

THE PHYSICIAN'S CODING COMPLIANCE ALERT™

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

A Matter of Complexity: Accurate Coding of Daily Hospital Visits

The codes used to bill for hospital rounds are often selected incorrectly, according to the Office of Inspector General (OIG) for the US Department of Health and Human Services. As a result, the claims bearing them are closely examined. If your paperwork doesn't hold up under scrutiny, you could find yourself writing the government a very large check.

Since the OIG began tallying Medicare payment error rates in fiscal year 1996, coding errors have accounted for two to three billion dollars' worth of erroneous payments, according to the OIG's February 2002 report, Improper Fiscal Year 2001 Medicare Fee-for-Service Payments. Overall, the review found that 6.3% of payments made by the Centers for Medicare and

Medicaid Services (CMS) in 2001 were in error, and 17% of these were due to coding mistakes. Two evaluation and management (E&M) codes have proven especially troublesome year after year: 99214, for outpatient visits involving decision-making of moderate complexity for an established patient, and 99233, a code entered for subsequent hospital care requiring decision-making of high complexity. Their misuse reached an all-time high in 1999, and in June 2000, the CMS sent Medicare doctors a letter warning that documentation for many of the services submitted under these two codes more properly supported the use of a lower code—for hospital visits, 99231 was generally deemed to be the correct choice. Nonetheless, a substantial percentage of claims for hospital visits continue to be coded wrongly.

Specifically, a review of 338 services labeled 99233 in 2001 indicated that 142, or 42%, were coded inappropriately. Subsequently, 129 were down-coded by the CMS; the remaining mistakes were attributed mainly to documentation irregularities. In fact, between 1996 and 2001, an average of 40% of 99233 claims were found to be in error (see table, page 6). Improper use of CPT code 99232, a subsequent hospital visit associated with less complex decision-making, has averaged

29% over six years. In 2001, 146 of 964 services reviewed—15.1% of services—were labeled erroneously. For 109 of these, the medical records indicated a lower-value code was in order.

"I don't think anyone questions that a service is being provided, in most of these cases," says Kevin Gerold, DO, JD, Deputy Director of Program Integrity for CMS. "The most frequent bone of contention between doctors and the CMS contractor review staffs is over one level of service. These claims aren't being denied on medical review, they're being down-coded. So the doctor submits a claim for a 99233 and it gets paid initially as a 99233. But when the case is reviewed, the documentation supports a 99232. That's where the vast majority of the problem is, and that just sets doctors' hair on fire." They tend to think the agency is being overly scrupulous, he says.

Of course, physicians dislike being down-coded on these post-payment reviews because the CMS is required by law to ask for its money back, Gerold notes. "Doctors see it as a penalty, but it's really not," he claims. "It's a remedy under contract law. You should never have gotten that money. We're not charging you interest, we're not charging you a penalty, we just want our money back."

In a typical example from the OIG's report, a physician was paid \$957 for

(Continued on page 6)

CONTENTS

Editorial

Ready Or Not... 2

Commentary

Claims Compliance:
A Duty To Be Shared By
Every Practice Employee 3

Questions From Readers

Same Patient, Different
Practice: How Should the
Visit Be Coded? 5

Ready Or Not...

Nearly 40 years ago, the venerable songster Bob Dylan noted, "the times they are a-changin'." While it's safe to assume he wasn't singing about physician reimbursement, the sentiment accurately reflects the current coding climate. Consider for example, that as of October 1, 2002, you have 146 ICD-9-CM coding changes to ponder. More daunting, you can expect your Medicare reimbursements to decline in 2003. The Centers for Medicare and Medicaid Services estimate that physician fee schedule payments will slide by 5.1% during the coming year. However, if a suggested modification of the formula for configuring the Medicare Economic Index—a crucial factor in determining fee schedule rates—is approved, payments will drop by a slightly smaller 4.4%. That's little comfort, to be sure.

