

THE PHYSICIAN'S CODING COMPLIANCE ALERT™

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

Practices in Underserved Areas May Qualify for CMS Incentives

For many rural physicians, the patient load is large and poor, colleagues are few, and the hours are seemingly endless. These factors not only cause doctors to leave practice early, but make it difficult to find replacements. The Rural Health Clinic (RHC) program, started by federal mandate in 1977, was designed to help address these problems and improve access to primary care.

"A huge number of trained midlevel practitioners—nurse practitioners (NPs) and physician assistants (PAs)—were coming back from the Vietnam War and needed jobs," recalls Dennis Owens, president and chief executive officer of Rural Health Associates in Wichita, Kan. "And there was a tremendous shortage of health care providers in rural areas.

The sponsors thought that with incentives, these extenders would go to rural areas and find a place to work—which is what happened."

RHC status can be very helpful to the struggling country practitioner. "If you're a single doc out there who's really having trouble being on call 24/7, it gives you the ability to pay an extender to help out," he notes. "In addition, reimbursement is cost-based, and this allows you to at least cover the costs for services you provide to Medicare and Medicaid patients."

How payment differs

RHCs can be hospital-based or physician-owned. Either way, RHCs are entitled to so-called special reasonable cost reimbursements from Medicare and Medicaid. Whereas physicians in a typical practice code for each separate service they've provided and are reimbursed accordingly, those in RHCs get a flat fee per visit based on their annual expenses, Owens explains. Each year, the clinic submits a detailed cost report to the Centers for Medicare and Medicaid Services (CMS), and the reimbursement per patient visit for Medicare patients is determined by dividing the clinic's allowable costs, including salaries, utilities, supplies, and building costs, by the number of Medicare visits, up to a current cap of \$64.78 per visit.

(That figure increases each January and is tied to the percentage increase in the Medicare Economic Index related to primary care physician services.) Medicare pays 80% of that, and the patient is responsible for the other 20%.

For Medicaid patients, states can adopt a similar prospective payment system or they can structure their programs differently—as long as RHCs receive payment comparable to what Medicare is giving them. This means that most clinics get up to \$64.78 for both their Medicare and Medicaid patient visits. Using a very rough gauge, Owens estimates that RHCs probably receive \$13 to \$15 more than a conventional practice for each Medicare visit and about \$25 more for each Medicaid encounter.

Unlike outpatient services delivered in a standard setting, those provided through RHCs are covered under Medicare Part A. Instead of using CPT codes to describe services rendered to Medicare and Medicaid patients, RHC physicians seeking the predetermined fee-per-visit select from a handful of hospital revenue codes—521 and 522 are common choices. These are entered on the CMS-1450, also known as the UB-92, a form usually reserved for hospital billing.

However, services outside the scope

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Don't Give It Away!

After a long day of caring for your patients, you may have little energy left to care about your paperwork. While billing is not about life and death, it is crucial to your livelihood.

For that reason, you should ensure that your billing staff has the necessary vigor. All available evidence suggests claims will be examined more closely in 2003 than ever before. What's more, Medicare wants to reduce the time period for resubmission of claim denials from six months to 120 days. Confirming that your paperwork is correct before it leaves the office is the best way to prevent unnecessary losses. A number of errors commonly spur payers to bounce back claims. These include:

- Insufficient evidence of medical necessity
- Unbundled codes
- Missing modifiers
- Diagnosis procedure code and service are mismatched
- Procedure code conflicts with selected modifier
- Procedure code conflicts with place of service
- Diagnosis conflicts with patient age, sex, or procedure
- Duplicate billing
- Beneficiary is not covered
- Provided service is not covered

For example, physicians must review at least two body systems and adequately document these reviews in order to substantiate medical necessity based on the patient's presenting problems. Indeed, documenting two body systems can mean the difference between submitting a 99212 code or a 99213 for an established office patient.

