should we list all of the diagnoses on the bill, or should we choose just one? If, for example, we use CPT code 99213 to bill for the outpatient visit, will we be paid more because we addressed two issues?

A: “Reimbursement is not determined by the number of diagnoses listed,” says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. Instead, reimbursement is tied to the level of service provided. However, the diversity of a patient’s complaints is likely to affect the intricacy of the history, the examination, and the decision-making process. These three elements are crucial in choosing an appropriate evaluation and management (E&M) code. The number of possible diagnoses and treatments is just one of three factors considered when gauging whether the path leading to your conclusions was straightforward or of low, moderate, or high complexity. You must also weigh the amount and difficulty of information to be retrieved and digested, the patient’s additional health problems, and the risk of complications, morbidity and/or mortality attending the illness and potential therapies.

A good rule is to include only the diagnoses that are relevant to the date of service for which you are billing, Picou advises. For example, when a patient with a history of hypertension

is evaluated and treated for streptococcal pharyngitis, you would not include the diagnostic code for hypertension—unless you specifically addressed the patient’s blood pressure in addition to the signs and symptoms of infection. On the other hand, a patient’s history of asthma is important when considering a prophylactic regimen for chronic migraine headaches, since certain β -adrenergic blocking agents could exacerbate the condition. Here, you would support the complexity of your decision-making process by noting both diagnoses. Always bolster your code choices with detailed documentation. If a payer down-codes a claim because the level of service billed was not supported by the diagnoses reported, review your paperwork to see whether the selected codes accurately portray the work you did.

Q: If a patient is admitted to the intensive care unit (ICU), do we use the E&M codes for initial hospital care (99221 through 99223) or for critical care (99291 or 99292)?

A: Depending on the circumstances, you might use both, says Thomas Loughrey, MBA, CCS-P, chairman and CEO of Economedix, LLC, a physician training and consulting company based in Orange, Calif. First, use one of the initial hospital care codes to report admission. Then, if the patient requires 30 minutes or more of critical care on the same day, you would add on code 99291 for the first 30 to 74 minutes of critical care services. For each ensuing block of 30 minutes, use 99292 as often as necessary. The next day, you would start again with 99291

for the first 30 to 74 minutes. You should also remember to bill for subsequent hospital care (99231 through 99233) when applicable.

Critical care can be provided in any hospital locale; the patient need not be in a critical care unit, Loughrey observes. Similarly, patients are not necessarily receiving critical care services because their beds are located in the critical care unit.

Q: One of my patients requires venom immunotherapy to protect him from severe systemic reactions to the stings of honeybees, white-faced hornets, yellow hornets, and yellow jackets. The initial treatment involves six injections: three containing honeybee venom and three containing mixed vespid venom. In billing for these, I used CPT code 95130, three units, and 95132, three units. The insurer has denied the charges, stating that I can’t use a unit value of three because the CPT code notes there are three injections. How can I clarify that the CPT code emphasizes the number of insects, not the number of injections?

A: The codes for stinging insect venom, 95130 through 95134, should be reported per injection, Picou emphasizes. In this case, you would report CPT code 95130, single stinging insect venom, three times (one unit each) to denote each separate injection of honeybee venom. Similarly, you would put down CPT code 95132, three stinging insect venoms, three times to represent each injection of mixed vespid venom.

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.

CEO of Economedix, LLC, which is based in Orange, Calif.

Who's responsible?

Establishing medical necessity for testing seems to be especially challenging for doctors. (See page 7, for examples of medical necessity errors.) One source of confusion centers on whether the hospital or the ordering physician is responsible for providing ICD-9-CM codes. In fact, it's up to the laboratories to provide the codes, and it is the doctor's responsibility to give the diagnosis to the facility, stresses Loughrey. If the claim is denied, the laboratory cannot bill the physician. "The lab can only bill the person who incurred the charge; that is, the patient," he notes. What's more, the laboratory can only bill the patient if an advance beneficiary notice (ABN) has been signed—the ABN for laboratory services is different from the one used for general purposes. (Copies of both forms can be found at <http://www.cms.hhs.gov/medlearn/ref/abn.asp>.)

"The problem is that there is no real incentive for doctors to spend a lot of time documenting medical necessity because the physician is not reimbursed for that time," observes Loughrey. Similarly, doctors have no real incentive to see that ABNs are completed, since it is the laboratory that is (or is not) reimbursed.

Often, medical necessity is not clear to physicians. "There are plenty of definitions for medical necessity out there," says Randy J. Gershwin, M.D., CPE, medical director of Deaconess Medical Group, located in Evansville, Ind. "The payers, the laws, and even the courts all use different definitions," he adds.

Nonetheless, omitting necessary information is costly for practices as well as for the laboratory. "No lab will bill without a diagnosis, and it will therefore have to call the doctor's office for a diagnosis, which means wasted time and resources for the practice," says Loughrey.

"There's much to be said for getting it right the first time," agrees Charles E. Colitre, president of Med-Management Group Inc, headquartered in Akron, Ohio. "Otherwise, what you get is denials or audits that show claims without medical necessity, even if the services were provided but are under-documented."

Avoiding errors

How can practices overcome these obstacles and live in peace with the more stringent regulations? The experts suggest several tactics.