Those in the know also say you can expect managed care companies to more closely examine your coding utilization in the near future. In addition, private payers and the Federal government will be sharing their findings from coding audits. Increased scrutiny, coupled with frequent changes in guidelines and regulations, make it imperative that medical practices begin to take these issues seriously. Many physicians are moving too slowly—it's believed that only 30% of practices are ready to comply with the Health Insurance Portability and Accountability Act (HIPAA). That's a serious problem when you recognize that HIPAA-related security and code sets will begin use this month, and privacy regulations will be enforced starting in April 2003.

We can help you get up to speed. In this month's issue, we detail how to best use daily hospital visit codes and how to get everyone in your practice involved in coding compliance. You can find answers to a pair of intriguing questions posed by readers. If you're looking for an extra opportunity to hone your coding skills, participate in a teleconference entitled "How to Develop and Implement a Coding Compliance Program" scheduled for Wednesday, October 23, 2002. This 60-minute presentation will focus on the steps necessary to ensure compliance. As chief executive officer of a major physician practice advisory company, I will weigh in, as will a physician coding compliance expert, and a retired Federal Bureau of Investigation agent who took part in healthcare-related investigations for many years. For more information on this event, visit our Web site at www.Coding-Compliance.com.



John W. McDaniel

Editor-in-Chief

Toll-free phone: 1-800-764-2633

E-mail: jmcdaniel@premierhealthcare.com

Paul M. Allen, MD, MHA
The Women's Center for Healthcare
Pascagoula, Miss.

Jerry E. Block, MD
Southeast Kansas Internal
Medicine Associates
Coffeyville, Kan.

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

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

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

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

Joseph Skeens, CPC, CCP, CBCS
Managing Director and CEO
Physician Educational Services, LLC
Sarasota, Fla.

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
Web: www.Coding-Compliance.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.

Claims Compliance: A Duty To Be Shared By Every Practice Employee

Claims development is the major compliance issue for medical practices. While most employees tend to consider the necessary chores of accurate documentation, appropriate coding, and proper completion of the HCFA 1500 form to be the responsibility of physicians and the billing department, the truth is that all staffers who interact with patients contribute to the success, or failure, of correct claims compliance.

The process normally starts with a phone call to the front desk. Employees who schedule appointments must first ensure that the physician to be seen is on the panel of the patient's managed care plan, whether that is Medicare or a private payer. If the physician is not credentialed to that plan, the patient should be informed in advance that the visit would not be covered by the insurer. This avoids the problem of surprising patients later with a bill they did not expect to receive.

On the patient's arrival, the receptionist must be sure to verify insurance coverage, preferably by making an updated copy of the patient's insurance card. For those on Medicare, it's essential to determine whether other applicable insurance exists, and if so, the information must be shared with the government agency, as required by the Medicare Secondary Payor policy. Insurance numbers must also be matched with plan coverages to ascertain that the physician does not perform examinations, tests, or other procedures that aren't covered without first informing the patient. As you know, Medicare coverage requires obtaining an advanced beneficiary notice (ABN).

If you supply excluded services without first informing Medicare enrollees that they will be expected to pay out-of-pocket, patients cannot be

held responsible for the fees—and neither can Medicare. Keep in mind that as in 2001, the Office of Inspector General (OIG) plans to examine the use of ABNs as well as their financial impact on beneficiaries and providers, an intention laid out in the 2002 General Work Plan. The OIG has found that the point at which ABNs are given to patients varies greatly, particularly when noncovered laboratory services are to be ordered.

Record all efforts

Physicians, physician assistants, nurse practitioners, and other providers must carefully document their patient encounters to support the CPT codes used in billing. Evaluation and management (E&M) coding is especially demanding in the area of documentation. Each E&M code requires that specific levels of the history, examination, and medical decision-making be suitably noted in the patient's chart to support the assigned code. This already-complicated task is made more difficult by the existence of two sets of E&M coding documentation guidelines, one from 1995 and another from 1997. Physicians can use whichever they prefer, but one or the other must be used consistently.

Inadequate documentation is a very common problem that's not necessarily corrected with the addition of more copious information. Rather,

employees who participate in patient care should strive for succinct descriptions of every part of an encounter. Providers often forget to document a second, unrelated complaint or a minor procedure or injection performed during the same visit. These oversights mean the practice is not billing for all services provided. While the individual dollar amount is usually small, over the course of a week or month, the practice may inadvertently be losing thousands of dollars in hard-earned revenue.

