

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

Physician Recruiting: When Does an Offer Violate the Law?

Hospital X, a nonprofit facility, had 40 rehabilitation beds and three physiatrists on staff. Seeing a business opportunity, the physiatrists decided to build their own rehabilitation facility in the area, and the resulting competition emptied the rehabilitation beds in Hospital X. In desperation, Hospital X hired other physiatrists at more than twice the usual fee for that specialty and region. The original three physiatrists reacted by contacting the Office of the Inspector General and blowing the whistle on the hospital for private inurement (private enrichment with public funds). The fees were found to be excessive, and the hospital was forced to renegotiate the contracts with the new physiatrists and was subject to large fines for each day it took

to rewrite the contracts.

In another case, federal agents raided a California hospital in a large health system, and its chief executive officer (CEO) was indicted for relocation agreements made with physicians (see "A Disquieting Case For The Nation's Hospitals," page 2).

The two most important risks when coaxing physicians on board are charges of private inurement under Internal Revenue Service (IRS) rules or charges of anti-kickback violations under Medicare fraud and abuse laws. Private inurement rules apply only to tax exempt, not-for-profit hospitals. When a not-for-profit hospital gives funds to a doctor, it is considered inurement of public funds unless it is in exchange for services of equal value. All medical entities are subject to the anti-kickback statute.

Dallas, Tex. "The problem is, they are really desperate for subspecialists because of the short supply." As a result, some might be tempted to offer incentives that may break the rules.

Hospitals aren't the only ones at risk, however. Large private groups must also be careful when recruiting, as must physicians being recruited. It is up to them to know the rules, since they are subject to criminal charges, fines, and exclusion from Medicare programs for illegal agreements. "Doctors, especially younger doctors, get plenty of information from colleagues, and half of this is probably wrong," says William M. Miller, Esq., a health care attorney with Musick, Peeler, & Garrett in Los Angeles, Calif. "But when the contract is in front of you, you need to know the legal implications," he urges.

One problem is inflated expectations. "Headhunters do doctors a disservice by promising them lots of money," says Jack S. Schroder, Jr., Esq., a health care attorney with Alston & Bird in Atlanta, Ga. "Doctors don't always know the law and recruiting firms don't have to worry about the law, but doctors cannot risk committing a felony, which carries a minimum of one year imprisonment and a \$10,000 fine," he says.

Recently, the IRS shed light on the law for hospitals that are tax-exempt

(Continued on page 6)

CONTENTS

Editorial

A Disquieting Case For The Nation's Hospitals2

Strategy

Educational Programs Are Vital to Your Practice's Compliance Efforts3

Coding Update

New ICD-9-CM Codes, Coding Policy Take Effect Soon.....5

Who is at risk?

"An investigation often begins with an employee, former employee, or competitor blowing the whistle," says Paul DeMuro, Esq., a health care attorney with Latham & Watkins in San Francisco, Calif. "Hospitals are very cautious and have attorneys and certified public accountants that know how to protect them from errors," adds Casey Hughes, chief operating officer for Search One, a physician placement firm based in

A Disquieting Case For The Nation's Hospitals

In some endeavors, people say, timing is everything. That is certainly true of our cover story on physician recruitment. As this issue of *The Physician's Compliance Alert* was going to press, Tenet Healthcare Corporation, based in Santa Barbara, Calif., announced that a federal grand jury in San Diego had indicted Alvarado Hospital Medical Center Inc., located in eastern San Diego County, and Tenet HealthSystem Hospitals Inc., alleging illegal use of physician relocation agreements. The question is whether agreements made with physicians violate anti-kickback laws. That is, were physicians provided with an incentive to make referrals to the hospital? A month earlier, Alvarado's chief executive officer was indicted for allegedly approving payments to physicians in exchange for referrals. At this point in time, federal prosecutors are combing through physician-recruitment-related documents from all 114 of Tenet's hospitals and are particularly concentrating on seven facilities in Southern California.

