

THE PHYSICIAN'S CODING COMPLIANCE ALERT™

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

Small Risk, Big Stakes: Considering Insurance for Coding Errors

A relatively new insurance product can help physicians defray the costs of defending against allegations of Medicare and Medicaid fraud and abuse as well as possible violations of other laws, such as the Health Insurance Portability and Accountability Act (HIPAA), the Emergency Medical Treatment and Active Labor Act (EMTALA), or the Stark laws. Coverage can include fees for lawyers and consultants, and the payment of resulting fines or penalties. The policies can also indemnify a practice for the expenses incurred in dealing with a private payer's audit. A comprehensive policy runs between \$1,000 and \$2,000 per physician, depending on practice size and coverage options.

Viewed in light of the possible

penalties, that may be a bargain. If you're convicted of defrauding Medicare or Medicaid, the civil fines can run from \$5,500 to \$11,000 per infraction—and each contested claim can be regarded as an infraction. On top of that, you must return the money in question, and you can be assessed punitive damages of three times that amount. Should your infraction be deemed criminal, you may even risk jail time.

And because you have the forces of the Federal government mobilized against you in these cases, the chances of winning are often poor. Even if you do eventually prevail, cases may drag on for years, and the legal costs can be staggering. One Montana family physician, who settled last year after a four-year battle with the US government, estimates that her case cost her more than \$300,000 in legal bills. That's not including what, if anything, she paid to settle. The court sealed the agreement.

Of course, good coding, good documentation, and strict compliance to the payers' rules are the best protection against legal woes. What happens if you make an honest mistake?

"The False Claims Act, under which these cases are prosecuted, states that 'no proof of specific intent to defraud is required,'" says Scott A. Dutton, of The Cunningham Group,

an insurance agency in Oak Park, Ill. "You don't have to intend to defraud the government to be accused. If you do so accidentally, or there's a clause you're not aware of, it doesn't matter." That's why Dutton and insurance agents like him who specialize in health care have begun to offer billing errors and omissions (E&O) coverage, or, as it's more popularly known, "fraud and abuse insurance."

How great is the risk?

Although defrauding the Medicare and Medicaid programs has always been illegal, the stakes began to go up in 1981 when the US Department of Health and Human Services (HHS) was authorized to impose civil monetary penalties. They rose even higher with the passage of the Medicare and Medicaid Patient Protection Act in 1987, and HIPAA, passed in 1996, increased penalties and added new infractions. In addition, around 1995, the HHS's Office of the Inspector General (OIG) made health care fraud and abuse a top priority, assigning investigators who had been involved in the savings and loan crisis to examine the billing practices of the nation's health care providers.

Since 1996, Medicare program recoveries have topped \$3.5 billion. In 2001, investigations and prosecutions resulted in \$17.6 billion in savings for

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Signs and Symptoms of Frustration

The aggravation quotient associated with contemporary medical practice is driving some physicians into risky territory. Normal daily operations are inherently hectic. Add on abundant regulations, increasing expenses, declining reimbursement, and an overall flattening of income. These pressures could tempt the most stalwart practitioner to look for ways to ease the burden. For example, too many physicians shrug off the need for coding compliance programs because the law does not require them. Most practitioners believe they are choosing appropriate CPT-4 codes and providing adequate documentation, yet this often proves untrue when their use of evaluation and management codes is compared with the government's audit standards. While compliance programs remain voluntary, penalties for infractions are mandatory.

A new study in the May 27, 2002, issue of the *Archives of Internal Medicine* indicates that a minority of physicians would actually bend insurers' reimbursement rules. Participants were given one of two hypothetical scenarios in which an insurer denied the patient—a 55-year-old woman with severe angina or a 55-year-old man with moderate low-back pain—a medical service. Seventy-seven percent of physicians surveyed would appeal the decision, 12% would accept it, and 11% were willing to "misrepresent the facts" to get the patient additional care.