Numerous documentation and coding tools in the marketplace can guide the provider through E&M encounters. Laminated pocket-sized guides, slide-rule-like devices, handheld electronic pads displaying touch templates, and conventional checklists that can be incorporated into the chart are all available or can be developed in customized form for the practice or individual physician. When using such tools, it is recommended that they be standardized within the practice or at least within each specialty in a practice to avoid disparity in documentation and coding patterns that might trigger a carrier audit.

Talk often

Of course, the information gleaned from the patient encounter form or superbill must be correctly transferred to the claim form, whether it's

(Continued on page 4)

(Continued from page 3)

the HCFA 1500, that of another third-party payer, or an electronic equivalent. Questions concerning the matching of diagnosis and provided services with the chosen CPT code and appropriate modifiers must be correctly resolved prior to submission.

To that end, cordial, ongoing communication is essential between health care providers and billing and coding personnel. The billing staff should be considered a ready resource for coding and documentation questions. Equally important is the ability of the staff to bring questions to the providers when they believe documentation is insufficient, coding is improper, or handwriting is illegible. So-called assumption coding, the practice of guessing the proper CPT code when unsure—should never

all rejected claims, from Medicare or commercial payers, are not just written off without being examined. To do so results in lost revenue and a missed opportunity to correct systemic compliance issues. An examination of rejected claims can unearth important problems in the claims submission process. Insufficient documentation, improper coding, outdated coding books and software, and missed carrier bulletin updates are trends and situations that can be identified, and more importantly, corrected through a careful and ongoing review of denied payments.

The practice compliance officer or practice administrator should be responsible for scheduling periodic audits of the billing process. While some of these audits may be conduct-

together to promptly handle billing complaints from patients. Doing so should not only improve patient satisfaction, but can also prevent a potential investigation that could cost you far more than the loss of the original claim charges. Remember that Medicare and groups such as the American Association of Retired Persons now encourage patients to routinely examine their Explanation of Benefits for charges that might be in error. Calls to resolve such concerns should be considered an opportunity to head off a situation that might trigger an angry complaint to the Medicare fraud hotline. The entire encounter should be examined closely and calmly, and if warranted, amended claims or refunds should be processed as quickly as possible.

Similarly, the Health Insurance Portability and Accountability Act of 1996 made it a criminal offense to defraud not only Federal health care programs, but also private and commercial programs, so complaints involving nongovernmental payers can't be ignored. As with diagnosis and treatment, any complaints must be completely documented, along with the subsequent investigation, resolution, and feedback to the patient. The record should then be retained for six to 10 years.

An effective compliance program incorporates individual responsibilities into an integrated system of policies and procedures. Staffers should understand their particular duties and know how these fit into the big picture of the claims process. As a result, claims compliance can be greatly improved by the team effort, as can overall business operations and practice revenue.

Written by Charles E. Colitre, in Akron, Ohio. More information on compliance programs is available on our Web site (at www.Coding-Compliance.com).

An effective compliance program incorporates individual responsibilities into an integrated system of policies and procedures.

occur because employees are afraid or unable to approach physicians with their inquiries.

Frequent meetings between providers and the billing staff usually help to establish a much better understanding of one another's procedures and concerns and to encourage good communication. Another approach used in some practices is to position the billing office near the examination and procedure rooms or dictation stations to help create and facilitate the dialog. Yet another tactic to spur this crucial exchange of information is to place a workstation close to the providers and rotate billing and coding personnel through it on a daily or weekly basis.

Examine any errors

The billing manager must check that

ed internally, an annual documentation and coding audit should be done by an outside source. The initial audits must, at a minimum, be benchmark audits to identify documentation and coding practices, CPT code utilization, and claims error rates. Based on the data gathered, a corrective action plan should be established for any problematic areas. Responsibility for implementation of the corrective action plan should be assigned, and the compliance officer or practice administrator should assist in providing necessary training or other needed resources. Regularly scheduled follow-up audits will determine whether remedial efforts have been effective.