Often, practices lose money when they fail to justify use of the modifier "-25" by not completely documenting multiple services performed on the same day for the same patient. The rationale for a particular evaluation and management service must be clearly delineated.

Software tools can help capture essential details, and three are described in this issue. Our cover article explains why physicians practicing in rural, low-income areas may be entitled to extra financial help. We also discuss the appropriate use of consultation codes, which are frequently overlooked in favor of lower-paying codes. While many physicians have adopted a conservative coding strategy in the past, increasing numbers of health care practitioners are striving to improve their coding proficiency. It could pay off!



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Miscoding of Consultations: A Common and Often Costly Mistake

Consultations are provided when a physician gives an opinion regarding evaluation and/or management of a patient's specific problem to another physician or other appropriate source who seeks it. That key definition sounds fairly straightforward, but choosing from among the pertinent CPT codes, which range from 99241 to 99275, can be a puzzling task.

Consider some sample scenarios:

- Dr. Smith saw a patient who was sent by her primary care physician (PCP). The visit was coded as a new patient visit because he knew he would be providing more care, as stated in a note to the PCP.
- Dr. Jones, a PCP, saw one of her established patients for a pre-surgical clearance visit, coding it as an office visit for an established patient.
- Dr. Miller saw a hospital patient at the request of a colleague, and he coded the encounter as a visit for subsequent hospital care. His notes were recorded in the patient's chart, but were not sent on to the physician who asked for his appraisal.

The fact is, all three of these encounters could and should have been coded at a higher reimbursement rate—as consultations rather than the service selected by the provider. Misunderstanding the differences can add up to significant over-coding or under-coding.

Confusion reigns

Many practices miss opportunities to bill for consultations, says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, headquartered in New Orleans, La. The consequences of over-billing, which include possible refunds or fines and charges of fraud if the abuse is intentional, create some reticence among physicians. As a result, practices tend

to under-code when it comes to consultations, an approach that results in lost revenue. Ironically, consistent under-coding can also place a practice outside of the bell curve for its area of practice, which can in turn gain the attention of auditors from the Office of the Inspector General (OIG) for the US Department of Health and Human Services.

"Often, physicians are afraid to bill for a consultation because they aren't sure about the guidelines," Picou notes. There is also a lot of misinformation on this service—another reason to know and, more importantly, understand the guidelines.

"It's a widespread mistake," agrees Charles E. Colitre, president of Med-Management Group, Inc., in Akron, Ohio. "One reason is that the terms referral and consultation are often used interchangeably, but they are not interchangeable," he points out. Yet, the technical distinction between the two is fairly clear, says John W. McDaniel, president and CEO of Physician Management Group, based in New Orleans, La.

A consultation must meet several requirements, most of which delineate a formal exchange of information between the first party and the consulting physician. As noted, one physician renders advice about the assessment or treatment of a particular condition at the written or verbal request of another physician—or another "appropriate" source, such as

an insurer, a lawyer, a physical therapist, or a psychologist. The request, as well as the need for it, should be documented in the patient's medical record. In addition, the consulting physician's opinions must be recorded in the patient's medical record, along with a description of any services ordered or performed. Consultants can begin diagnostic testing and treatment during the first visit or later encounters. Finally, all opinions and findings must be relayed in writing to the initial physician or source.

Simply put, if the patient—and documentation of findings and services—returns to the original physician after being seen, the visit was a consultation. If the patient is sent to a physician who then assumes care without providing feedback to the original caregiver, the encounter, a referral, is coded as a new patient visit. Likewise, if the receiving doctor continues to treat the patient in subsequent visits, these are coded as established patient visits.

For the most part, consultation and new patient codes are built on the same key components, but consultations pay a higher reimbursement rate. A patient or family member can initiate consultations (eg, second opinions), and depending on the circumstances, these are coded as confirmatory consultations or office visits (see "Clarifications on Consultation Coding"). Any consultation-related diagnostic and therapeutic services

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Clarifications on Consultation Coding

Understanding the four categories of CPT codes for consultations can help eliminate coding errors. Each has several CPT codes, based on the status of the patient and the time spent with that patient.