The percentage willing to go this last route increased with the so-called hassle factor associated with the appeals mechanism—as the likelihood of a successful appeal dropped dramatically from 95% to 50% or when the appeals process climbed from 10 minutes to 60 minutes. Most important was disease severity: 16% would alter the facts for the woman with severe angina; 3% would accept the restriction. Corresponding figures for physicians treating the man with back pain were 7% and 20%, respectively.

Good intentions; dangerous tactics. You can be an effective clinician and patient advocate without jeopardizing your livelihood. Numerous resources are available to improve proficiency in coding and documentation. In this issue alone, we address insurance for compliance failures, answer readers' coding questions, and make an important correction. We also encourage you to learn from practice audits, the last of three important steps in a solid coding compliance program. Although there is a single-digit chance of being audited, if I were a physician, I am not sure I would be willing to take that risk.



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Audits Are Ineffective If Findings Are Ignored, Experts Advise

Chart audits can identify serious coding problems, but where do you go from there? The experts agree that the information gathered is useless if it doesn't fuel necessary changes. "The important thing is to implement a corrective action plan," says Charles E. Colitre, president of Med Management Group, Inc., in Akron, Ohio. "That's where most practices fall down, but developing an effective plan can decrease your risk of fines and paybacks and even help you capture potentially lost revenue."

Developing an action plan

The first step is to determine where and why your practice deviates from Medicare standards. "Is there something about your patient demographics that causes your practice to fall outside of benchmarks compared with others in your field?" asks Joseph Skeens, CPC, CCP, CBCS, managing director and CEO of Physician Educational Services, LLC, in Sarasota, Fla. If the discrepancies are based on a distinct profile of medical cases, there's no problem. But if miscoding is the culprit, action is needed, he asserts.

Next, consider a more focused audit to ensure that the errors are true findings and not simply sampling artifacts. "Say you've identified three instances in the general audit where you've missed coding for medications," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, in New Orleans, La. "You should then expand the audit to focus on that area," she says. Focused audits can also be done for particular physicians or evaluation and management (E&M) codes.

Training is critical

Once you have identified true coding problems, "training is what it's all about," emphasizes Picou. "If you

don't learn how to make changes, the audit is worthless." Training should include everyone who participates in coding tasks, including physicians, clinical staff members, and check-out and appointment staff, says Picou. "The information should be shared with everyone and understood by everyone," she adds. Generally, doctors and staff people should be trained separately, since the two groups usually have different questions and issues. "Group training can work, but if the problem is specific to one doctor, then one-on-one training is most effective," says Colitre.

"The doctor who routinely overutilizes codes puts the entire practice at risk of fines, paybacks, and charges of fraud," notes Skeens. "One-on-one training is ideal because I can sit with the physician, compare the contents of the audited chart notes against the Centers for Medicare and Medicaid Services' (CMS) guidelines, and point out why each encounter was under- or over-coded."

A serious issue readily detected during the auditing process is illegible handwriting, and the courts are getting serious about that, Skeens observes. "As a case in point, 30% of all handwritten prescriptions must be reworked because of illegibility," he adds. To eliminate the problem, some doctors use handheld devices or hos-

pital computers that interface with local pharmacies.

"Physicians should also be aware of when and how to use modifiers on E&M codes," Skeens points out. He gives the example of the patient who is seen for a wellness visit, then mentions a boil that requires incision and drainage. "That's a separate procedure requiring the addition of a two-digit modifier to the E&M code; otherwise the doctor will not be paid for the procedure," he counsels. Another common coding oversight is made when a patient is discharged. "Many doctors don't know that there are two levels of discharge, one for when the doctor spends less than 30 minutes with the patient and another for 30 minutes or more," he adds.