Physicians, practice administrators, billing managers, patient advocates, and front-desk personnel must work

Same Patient, Different Practice: How Should the Visit Be Coded?

Q: *I terminated my employment with a group to open a solo practice, and patients I saw in my previous setting immediately followed me. What is the proper billing code for their initial visit to my new office? Are they considered new or established patients?*

A: While these patients are coming to your practice for the first time, their relationship with you has already been formed and has, in fact, been steadily maintained. Thus, that primary appointment is billed as an established patient visit, according to Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, based in New Orleans, La. *The American Medical Association's Current Procedural Terminology: CPT 2000* defines a new patient as someone who hasn't been under your care during the previous three years. So although you are treating these patients in a new venue, they aren't new patients. In the group setting, patients are classified as new when they haven't received professional services from any of the physicians who practice the same specialty within that group during the three years preceding the visit. For example, if you are one of several internists in a group and a patient chooses to get care from you instead of the colleague he or she has seen before, the encounter is an established patient visit, even though the patient is new to you.

Relative value units, which help determine the monetary worth of a code, are based on work, expenses, and malpractice risk. Because new patients require more of each, the relevant codes draw higher reimbursement. It's true that you will bear the extra cost of

setting up new records, but the malpractice risk associated with treating an established patient is generally lower. With a bit of forethought on your part, the amount of work should be similar to that expended for any established patient, Picou continues. "Try to obtain copies of the patient's previous medical records before the visit so that you will not need to perform a complete initial assessment on patients you already know," she advises. Review and update the chart on the first visit to the new practice. Document the additional work in your notes for coding purposes. This tactic should satisfy third-party payers who perform chart reviews.

Q: *In a single week, I read two articles, including a piece in the April 2002 issue of The Physician's Coding Compliance Alert, which recommended that an office have a certified coder. Do you really need one if you have an electronic medical records (EMR) program?*

A: Having a certified coder on staff is probably an ideal scenario. But for one reason or another, it's not one that every practice can arrange, Picou says. For example, it might be difficult to find the right candidate. If you do, a certified coder is also likely to require a higher salary than other members of the office staff.

In the meantime, a comprehensive and reliable EMR program that performs coding tasks can be helpful. Still, somebody on staff, certified or not, needs to have some degree of coding proficiency. "For example, a program that identifies coding irregularities and asks the user for specific data must be operated by somebody who can identify the pertinent information and enter it," Picou says. "In

some cases, employees first learning how to handle an EMR program report an even greater need for coding expertise because it identifies issues that have never been considered before." This problem generally evaporates with additional coding education and experience.

If you are relying on an EMR program with coding applications, be sure that you have access to frequent software updates and you can individualize billing to fulfill each payer's requirements, Picou advises. When working with the program, gauge your need for coding assistance by keeping a log of all coding-related questions and problems that arise. If the volume is not overwhelming, you may find that a current staff member can be educated to handle most coding quandaries. Or you may only need a certified coder on a part-time basis. "Computerized systems can only do what they are programmed to do," Picou remarks.

One of her main concerns is that some programs trigger excessive documentation and, in turn, assign higher levels of evaluation and management (E&M) coding than are truly warranted. To keep this problem in check, it is imperative that you periodically compare your utilization of E&M codes with the national audit standards of the Centers for Medicare and Medicaid Services—a wise recommendation whether you use one of these programs or not.

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 in response.

five hospital visits coded at 99233. “However,” the report concludes, “the medical records indicated that the patient was stable rather than in critical condition.” They also supported decision-making of moderate complexity rather than the medical decision-making of high complexity required for a code of 99233. In addition, the documentation suggested an expanded, problem-focused examination and history instead of the more thorough detailed examination and history. For these reasons, \$697 was then denied to the physician.

Why the discrepancies?

What’s behind the high error rates for these two codes? For starters, Gerold says, “one big problem with E&M coding in general is that these codes are based on very subjective descriptors. The codes don’t always reflect how doctors think and process information in practice. The issue that I always find troublesome is the criterion for complexity of decision-making.”