- **Office consultations** (CPT codes 99241-99245) are consultations for a new or established patient in the office or other outpatient facilities, including hospital services, home services, rest home services, and emergency department services. If the consulting physician receives an additional request for an opinion, the office consultation code may be used again. The referring and consulting physicians can be from the same specialty.
- **Initial inpatient consultations** (CPT codes 99251-99255) are consultations to hospital inpatients or residents of nursing homes. Only one consultation is allowed per admission.
- **Follow-up inpatient consultations** (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent consultative visits requested by the attending physician. They include monitoring the patient's progress, recommending care or management modifications, or recommending new care plans in response to changes in the patient's status.
- **Confirmatory consultations** (CPT codes 99271-99275) provide a second or a third opinion in any setting. Consultant doctors are expected to offer opinions only, and any other services provided are not considered confirmatory. If the opinion is required by a third party, the modifier "-32" (mandatory services) should be used.

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that can be identified with a specific CPT code should be reported separately. If after the consultation the consulting physician assumes the management of all or a portion of the patient's condition, consultation codes should not be used for follow-up visits. In these cases, a hospital care code should be used for the inpatient setting and an established patient code should be used for the office setting.

Applying what you've learned

One common coding error occurs when the patient is referred back to a physician for continued care. "Most doctors don't realize that they can still bill the first visit that occurred as a consultation rather than a first patient visit. It doesn't account for a huge amount of money, but over the period of a year, it adds up," says Picou.

Another mistake is often made concerning pre-operation clearance visits. "When a PCP sees an established patient for a pre-operation clearance visit, that can be coded as a consultation. That is, if there is a request for the visit from the surgeon, and a report is forwarded to the surgeon by the PCP," reminds Picou. Many physicians miscode for these visits, losing money in the process, she laments.

Common errors are also made in the hospital setting. "At the hospital, the consulting physician does not need to send a report to the referring doctor if the notes are put into the patient's chart," Picou advises. "This is because everyone in the hospital shares the same chart."

Another scenario that can cause confusion involves the patient who is

sent for a consultation, then returns in a month or so as a referral. If the second physician follows the patient for that problem, the appointments are coded as established patient visits for as long as he or she is seen. "If there is a lapse of three years between visits to you or anyone in your practice, however, another visit from the patient would be coded as a new patient visit," notes Colitre. Or, if the original physician sends the same patient back to the consultant with a new request for an opinion, the visit is again considered a consultation—even if the previous consultation was only a month earlier, Picou adds.

Errors such as these are so common that the OIG has chosen to target consultation coding for the first time in its General Work Plan for fiscal year 2002, says McDaniel. The Work Plan is a list of problem areas identified by the OIG to be particular priorities in audits. Therefore, understanding the codes for consultations is critical for practices. To make certain that you are coding consultations and referrals correctly, the experts interviewed recommend the following:

- Memorize the few pages in the guidelines for coding for consultation and referral visits.
- Check regularly to ensure that you fall within the parameters of the bell curve for your specialty for consultation codes.
- Be certain that for each coded consultation, there is a report in the chart that was sent to the consulting physician.
- Train staff to look for this supporting documentation as well.
- Establish a coding compliance program that includes periodic chart audits.

Reported and written by Deborah Epstein, in West Milford, NJ. More information on proper use of codes is available on our Web site (at www.Coding-Compliance.com).

A Trio of Products Aims to Save Time and Simplify Coding

Some time ago, family practitioner Allen Wenner, MD went in search of software that would assemble a detailed medical history. When he found it didn't exist, he gathered people with computer know-how and began to create his own. "I thought we could make a medical history-taking program in about 18 months," Wenner recalls. "Now, 15 years later, we have what we were striving for."