The basic concept of medical coding involves matching the correct diagnosis with the procedure or service being performed and assuring that the physician and relevant staff understand this very important relationship, says Skeens. For this, the right tools are helpful. "The traditional subjective, objective, assessment, and plan (SOAP) notations format does not lend itself to adherence to the E&M documentation guidelines and is an impediment to both the documenting and auditing process," he asserts. "I recommend that the practice develop a template

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Squaring Accounts After An Audit

An audit may uncover claims that were over-billed, under-billed, or are eligible for appeal. It's important to resolve loose ends.

If an audit reveals that your practice has over-billed Medicare, for instance, a refund should be sent within 30 days, says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, based in New Orleans, La. "Even if it's only 25 cents, the law mandates that Medicare gets a refund," she adds. Some Medicare carriers recoup their money electronically, so it's best to determine the system used by your carrier. If you're uncertain of the carrier for your state, you can locate it online by searching your state name, followed by the word Medicare. "No matter how you do it, be certain there's a tracking mechanism in the system that shows when you identified and paid the over-bill," Picou says.

If the amount you were overpaid is more than a minimal amount, you should seek advice from a health care attorney on how to return the payments, says Charles E. Colitre, president of Med Management Group Inc., in Akron, Ohio. "Legal advice is needed in these cases because there may be issues of fraud that could involve investigation by the Federal Bureau of Investigation or the Office of the Inspector General." He adds that "if your Medicare carrier happens to catch the over-bill and demands repayment, you should repay the amount and hope that's the end of it from the government's point of view. It's vital, however, to determine the reason for the over-payment and initiate corrective action to avoid having the problem recur, which is a surefire trigger for government scrutiny."

Other third-party over-pays should also be reconciled. Some of these will credit a patient's account rather than requesting payment, so it's best to determine the system used by each third party.

Whether to re-bill or to appeal

If an audit shows under-billing or a denial by Medicare, you must decide whether to re-bill or appeal the decision. "For example, if you forgot to include a modifier, you can add the correct code and resubmit the bill," says Picou.

"I suggest that practices take a vigorous approach to re-billing," says Joseph Skeens, CPC, CCP, CBCS, managing director and CEO of Physician Educational Services, LLC, in Sarasota, Fla. "According to Medicare's own statistics, roughly 60% to 70% of re-bills are paid fully or partially in favor of the physician," he adds. "To routinely decline to re-bill or utilize the available mechanisms of appeal that are built into the system may adversely affect a practice's bottom line."

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utilizing the main headings outlined in CMS' E&M documentation guidelines to replace its existing dictation formats." These can be found with the search words "documentation guidelines," at <http://www.hcfa.com>.

Develop a re-audit schedule

After the staff and physicians have been trained, it's critical to evaluate whether or not the education efforts have worked. Repeat the audit every one to three months to determine

whether more action is needed.

"I like to train staff people to do audits themselves and contact me if they have any problems," comments Skeens. "The staff can pull 10 charts for the physicians periodically, and then help them understand where there are errors. It's a team effort."

What about the physician who isn't interested? "The auditing and training process is a forced march for some physicians," Skeens observes. "In these instances it is essential that the entities who bring in outside auditors apprise the practitioner of the importance of the audit."

"Just walking physicians through the E&M coding guidelines is very eye-opening," Colitre adds. "But if you can't cure the problem, then other remedial action, including sanctions or discharge, may be needed. Otherwise, you could be subjecting your practice to liability."

The right staff

A qualified, trained staff is crucial, and practices should consider hiring a certified coder as a go-between for doctors and other employees, Colitre suggests. Staff members are often reluctant to go back to doctors with questions, and a professional coder could help develop a rapport and catch more errors. Practices should also encourage and invest in their staff's certification and continuing education efforts.

Finally, it's important to know that Medicare isn't out to get physicians, says Skeens. "If your staff is well-trained and supervised, and knows the rules and how to code for services, you can survive—as well as grow your practice—in this managed care environment," he concludes.

Reported and written by Deborah Epstein, in West Milford, N.J. To learn more about compliance programs, see our Web site (at www.Coding-Compliance.com).