"The CMS looks at you and your peers to decide who will be audited, based on who is charging more for services," says Grostick. She gives the example of a physician working at a

hospital system who had the shortest hospital stays in his specialty in the nation. "Medicare contacted him, wanting to know why his patients had the shortest stays. It became apparent that he performed surgery and procedures more quickly, and he therefore became the benchmark for his specialty," she points out. The lesson here is that doctors should also use benchmarks to determine whether they are charging and filing in line with their colleagues, advises Grostick. If not, they may be flagged for auditing.

Practices should strive to improve the business side of patient care, she urges. "There is usually a loose management structure in the physician's office, but practices need to strengthen these to handle compliance issues." Someone should be aware of what Medicare is looking at if and when a practice is audited, she adds. This should be a full-time employee with a business—rather than a clinical—background, this administrator recommends. Or, practices may opt to use a consultant for periodic audits. In either case, the focus should be on coding for evaluation and management. Are reports from consultants in the record? Are the dates correct for diagnostic tests? Are you over-coding or under-coding?

Then, practices should listen to what the consultant or employee has to say. "A good coder will make

Medicare Payment Errors in 2002

Type of payment error	1996	1997	1998	1999	2000	2001	2002
Documentation errors	46.8%	44.3%	16.8%	40.4%	36.4%	42.9%	28.6%
Medically unnecessary services	36.8%	36.9%	55.6%	32.8%	43.0%	43.2%	57.1%
Coding errors	8.5%	14.7%	18.0%	15.8%	14.7%	17.0%	14.3%
Noncovered/other	7.9%	4.1%	9.6%	11.0%	5.9%	-(3.1%) ¹	0.0%

1. This negative amount (-3.1%) applies primarily to "other" errors. In such cases, medical reviewers determined that the amounts billed should have been higher or that amounts previously denied were correct.

Source: *Improper Fiscal Year 2002 Medicare Fee-for-Service Payments*, Office of Inspector General for the US Department of Health and Human Services.

suggestions and assist with documentation issues,” notes Grostick. On the other hand, an unskilled coder will certainly have a negative impact. “One practice of 11 doctors found during an audit that their coder rarely resubmitted denied claims. As a result, that practice was losing millions of dollars,” she says. A knowledgeable coder will also have time to do the digging that may be necessary. “An on-staff person would know to contact the CMS or the OIG and ask for help when it’s needed to resolve questions about medical necessity or other issues,” counsels Grostick.

“We have two full-time coding analysts—a nurse certified in coding and another certified coder—in our group,” says Gershwin. The 12-site group includes 25 physicians and three nurse practitioners. As a result of tightening its coding management, the practice reduced under-coding by 26% in six months, significantly increasing revenues, he adds.

Other steps to take

Software can also be useful for reducing denials and staying compliant, although the quality varies considerably among different products. “There are products that can flag problems and catch them before the patient even leaves the offices,” says Gershwin. “They can save plenty of time and administrative expenses.” His group is currently performing a cost-benefit analysis on a software module for checking claims. “It would be nice to know right at the front end if there is a problem,” he comments. “And there are so many regulatory changes, especially for our group, which has sites in three states. The software would help keep track of all changes for every one of our sites.”

Staying up to date means keeping up with reports from your Medicare contractor, Gershwin adds. “These

Examples of Medically Unnecessary Services

Medical necessity errors can be costly, as these examples given in the OIG report reveal:

- A hospital was paid \$11,751 for a beneficiary admitted for an aortogram to check the status of a bypass. Bilateral stents had been inserted in an outpatient procedure. The medical reviewer determined that the patient could have been evaluated in an observation setting and did not require an acute care admission. As a result, the entire payment was denied.
- A hospital was paid \$13,750 for a beneficiary admitted with complaints of upper chest pains and a history of severe chronic obstructive pulmonary disease. The hospital’s physicians indicated that the patient’s examination revealed wheezes; however, no significant abnormalities were noted in the patient’s oxygen level, and the person was discharged the day after admission. The medical reviewer determined that the care could have been provided in a less acute setting and denied the total payment as a result.
- A hospital was paid \$3,457 for a beneficiary admitted with complaints of swelling of the knee. According to the medical records, the patient was not in acute distress and had no fever. The medical reviewer determined that the care could have been provided in a less acute setting, denying the total amount.

come out regularly, and our coding analysts review them regularly,” he says. Getting everyone on board is also a key component. “We use a team approach and have a board of physicians and hospital administrators. As a result, all decisions are self-generated.”

Intensive education is another critical element. “I tell our doctors to always assume that someone is looking over their shoulder when they write notes,” says Gershwin. “We have an outside consultant visit once a year for one-on-one education with our doctors.” In addition, the group’s coding analysts evaluate the physicians and use a scoring system to rate their accuracy. If a physician falls below 80% accuracy, he or she is given more education and re-audited in one month. With 80% to 90% scores, they are re-audited in three months. “And everyone is audited at least two times a year,” Gershwin says, adding that it

is important to include hospital charges, although many practices neglect to do so. “The CMS will soon audit coding for hospital visits, so we provide education to our staff on this as well,” the physician points out.

ABNs are especially important because they are the only way to prove to Medicare that the patient was told in advance that the service would not be covered. They also help prevent accusations of fraud, Gershwin indicates. He suggests that practices not use generic ABNs. Instead, the forms should be specific for each patient.

The essential thing to keep in mind is that the system is not out to get you and that Medicare is just doing its job, concludes Grostick. “Remember, it’s a partnership.”

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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