One doctor’s complexity can be another’s everyday experience. “The dilemma becomes how you define complex decision-making,” says Gerold. “My background is as an intensivist in a university intensive care unit (ICU) at a tertiary referral center. The decisions I make in that ICU with very, very sick patients on a

daily basis are my routine. If general practitioners or general internists were confronted with the same patient, they would view that patient as highly complex. Does that mean we should pay the generalist more than the specialist, because the specialist is doing his or her average thing? That’s a very tough call. The specialists think they should be paid more because their work is harder than that of the generalists. Therein lies one fundamental tension in the E&M coding scheme.”

The codes also don’t reflect the way doctors view their hospitalized patients. “Frankly, the documentation requirements do not fit well in the hospital environment,” says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, in New Orleans, La. “Doctors tend to code based on their sense of the severity of the patient’s illness. If the patient is in the hospital, they feel more comfortable with higher-level codes because the patients are obviously sicker than usual, or they wouldn’t be there. The level-one codes are not used much because the feeling is that if they’re only at level one, they probably don’t need to be in the hospital.”

But that, of course, is not the way that CMS intends the codes to be

used. According to Joseph Skeens, CPC, CCP, CBCS, managing director and CEO, Physician Educational Services, LLC, headquartered in Sarasota, Fl., “when a patient goes into the hospital, he or she will require more intensive levels of care during the first several visits after admission, and you would be coding these encounters accordingly. However, a lot of physicians forget what they need to do to justify higher levels of care, and they continue to code the 99233 level throughout the stay. Patients are actually supposed to be getting better as they move towards discharge, requiring less time and energy on the physician’s part. As a consequence, you should be coding at levels that most accurately reflect your work with the patient, which may include 99232 and 99231.”

Just as some physicians will code high to reflect their sense of the seriousness of a patient’s illness, Gerold suspects that some physician upcoding has to do with relatively low CMS payments for routine hospital visits. “Another tension in the E&M coding scheme is that Medicare, or more appropriately, Congress, is not providing practitioners with enough money for that code,” he says. “Thus, the desire to upcode is not fraudulent or abusive, but an attempt for the doctors to capture what they think their time is worth, based on their overheads.” Unfortunately, the codes don’t work that way, either.

You must also keep in mind that the E&M codes are on a per-day basis. Regardless of how often you may actually see the patient, you only get to bill once a day. If you do see a patient more than once, consider the concerns that brought you back. Do they justify a higher code?

Documenting what you do

One problem is that the hospital

(Continued on page 7)

Erroneous Use of CPT Code 99233

Fiscal Year	Number of Services Reviewed	Number of Services Questioned	Percent of Services in Error
1996	217	115	53.0%
1997	416	128	30.8%
1998	457	114	25.0%
1999	187	102	54.6%
2000	449	220	49.0%
2001	338	142	42.0%

Source: Improper Fiscal Year 2001 Medicare Fee-for-Service Payments (A-17-01-02002).

Available at: oig.hhs.gov/oas/reports/cms/a0102002.htm.

(Continued from page 6)

situation doesn't lend itself to thorough documentation. It's not as easy to come up with a superbill-type checklist that will cover all the possibilities for hospitalized patients. But the experts seem to concur with the OIG report, which notes that the degree of documentation for many of these services more appropriately supported CPT code 99231 than 99233. That means poor charting can cost you money.

It can also impede health care delivery. The OIG's report points out that thorough, chronologic detailing of "pertinent facts, findings, and observations about a patient's health, history (including past and present illnesses), examinations, tests, treatments, and outcomes" is essential to high-quality care. Comprehensive medical records assist in the evaluation and planning of the patient's immediate treatment and follow-up. Communication among all members of the health care team is facilitated, as is continuity of care. The records are also valuable in utilization review and quality-of-care evaluation.

"Typically, physicians don't write enough to support the submitted level of service," Gerold comments. "In the claims that we've looked at for hospitalized patients, the doctor will write two or three lines of incomplete sentences, little scribbles, and then bill a level-3 or level-4 code, expecting that to meet the documentation requirements."