What Must We Do To Be Appropriately Paid?

Q: Whenever we file a claim with a procedure, such as a wart or a lesion removal, the insurer usually denies payment for lack of chart notes. And, if we bill it along with an office visit—generally a level two—and attach a modifier, they almost never pay. We have even begun sending notes each time we bill these codes, which is very time-consuming since we have to print the claim instead of filing it electronically. Is there any way to avoid this?

A: First, examine the provider manuals from the insurance companies that are turning down your claims, says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, headquartered in New Orleans, La. Perhaps these resources offer some guidance on how you should bill when an office visit has included evaluation and management (E&M) services as well as a procedure. Failing that, the insurer may offer support by telephone.

Consider whether the procedure codes you've used are payable; if they are, investigate whether or not they have been paid when paired with any of the diagnosis codes you've resorted to in the past. While some insurers might allow you to bill for the procedure and E&M services separately and will reimburse you for each, others may suggest that the two be bundled. When a company does permit you to bill the services on an individual basis, ask whether documentation is required to verify that both were done, Picou suggests. Submitting the extra materials can be a nuisance, but doing so can

ensure that you receive money you've already earned.

An unwise practice is to tack on a low-level E&M code when billing for a procedure. Procedures discussed in advance and scheduled typically do not generate enough extra work to support an additional code, Picou observes. Routine pre- and postprocedural services do not qualify.

However, if you are indeed submitting charges for unconnected E&M services that were performed at the same time as the procedure, make certain you document everything independently. By doing so, you underscore for those reviewing your claims that you have provided two or more distinct types of care, she asserts. In addition, make certain you have appended the "-25" modifier, denoting a "significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service," according to the American Medical Association's *Current Procedural Terminology: CPT 2002*. Apply the code that best supports your level of documentation. Although you might think it's safer to stick with low-level codes, you may, in fact, appear to be indiscriminately affixing codes to fortify your charges. Follow these steps, and you are more likely to be properly paid for your efforts. If billing problems continue, think about scheduling an appointment with a company representative to discuss the best possible billing methods. Bring all pertinent data with you—the more detailed, the better.

Q: A primary care practitioner (PCP) refers a patient to a sur-

geon. That surgeon then returns the patient to the PCP, requesting a preoperative evaluation and clearance. The PCP performs the necessary examination, fills out a form, and the patient goes back to the surgeon. How should the PCP correctly code this service?

A: These encounters are confusing, and as such, are frequently misunderstood—and miscoded, Picou says. Keep in mind that a referral, as it relates to coding, occurs when one physician sends a patient to another physician, who then treats the patient for a particular ailment. In contrast, a consultation is rendered when one physician sends a patient to another for evaluation, and the second physician returns the patient to the first one, providing findings and an opinion rather than treatment.

The scenario you describe should be coded as a consultation, even though the PCP had been treating the patient before the need for surgery arose. The surgeon sent the patient back to the PCP for an opinion regarding the patient's overall medical condition and her or his ability to undergo surgery. In turn, the PCP provided preoperative clearance and a written report supporting the conclusions. The patient then goes back to the surgeon to undergo the indicated procedure. Coding the work as an established patient visit would be incorrect, even though the patient has been part of the PCP's practice. *Editor's note: Readers of The Physician's Coding Compliance Alert are invited to visit our Web site at www.Coding-Compliance.com and submit their questions. Members of our Advisory Board will offer their expert opinions.*

What To Know Before Writing A Check

Comprehensive billing errors and omissions coverage has been available to hospitals for about four years. More recently, it has been extended to physician practices. Because such coverage is so new, physicians—and sometimes even their insurance agents—may not know about it. Boynton and Boynton carries the low-limit, defense-only policies for some 15,000 physicians and has comprehensive coverage policies, with the \$1 million limit, for only about 2,500, estimates Ron Gillaspie, a senior vice president for Boynton and Boynton. “We find only the few agents who are really familiar with the product can go out and distribute this policy because they’re the only ones who understand it,” he adds.