For its part, Tenet states in a July 15, 2003, press release that "physician relocation agreements are a common and accepted practice used by hospitals across the country to meet a demonstrated need in their communities for additional or specialized health care resources. Typically, hospitals pay a portion of a physician's cost to relocate from one community to another plus income guarantees for a set period of time, usually one year. In return, physicians typically commit to provide health care services in the local community for at least three years. The agreements permit the physicians to refer patients to any hospital, not just the facility that helped them relocate." Indeed, the process works in this manner, but whether it can be proven that that's not what happened here remains to be seen. Hospitals and recruiting companies are closely watching as relevant events continue to unfold.

This month we also take a look at compliance education. All aspects of medical practice are bound by regulations that you and your employees need to understand. We suggest ways to accomplish training with minimal hassle. Of course, Autumn brings a new fiscal year for the federal government and changes in ICD-9-CM codes. You'll get a preview of these in this timely article. All of these topics are likely to be thought-provoking.



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.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Educational Programs Are Vital to Your Practice's Compliance Efforts

It's September, a good time to gather up pristine notebooks, sharp pencils, and new ideas—regardless of how much education you already have. While most state boards require physicians to obtain continuing medical education hours, participation in compliance training is not mandated. Neither are compliance programs. Still, the best way to prevent costly mistakes is to ensure that you and your employees are well versed in the regulations governing medical practice.

The Office of Inspector General (OIG) for the US Department of Health and Human Services outlined seven components deemed essential to a successful claims-related compliance program in the October 5, 2000, issue of the *Federal Register*. One of these is training and education. When planning any such endeavor, include three basic steps, advises the OIG. First, identify employees who would benefit from training. Then, select an optimal mode of instruction. Finally, decide when training should take place, how often education should be offered, and how much each employee requires. While these measures are suggested for programs directed at coding and billing compliance, they can certainly be applied to other areas of compliance activity.

Possible subjects for training sessions abound. "If you haven't spent time on the Health Insurance Portability and Accountability Act (HIPAA), you need to do that now," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc. (PMG), headquartered in New Orleans, La. Classes in billing and coding practices offer other obvious possibilities. Clinical compliance topics such as needlestick prevention are essential, too. The Occupational Safety and Health Administration requires that employees at risk of occu-

pational exposure to blood or other potentially infectious materials receive initial and annual training on the dangers of exposure and the protective measures that can reduce the likelihood of its occurrence (see "Some Web Sites Worth Surfing," page 4).

Picou suggests that practices also develop guidelines for thorny, if less official, practice matters and that employees be trained vigorously in these areas as well. For example, develop practice policies that describe where sample medications and prescription pads are best stored as well as tactics for dealing with violence in the workplace and the handling of irate patients. "I'd educate staff members on customer service issues, and I would track their progress with patient satisfaction surveys," she continues. "Then I'd discuss the survey data at follow-up educational programs."

Who, what, and when

Education should be geared to the staff members' positions and job duties, says D. Scott Jones, CHC, vice president of risk management for InLight Risk Management, based in Oklahoma City, Okla. For example, those whose tasks are clerical rather than clinical may not need to participate in infection control education. Certain programs, such as those designed to help the practice meet the statutory requirements of

HIPAA, should include all employees. The same is true for education pertaining to coding and billing.

"The OIG recommends one to three hours of basic training in compliance areas per staff member per year," Jones says. Employees with specialized skills would benefit from more intensive programs. "Certified coders have training requirements set by the certification board," Picou adds. Similarly, employees of practices with special accreditation, like those recognized by the Joint Commission on Accreditation of Healthcare Organizations, would need to put in additional training time.

Such training can be obtained in a number of ways. Outside seminars, in-service events, and self-study programs are all good options. In addition, you can incorporate less formal methods. For example, you can route articles addressing compliance issues to everyone in the office. Tack compliance-related news to a centrally situated bulletin board. When the results from a practice audit are available, review the findings with your staff people.