The key to getting paid for a 99233 visit is to document the three criteria for the higher code:

- A detailed interval history;
- A detailed examination; and
- Medical decision-making of high complexity.

The American Medical Association's Current Procedural Terminology: CPT 2000 notes that the patient is usually unstable or has developed a signifi-

cant complication or new problem. As a result, the physician often spends about 35 minutes by the bedside and on the patient's hospital floor or unit.

While the CPT code description calls for evidence of at least two of the three components, it's better to get into the habit of covering all three, urges Picou. "Demonstrating the complexity of medical decision-making also has three components," she adds. "The first is the number of possible diagnoses or management options that must be considered—this is one of those places where it's as important to record what you're ruling out as what you're ruling in. Next, there's the complexity of the existing medical records—the number of diagnostic tests, other records, and any other information that must be obtained, reviewed, and analyzed. And finally, there's the risk of significant complications, morbidity or mortality, and comorbidities, either from the patient's presenting problem, the diagnostic procedures, or the possible management options."

According to the CMS's 1995 Documentation Guidelines, if the patient is worked up for a new problem, the following categories can bring the case under the aegis of complex decision-making:

- One or more chronic illnesses with severe exacerbation, progression, or side effects from treatment;
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function. These could include, for example, multiple trauma, acute myocardial infarction, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness that generates a possible threat to self or others, peritonitis, or acute renal failure;

- An abrupt alteration in neurologic status, such as seizure, transient ischemic attack, sudden weakness, or sensory loss.

"Doctors also often overlook the fact that the major difference between 99233 and 99232 is the complexity of decision-making," Picou observes. "For a 99232, which requires medical decision-making of moderate complexity, the patient will probably be responding inadequately to therapy or has developed a minor complication. So the difference is often a fairly subtle matter of degree."

Although the suggested time spent with the patient to support these codes—35 minutes for 99233 and 25 minutes for 99232—is rarely used as the determining factor unless counseling or coordination of care is the dominant component of the service provided, it can offer a rule of thumb against which to check your coding. While time is not a qualitative measure, it does give a rough approximation of the amount of involvement the patient required.

When all else fails, review the codes and guidelines as issued by CMS, making sure you've covered the bases as specified. "Fundamentally, in a fee-for-service system where you have a stratified payment scheme, you have to have a means of discriminating one level of service from another," says Gerold. "And those exist in the CPT codes, clarified by the guidelines. Too often, when these claims are subjected to medical review, they don't meet that threshold. The physicians document very little, and they write me letters saying how hard they work and how unfair it is. I'm very empathetic. But there has to be something to support the claim."

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

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

How to Develop and Implement a Coding Compliance Program

Learn expert strategies to ensure appropriate reimbursement with minimized audit risk!

Learning objectives for this teleconference include:

- What the government is looking for from a retired FBI agent involved in compliance auditing
- How to profile your coding utilization against CMS audit standards
- What documentation is essential to support medical necessity
- The latest coding compliance strategies

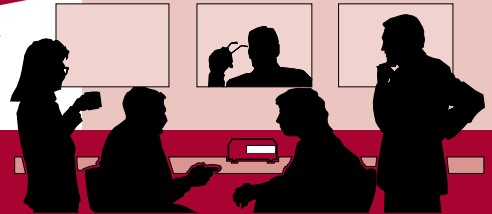
Sign up now for
How to Develop and Implement a Coding Compliance Program,
a teleconference to be held
on **October 23** at 1:00 pm EDT.
Call 800/464-9051

Safeguard your practice from fraud charges stemming from:

- Insufficient documentation
- Noncovered services
- Coding errors

This teleconference will help satisfy your medical practice compliance requirements.

Limited Space Available! Register Today!



Tuition fee is \$249 for either the teleconference or audiotape and \$399 for both the teleconference and audiotape (a \$100 savings). Note: Conference materials are accessed via e-mail link to our Web site. 100% money-back guarantee.

Visit www.Coding-Compliance.com

THE PHYSICIAN'S October 2002

CODING COMPLIANCE

ALERT™

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSR STD
U.S. POSTAGE
PAID
Permit No 664
S.Hackensack, NJ