Yet, a knowledgeable broker is necessary because the issues may become complex. Before buying a policy, scrutinize the details. Be sure to check:

- **What’s covered.** Will your policy involve only Medicare and Medicaid? What about protection pertaining to the Health Insurance Portability and Accountability Act, the Emergency Medical Treatment and Active Labor Act, the Stark laws, or private insurer’s audits?
- **What’s provided.** Does the policy cover both lawyers’ fees and shadow audit expenses? Will it pay fines, penalties, settlements, and other judgments? Will the coverage provide cash-flow protection?
- **The policy’s limits.** If you face prosecution, \$1 million may be a much more realistic figure than \$25,000.
- **Whether a compliance program is required or optional.** Are discounts offered when a program is in place?
- **Who chooses the lawyer.** Do you have access to a panel of experts? Are you locked in to the insurer’s choice of attorneys?
- **Whether the coverage is retroactive.** How far back does protection go?
- **Whether the insurer pays on your behalf.** Or must you lay out the money and wait to be reimbursed?
- **The insurer’s rating.** Seek an insurance company with a grade of B+ or higher from Standard & Poors, a rating agency in New York, and A.M. Best & Co., in Oldwick, N.J.

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the US government, according to OIG spokeswoman Judith Holtz. Of that, approximately \$16 billion was in disallowances—such things as hospital days billed but not approved. Some \$1.6 billion was recovered as the result of civil and criminal prosecutions, but that included settlements in high-profile cases involving national chains. “A couple of big settlements will kick that number up very high,” observes Holtz. “The rest of it is made up of plenty of cases

resulting in much smaller amounts.”

According to Holtz, an individual doctor’s likelihood of being charged is not very great. “We don’t prosecute for billing errors,” she says. “There are 800,000 physicians out there practicing, and the reality is that over the last three years our office has taken action in investigations against probably 30 physicians in each of those years.” In 2001, 423 criminal cases and 416 civil cases were brought by the US Justice Department as a result

of OIG investigations of health care providers, a category that includes laboratories, hospitals, nursing homes, home health care providers, and durable medical equipment sales, in addition to physician practices. About 3,800 providers were excluded from the Medicare or Medicaid programs in 2001, but, Holtz says, “a large number of those—1,000 to 1,200—were for failing to repay student loans, which is one of the conditions for which we must, by law, exclude them. Others were excluded following state licensing board revocations. A small number of these are the result of prosecution.”

But as with any evaluation of risk, likelihood is only one factor. The other is impact, should the unlikely occur. “It’s not unlike any other insurance product you’d purchase, such as your homeowner’s insurance or your auto insurance,” notes Dutton.

“Sometimes, clients will ask if buying insurance makes them look guilty,” Dutton continues. “No one should buy insurance because they think they’re doing anything wrong. You buy it so that if you are accused of wrongdoing, you have the financial resources to keep your business viable while you’re defending yourself. If you don’t have that, all that money’s coming out of pocket, with the potential of shutting down the practice.”

Defense-only versus comprehensive coverage

Malpractice liability insurance may include a small amount of what’s called “defense only” coverage for billing errors and omissions. Usually written with a limit of \$25,000 or \$50,000, this coverage will help defray legal fees, but usually cannot be applied to fines or penalties. Says Dutton: “Sometimes, to clarify the limits of what their policy is covering, an insurance company will give you a

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tiny bit of that coverage and limit it to a specific dollar amount. That way, it's crystal clear exactly how much coverage they will or will not provide. In effect, they're including it to exclude it, because \$25,000 worth of coverage today is insufficient. That may cover a retainer at a law firm to get them to talk to you. But after they spend about two days working on your case, they're going to want another \$25,000 or \$50,000 to move forward."