Look for ways to get as many people as possible trained at one time with minimal disruption to the practice. Useful classes may be available through professional meetings, local hospitals, insurance carriers, medical societies, or companies that specialize in educating medical personnel on a

(Continued on page 4)

range of topics. However, sending more than one person at a time can be costly—and leave you short-handed. “Sometimes it’s more cost-effective to have an expert come in and do training in the office on an afternoon that you normally close,” Picou says. “Often practices will provide education at their staff meetings.” You can also look into modular training, which may be accomplished with computer programs, videotapes, or audiotapes.

Jones discourages practices from adopting a do-it-yourself approach to compliance training. “Unfortunately, many practices fall short of their own needs,” he observes. “Outside expertise gives you a broader perspective and usually, more detailed information, especially in such complex areas as coding and billing. Savvy practices bring in outside experts at least periodically, and this likely supports the good faith effort of the program.”

If employees paid on an hourly basis are required to train during what would ordinarily be time off, you must

pay them, Picou stresses. This is true even when patients are working on a modular program at home or listening to tapes during their commute home.

Leave a paper trail

Compliance training should teach employees how to comply with regulations and practice policies, but it must also provide an understanding of why compliance programs are critical to the work they do, Picou says. What’s more, employees’ involvement in training and compliance programs should be obligatory. “It’s crucial that training be considered when people come up for their annual evaluation,” she asserts. “If they haven’t participated as required, then that should be considered on their evaluation in a negative manner.”

Documentation of educational activities is important—as a mechanism for keeping track of employees’ input and as evidence that your practice is committed to a comprehensive compliance program should you ever be audited. “If an employee takes part

in a teleconference or seminar, make note of it in a central source,” suggests John W. McDaniel, PMG’s president and CEO. “If you route journal articles, email alerts, or newsletters, attach a sheet so that employees can initial that they’ve reviewed the material. Then file the form, which provides important documentation that you are educating and training your staff—not only within their particular specialty, but also regarding larger issues. We don’t usually think about documenting these activities.”

“A good educational program leaves a documentation trail that demonstrates the scope of the training process,” Jones agrees. He suggests that practices keep a file with materials from educational sessions that have already taken place within the practice. Store copies of handouts and other support materials, presentations, sign-in sheets, post-presentation comprehension tests or evaluations, and presenter credentials. Employees who attend outside meetings should be asked to share what they’ve learned at the next office meeting. Keep handy any materials they received in the office library so that others can look them over.

Overall, your staff should recognize that compliance is a must for the practice, that compliance programs are designed to uncover potentially troublesome issues, and that reporting a problem will not result in retribution. “Let employees know that if they report anything questionable, you’ll investigate fully and report your findings,” Picou concludes. “Tell them about accomplishments resulting from your compliance program. If they know that other people have pointed out apparent flaws, they’re more likely to relax and do the same.”
Written and reported by Cynthia Starr, editor. For more information on compliance, go to our Web site (see page 8).

Some Web Sites Worth Surfing

American Health Information Management Association: www.ahima.org

American Hospital Association: www.aha.org

American Medical Association: www.ama-assn.org

Centers for Medicare and Medicaid Services: www.cms.gov/physicians/
and www.cms.hhs.gov/clia/

The Federal Register: www.gpoaccess.gov/fr/index.html

Health Care Compliance Association: www.hcca-info.org

Health Privacy Project: www.healthprivacy.org

Medical Group Management Association: www.mgma.com

MEDLINEplus Health Information (US National Library of Medicine and the National Institutes of Health): Medlineplus.gov

Occupational Safety and Health Administration:
www.osha.gov/dcsp/compliance_assistance/index.html

Office of Inspector General, US Department of Health and Human Services (HHS): oig.hhs.gov/fraud/complianceguidance.html

Physician Management Group, Inc.: www.physician-management.com

The Physician’s Compliance Alert: (see page 8)

New ICD-9-CM Codes, Coding Policy Take Effect Soon

On October 1, 2003, the first day of the US government's fiscal year 2004, the Centers for Medicare and Medicaid Services (CMS) will require all paper and electronic claims for professional services submitted to Part B carriers to include an ICD-9-CM diagnosis code. Physicians have been obliged to enter ICD-9-CM codes on CMS-1500 forms since April 1, 1989. As of the start of October, the codes will be mandatory when submitting claims for other professional services, such as those provided by nurse practitioners, physician assistants, audiologists, physical therapists, ambulatory surgical centers, and independent clinical diagnostic laboratories. Only ambulance claims are exempt.