With his product, Instant Medical History (IMH), patients enter one or more complaints, and the queries begin, changing direction with individual responses. Ultimately, a document is produced, complete with a comprehensive history of present illness (HPI); past, family, and social history (PFSH); review of systems (ROS); risk factors; and when pertinent, the results of formal self-assessment scales. "It's not a template," Wenner notes. "I've put 50,000 patients at a computer, and no two reports are the same. We have 27,000 complaints in here, 34,000 questions, and 52,000 different findings." Along with the relevant information, the program captures data that physicians usually don't record—specifically, denial of symptoms.

As a result, IMH consistently produces the most complex history and matching documentation. At that point, your selection of a code can be driven by the extent of the examination and medical decision-making. Patients can enter the information into a computer while waiting to be seen. Or, if you have a Web site, the history can be compiled from the patient's home. The program also eliminates the need for a transcriptionist, since the information is in

hand before the physician even begins the examination.

IMH costs \$50 per month, and updates are released on a quarterly basis. For more information, you can visit Primetime Software's Web site at www.MedicalHistory.com or contact Dr. Wenner in Columbia, SC, at 803/796-7980.

Two products from Mobile Design Technologies, Inc. (MDT) allow you to code on a handheld computer at the point of patient care, explains Damon N. Spiegel, the company's chief executive officer. The E&M DocuMentor and MD Coder are designed to store plenty of patient information, such as chief complaint, medications taken, allergies, referring physician, and specific notes. You also enter the type of visit—inpatient, outpatient, emergency department, or surgery. Returning patients can be pulled from a patient list.

Once the patient is selected or a new one entered, the E&M DocuMentor, which incorporates the 1995 and 1997 Centers for Medicare and Medicaid Services' Documentation Guidelines for Evaluation and Management (E&M) Services, provides a series of templates for the three key components for each code: history, examination, and medical decision-making (MDM). The system provides as much help determining the appropriate code as you need.

For example, if you know that you have done an expanded problem-focused history, click on a drop-down menu and select that particular history type. Otherwise, enter more detail. Note how many aspects of the HPI you've evaluated. Move on to the ROS, and check the number of body

systems discussed. You can go further, identifying specific systems. Note the elements of the PFSH discussed. You can also document what you've done as you proceed. Similarly, the examination and MDM templates allow you to add whatever details you choose to document. When all is complete, the program will calculate the correct E&M code.

MD Coder cross-references CPT and ICD-9-CM codes to facilitate selection. Once the patient's file is retrieved, you may locate CPT codes by number or description. Frequently used codes can be added to a list of favorites. The product is especially useful for physicians who regularly perform numerous procedures, Spiegel says, adding that MDT has developed modules for an estimated 25 specialties.

The E&M DocuMentor and MD Coder can be purchased separately or integrated for physicians who would like both. A PC component permits transfer of information between the handheld device and the desktop as well as the printing of reports. If desired, the programs can also be incorporated into your billing system so that codes go directly into the claims. The annual subscription fee depends on the package you choose. "Overall, the process is so quick that an encounter can be accurately coded with five taps and 15 seconds," Spiegel claims. For more information on these, go to MDT's Web site at www.mobiledesigntech.com or contact info@mobiledesigntech.com.

Reported and written by Cynthia Starr, editor. More information on helpful software is available on our Web site (at www.Coding-Compliance.com).

of routine primary care services come under Medicare Part B. But the risk here is what's called "commingling"—being paid out of two funds for the same service, which is prohibited. To prevent that, clinics are expected to excise the costs of providing the care they bill to Part B from their annual RHC cost report. "If you want to remove facial lesions from a patient, Medicare will pay about \$100 for each lesion under Part B. But while you are treating that patient, Medicare is also paying you Part A monies to keep your operation open," points out Ramsey L. Longbotham, executive director of the Texas Association of Rural Health Clinics. "Theoretically, you have to carve the expenses you incurred while you were providing those Part B services—the nurse's salary, the receptionist's salary, the utilities, everything—out of your cost report. That can be hard to track. But if you don't, that's commingling because you're getting money from Part A and Part B at the same time."