Comprehensive coverage includes both defense costs (lawyers and consultants) and indemnity (fines and penalties). In addition, limits are higher. For example, Dutton's program offers \$1 million in coverage for individual physicians, more for groups. "We pick up both your defense costs—which can be staggering—and the indemnity for fines and penalties," explains Ron Gillaspie, senior vice president of Boynton & Boynton, the underwriting representative for Lloyd's of London's comprehensive physician E&O product. "If the doctor is civilly fined or penalized for violations, we cover that."

What's covered in a comprehensive program has grown over time. "Initially, it was primarily for Medicare and Medicaid," says Gillaspie, "but we've expanded to private billers also. Obviously, that's defense coverage, because they can't fine you. But they will investigate you, and you may have to spend a lot of money to defend yourself, so that's covered. We've added HIPAA along with Stark coverage against allegations of improper referrals and relationships as well as EMTALA."

Coverage can be retroactive, up to six years for qualified applicants. "Obviously if you're in the midst of an audit, you won't be eligible for that option," Dutton says.

Policies vary on how they pay—some repay costs after they're incurred,

where others pay up front. The Boynton product restricts physicians to a panel of expert attorneys and billing consultants and pays them directly. "The problem is there's been a lot of abuse in people setting themselves up as health care attorneys without any experience. Between not knowing how to defend these cases and billing for far too many hours, the costs were out of control," says Gillaspie. "We went out of our way to put together a panel of attorneys with long years of experience in defending these claims, so that they will defend them in ways that have been proven successful."

"We also have our own shadow audit team of specialists in billing and coding," Gillaspie adds. "If you leave it up to the government to determine what happens with your claims, they're going to find in their favor, obviously. So you're allowed to have your own auditors shadow what they're doing and give a separate opinion. The experts who do that are part of the defense team, and that's part of what we deliver in the program."

Help with compliance

At present, compliance programs are an option with comprehensive coverage, but they're not required. "In some of the programs, we sell or promote a compliance company along with the insurance product," says Dutton. "It's not mandatory because many of our clients already have compliance programs and their own consultants."

"You can get a few more discounts on the insurance by doing those things," Dutton adds. "It's also something the HHS/OIG considers when assessing fines and sanctions. Having an effective compliance program in place can be evidence of good faith."

Reported and written by Lauren M. Walker, in Cambridge, Mass. More information on insurance is available on our Web site (at www.Coding-Compliance.com)

Correction

Our June 2002 cover story, "Proper Use of Preventive Medicine Codes Can Improve Reimbursements," indicated that the preventive medicine codes 99381-99397 be used to bill Medicare for preventive services. Medicare pays only for elements of preventive care, and to bill correctly, you must affix the Healthcare Common Procedure Coding System G codes to the HCFA-1500, matching the G code to the pertinent diagnosis code. The G codes are as follows:

- G0101: Cervical or vaginal screening; pelvic and clinical breast examination
- G0102: Prostate cancer screening; digital rectal examination
- G0103: Prostate cancer screening; prostate specific antigen (PSA) test, total
- G0104: Colorectal cancer screening; flexible sigmoidoscopy
- G0105: Colorectal cancer screening; colonoscopy for patient at high risk
- G0106: Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- G0107: Colorectal cancer screening; fecal-occult blood test, 1 to 3 simultaneous determinations
- G0108: Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109: Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Attend a risk reduction teleconference, Wednesday, October 23rd—1:00pm ET (60 minutes)

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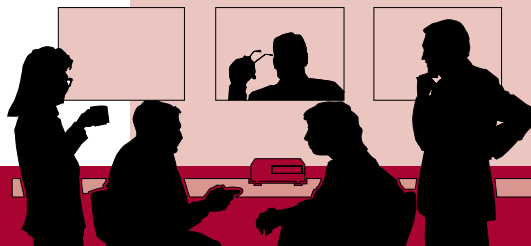
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