The new policy stems from implementation of the Health Insurance Portability and Accountability Act (HIPAA). While HIPAA only requires the ICD-9-CM code on electronic claims for professional services, the CMS is including paper claims in its directive to ensure consistency. Medicare carriers have been instructed to return all claims lacking a diagnosis code. For example, health care practitioners immunizing a large group of people against influenza would have to enter the appropriate code—V04.81 as of October 1—on each form. Claims missing the code will be bounced back. In addition, physicians and nonphysician practitioners are expected to provide an ICD-9-CM code or a corresponding narrative diagnosis to laboratories when ordering a diagnostic test. Otherwise, the laboratory will have to request the omitted information.

At the same time, scores of new ICD-9-CM codes will become effective as will a number of revised diagnosis code titles. More than 30 codes will be designated invalid as of October 1. Notable additions are codes 079.82, SARS-associated coronavirus; 480.3, pneumonia due to SARS-associated coronavirus; and V01.82, exposure to SARS-associated coronavirus. In the enduring quest for more specific codes, some diagnosis codes should no longer be used. For example, code 790.2, abnormal glucose tolerance test is being scrapped in favor of 790.21, impaired

fasting glucose; 790.22, impaired glucose tolerance test (oral); or 790.29, other abnormal glucose.

Some new codes appear in the accompanying table. The entire list is at the following CMS Web site: cms.hhs.gov/medlearn/icd9code.asp. You can find the *ICD-9-CM Official Guidelines for Coding and Reporting* at this Centers for Disease Control and Prevention Web site: www.cdc.gov/nchs/icd9.htm.

Reported and written by Cynthia Starr, editor. More information on billing for the services of nonphysician practitioners is available on our Web site (see page 8).

Selected New ICD-9-CM Codes

Code	Description
348.30	Encephalopathy, unspecified
348.31	Metabolic encephalopathy
493.81	Exercise-induced bronchospasm
493.82	Cough variant asthma
517.3	Acute chest syndrome
600.00	Hypertrophy (benign) of prostate without urinary obstruction
600.01	Hypertrophy (benign) of prostate with urinary obstruction
719.7	Difficulty in walking
728.87	Muscle weakness
780.93	Memory loss
780.94	Early satiety
781.94	Facial weakness
785.52	Septic shock
788.63	Urgency of urination
996.57	Complication, due to insulin pump
V04.82	Need for prophylactic vaccination and inoculation, respiratory syncytial virus
V25.03	Encounter for emergency contraceptive counseling and prescription
V58.63	Long-term (current) use of antiplatelet/antithrombotic
V58.64	Long-term (current) use of nonsteroidal anti-inflammatories
V65.46	Encounter for insulin pump training

under section 501(c)(3) of the IRS code. In a closing agreement with Hermann Hospital in Houston, TX, which was charged with private inurement, the IRS set out six conditions, one or more of which must apply for the hospital to pay recruiting incentives based on public benefit, says Jay D. Savage, chairman of MD Network, a physician recruiting firm in Dallas. These conditions are:

- A population-to-physician ratio in the community that shows a shortage of a specialty relative to the ideal ratio established by the Graduate Medical Education Advisory Committee. “The committee establishes specific ratios, such as one orthopedic surgeon for every 18,000 people,” points out Savage.
- A demand for a medical service in the community for which the physician is being recruited, and a documented lack of availability of the service or the existence of long waiting periods for the service.
- Designation of the community or a portion of the community where the physician will serve as a health professional shortage area (HPSA) or a medically underserved area.
- A demonstrated reluctance of physicians to relocate to a hospital due to the hospital’s physical location. This condition is intended for hospitals in rural or economically disadvantaged inner-city areas.
- An expected reduction in the number of physicians in the relevant specialty at the hospital because of anticipated physician retirement during the next three years.
- A documented lack of physicians serving indigent or Medicaid patients within the service area, provided the recruit commits to serving a “substantial” number of Medicaid and indigent patients.