Another useful example: As of January 1, 2001, diagnostic tests can be billed to Part B. "But one of those tests is the urine dipstick test, which takes almost no time to perform," Longbotham continues. "Our Medicare fiscal intermediary told us the clinics were supposed to carve out how long it took the nurse to unscrew the bottle, take the stick out, and put it in the urine. Many are saying that's a waste of time; they're not even going to bill for it. But if you did, that's considered commingling."

Unfortunately, the regulations are not always as explicit as they could be with respect to what is considered a specialty service. Owens, who calculates cost reports for his clients, says, "It's possible to interpret the regulation to mean that chemotherapy services, if performed at an RHC, should be covered under the same flat fee as

for the standard rural office visit. But if something costs \$1,000 per injection, the doctor can't be expected to include that in a \$50 office visit," he adds. "The position we've taken is that if a clinic is providing items that we feel are definitely outside the realm of the standard RHC visit, we take them out of our cost reports, so we're not charging the government for them under the RHC program. Then we charge them to Part B. As long as I'm not using that cost when I'm calculating the payment per visit, then it's not commingling."

Owens also attaches a cover letter to every cost report explaining what's been done. The same letter is included in the RHC's policies and procedures, which must also be approved by the state and federal government. "That allows me to say I'm not doing anything that wasn't approved. There's no intention of cheating," he explains. "We've successfully defended the policy in audits and surveys." He advises other RHCs to consult experts well versed in Medicare allowances and the RHC program when it comes time to compile the annual cost report. "If you don't get help, you might not get everything that's coming to you. Worse, you might end up in a situation where you didn't carve out the appropriate expenses and that's a definite no-no."

Location, location, location

Kendra Parry, a health care consultant based in Forestville, Calif, has helped set up at least 100 RHCs since the program began. "The typical call I get is from a rural physician who has a huge low-income patient population," she says. "The practice is going under, and the doctor doesn't know how to go forward. If he or she qualifies, this program works very well."

First, you must be physically located in a rural area, which is defined,

first, as "nonurbanized" under the US Census. Beyond that, more rigorous state designations often exist. "You can get this information from your state department of health services, rural health care agency, or through the federal Bureau of Primary Health Care, which maintains a list of rural counties by state," Parry says. The list can also be found on the Web at www.rhc.universalservice.org/eligibility/ruralareas.asp.

Once you've established that you're rural, you need to determine whether you're in a designated health professional shortage area (HPSA) or a medically underserved area (MUA). A location may qualify as one or the other, depending which criteria it meets. The Bureau of Health Professionals maintains information on HPSAs and MUAs, including searchable HPSA and MUA databases. Check the following Web site: bphr.hrsa.gov/shortage. "If you're in an area that isn't a designated HPSA, or whose designation is more than three years old, there's an application process," Parry explains. "The basic criterion is no more than one physician for 3,500 residents. We sometimes can get the designation in areas with one physician per 3,000 people, if other conditions are met—for instance, if there is a shortage of physicians who'll take Medicaid patients."

Parry cites as an example the Tahoe resort area, on the California-Nevada border. "The physicians there had no interest in Medicaid patients. You have people with second and third homes, and the service industry people. There was a huge poor population without health insurance and without access. They were driving hours into Nevada to try to get health care. The local hospital's emergency department (ED) was improperly utilized, and it was going broke. We helped the

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hospital get an RHC going, and they've attracted 12 physicians. That's the type of thing this program can do that we feel good about."

Does Medicare or Medicaid cover a high proportion of your patient base? That's important. According to a survey done by the National Association of Rural Health Clinics (NARHC), which represents some 3,400 RHCs, the typical RHC practice breakdown is about 27% to 29% Medicare, 30% Medicaid, 25% to 30% commercial insurance, and 10% to 15% uninsured. "RHCs are free to see privately insured patients, too," Owens adds. "All of the clinics I work with do. You can't be the only clinic in town and not do that."