If you meet one of these six criteria

and offer fees and benefits that fall within market value, you can generally safely recruit physicians. “Some hospitals limit themselves unnecessarily because they interpret the guidelines too narrowly,” emphasizes Savage.

What can be offered—or accepted?

Hospitals do have the right to request American-trained, university-trained, or community-trained candidates. “Hospitals are sometimes afraid to make these requests, but they are allowed to,” says Hughes. “They may not, however, recruit based on where a candidate is from. And if you already employ a foreign medical graduate, you may have to consider other foreign medical graduates.” That is a gray area of the law, he notes, and should be reviewed with an attorney.

The government also does not want a hospital to pay to move a physician from one hospital to another in the same town. “You must not only have a need for a particular specialist, but you must also enlist someone who is truly relocating,” says DeMuro.

Most serious recruiting errors center on what a hospital can give and what a doctor can accept financially. “Hospitals should begin recruiting by creating a medical staff development plan,” says John W. McDaniel, president and CEO of Physician Management Group, Inc., based in New Orleans, La. They would profile their staff and community and then determine the ratio of doctors to population that currently exists. This ratio must be compared with established ratios on how many doctors a population can support, notes McDaniel. “Hospitals that want to add a specialist only to compete with another hospital can have a problem.”

Hospitals should also design their physician fees and incentives based on fair market value. “Benchmarks

should be used to define fair compensation, which varies among specialists and geographical areas,” says Hughes. This data is compiled by the Medical Group Management Association and similar organizations. Generally, to recruit a physician to one of 125 metro areas in the nation, compensation packages should stay around the median percentile. For other areas, compensation can go into the 75th percentile, he estimates.

Exceptions to the rules

The federal government does provide hospitals with two safe harbors from the anti-kickback statute, explains Schroder. “One is very restrictive and covers only general practitioners at HPSA hospitals,” he says. “No hospitals located in cities have a safe harbor under this exception.”

Most recruitment arrangements are therefore made under the less restrictive safe harbor that allows for a personal services and management contract. With this, the physician pays back the fair market equivalent of any benefits extended by the hiring hospital. Payback can consist of cash payment, performance of public health education for the community, treatment of indigent patients, or providing other services for which the hospital would otherwise have to pay.

“The payback must total all the benefits that go to the physician, including income guarantees, stipends, and educational loan payoffs, and the physician must agree to pay the total fair market value of the benefits,” Schroder says. If a hospital offers a fair market value income guarantee of \$300,000 for three years and the physician only performs \$100,000 of services, that \$200,000 difference may be considered a kickback or private inurement if the hospital is tax exempt.

Under this safe harbor, all hospitals—private or public—must issue

1099 tax forms to doctors when they write off the loan. "This is income, and the doctor is required to pay taxes on such income," says DeMuro. Also, if a doctor does not stay in the practice long enough to repay the loan by remaining in the service area and treating patients, including Medicare, Medicaid, and indigent patients, or if the doctor does not acquire medical staff privileges at the hospital in the first place, the hospital cannot just forgive the loan, he advises.

Hospitals can also legally enhance physician recruitment packages with "generalized" inducements. "You can create a heart institute, for example, complete with a new building and so on," says Miller. "A hospital may pretty much do anything within reason to make an environment more attractive to a doctor, but the doctor must still earn his or her stripes by providing services to the community."

Hospitals can also create new employment opportunities to lure doctors. "A young physician, for example, could be made chief of a service or laboratory," says Miller. This arrangement must involve more than a title. "The salaries have to be reasonable, the services must be necessary, and the doctors must do the work. Otherwise, there can be big trouble," he emphasizes.

The hospital may also create a separate, not-for-profit institution for a physician to direct. "The doctor could then be compensated without violating anti-kickback rules, Miller says." Keeping doctors happy is job one for hospitals, though, so if you pay one doctor a million dollars a year, you better be willing to pay all the doctors that same amount to keep morale from suffering, he warns.

To lure subspecialists, some hospitals lease time in imaging and other centers to medical groups. This practice represents a potentially risky gray



Excess Benefits Transactions

Rules on excess benefits transactions state that chief executive officers, chief financial officers, medical directors, and board members may be subject to a 10% excise tax penalty for any compensation deemed to be in excess of fair market value. Physicians may also be required to pay a 25% tax and a punitive 200% tax if the excess amount is not corrected.

To avoid these penalties, hospitals should develop a "reliance-on-counsel" safe harbor, says John W. McDaniel, president and CEO of Physician Management Group, Inc., based in New Orleans, La. With the safe harbor, payments from tax-exempt hospitals are considered reasonable and of fair market value if three criteria are met:

- The hospital board must decide on the compensation arrangement.
- The compensation amounts must be based on comparability data.
- The comparability determination must be adequately documented.

"The solution for all of these issues is to ensure that physicians are paid fair market value for their services," says Jack S. Schroder, Jr., Esq., a health care attorney with Alston & Bird in Atlanta, Ga. If the benefits are considered excessive, the hospital could lose its tax-exempt status.

To do this, hospitals should use market profiles, physician-need analysis, and payer demographics to develop contracts, urges McDaniel. In addition, contracting parties should exercise due diligence in reviewing those contracts. They should also ensure the integrity of the documentation process, utilize audits, and designate contracting representatives in order to be certain they are conforming to regulations.

"We also recommend that any external counsel or consultant used by a hospital should meet the criteria for independent valuation experts," says McDaniel. The criteria for independent contractors can be found in 26 CFR §53.4958-1t(d)(4)(iii)(c)(1) through (3) of the Internal Revenue Code.

zone in the law, however. "In the past, a lot of imaging centers were joint ventures between radiologists and referring doctors, but the Stark Law precluded these joint ventures," says Hughes. Today, some hospitals lease time to a group, and the group bills for the services. Although this is not a joint venture, it may still be illegal. "Hospitals and doctors should check with a health care attorney before entering into these types of agreements," says Miller.

Finally, if a hospital wants to recruit a physician into an existing group, the hospital must ensure that benefits go to the physician being recruited, DeMuro suggests. "For example, if you give a doctor a subsidy of

\$200,000 per year and the group receives \$50,000 of it, that's as though the hospital paid the group to recruit the doctor, which can violate inurement rules."

Whatever enticements are considered, both hospitals and doctors should consult a health care attorney in advance of signing on the dotted line. "The hospital attorneys will know most of these rules," says Miller. "But the more familiar the doctor's attorney is with the laws on inurement, fraud, and self-referral, the better off the doctor will be."

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

MDCOMPLIANCE.com

Now Available Online!

Our FREE online resource includes:

MAXIMIZING REVENUE

Information focusing on how to appropriately code to maximize practice revenue while minimizing audit risk

MINIMIZE AUDIT RISK

Coding compliance strategies

RESOURCE LINKS

Links to coding compliance resources

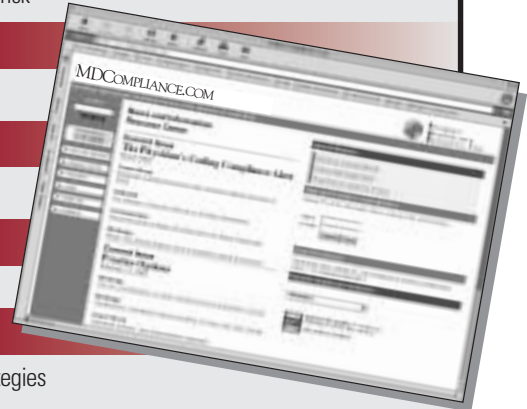
ASK OUR EXPERTS

Coding compliance Q&A and interaction

EMAIL UPDATES

Email updates on the latest coding compliance strategies

Bookmark **www.MDCompliance.com** to your Internet favorites



September 2003

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSRT STD
U.S. POSTAGE
PAID

Permit No 1354
S.Hackensack, NJ