Once you've established that your practice is in an area qualifying for RHC and HPSA status, you can turn your attention to the services the clinic is required to provide for its patients. First and foremost, the clinic must provide the normal spectrum of primary care services, and must have an NP, a PA, or a certified nurse-midwife (CNM) who is on duty at least 50% of the time that the clinic is open to see patients. The clinic must have a medical director—a licensed physician—who oversees the work of the midlevel practitioners and is present at least four hours a month, depending on state laws regarding supervision of midlevel healthcare workers.

Practices must also develop a remarkably detailed manual of policies and procedures. "For many practices, that's the kicker," Parry says. "Most people find it very difficult because you have to have a policy and procedure on absolutely everything that goes on in that clinic. And you need to have it in a certain order to match the regulations if you want the site review to go well. Usually, it's a three-inch, three-ring

binder, and it better be signed by the medical director and the people who put it together."

The clinic also must have a lab capable of performing several basic laboratory tests:

- Chemical evaluation of urine by stick or tablet method or both (including urine ketones)
- Hemoglobin or hematocrit
- Blood glucose
- Examination of stool specimens for occult blood
- Pregnancy tests
- Primary culturing for transmission to a certified laboratory.

As noted, these tests were included under the payment for a rural visit, but since 2001, clinics are permitted to bill Medicare Part B for them.

A good thing

In 1997, the US government did a study to see if the RHC program was actually bringing practitioners to underserved areas. "A concern at the time was why the existing practices were converting from traditional Medicare status to RHC status," comments William Finerfrock, executive director of the NARHC. "A question posed was, if the practice already existed, was access to health care really improved? Or are we simply paying more for providers to stay in areas where they had already established a presence?"

Mathematica Health Policy Research, an outside firm, took a random sampling of communities in five different states. "Two things were discovered," Finerfrock says. "First, since an RHC had to have a PA, an NP, or a CNM providing care at least 50% of the time that the clinic is open to see patients, they were bringing in clinicians and increasing access, even though the practice had previously existed. Many solo practitioners were being overwhelmed but

could not afford to bring in another physician. By becoming an RHC, the practice was able to recruit a PA or an NP into the community, which meant that more patients had access to the system and the physician wasn't getting burned out."

The findings also indicated a dramatic drop in ED use by the Medicaid population after the RHC designation was granted to a local clinic. "While the clinic wasn't refusing to serve Medicaid patients, very often it would be difficult for them to get in because the practice was overburdened," Finerfrock continues. As a result, patients with Medicaid would turn to the ED in order to be seen more quickly. But with RHC status, the practice has adequate reimbursement and more personnel, making it possible to handle more patients on a timely basis. "So instead of patients going to the ED and incurring a significant cost to Medicaid for emergency room visits, we've moved them into a much more cost-effective environment," he says.

"I think Medicaid and Medicare have done some tremendous good," Owens remarks. "I've been an administrator in rural hospitals, and I'm telling you that many of these patients are very proud. Without these programs, a lot of them would stay home and die if they couldn't afford to go to the doctor."

"We've turned gas stations and car dealerships into RHCs in rural areas that needed health care," Parry adds. "It's a darn good program that will continue to save a lot of country doctors and small rural hospitals. I'd fight fiercely if they tried to take it away because I've seen all the good that it does."

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

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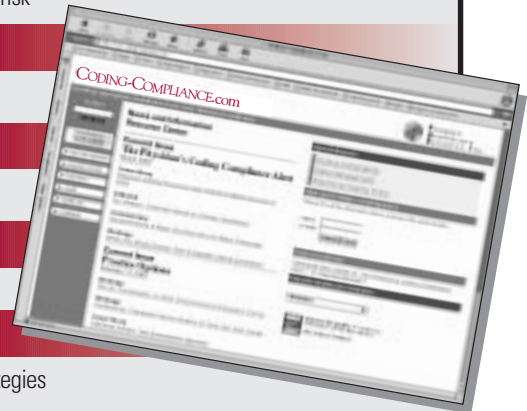
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