

# THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

## Contractor, Hourly, Salaried: Is Your Practice Getting It Right?

Physicians know they have to pay close attention to medical coding regulations, but many tend to be less vigilant when it comes to general business laws. Failing to comply with the laws that govern all small businesses—including medical practices—can be very risky, however, and you do so at your own peril.

“Medical practices tend to overlook the fundamentals of running a business,” says John W. McDaniel, president and CEO of Physician Management Group, Inc., based in New Orleans, La. “But like all businesses, practices must comply with government regulations, including labor and employment laws.” In fact, there are two important areas of employment law that tend to cause problems for medical practices, he

emphasizes. The first concerns the rules on whether a worker is an employee or an independent contractor and how payment to each of these types of workers should be handled to comply with tax regulations. The second area concerns the rules governing salaried versus hourly workers—in particular, questions on overtime payment, such as: Who is exempt from overtime payment, and who is not?

These regulations suffer the benign neglect of many medical practices, but it's very important to know the Internal Revenue Service (IRS) and Department of Labor (DOL) laws on how to categorize and handle those who work for you. Ignorance of these rules can return to haunt you at any time in the form of action by the IRS or the DOL—or even an expensive civil suit filed by an employee. Experts say you can avoid these common pitfalls, though, by following a few important guidelines.

### Rules on employees versus independent contractors

Employers do not have to withhold income taxes or withhold and pay social security, Medicare, and unemployment taxes for workers who are independent contractors. They are required to do so for their staff employees, however, and this is where many problems arise. Medical prac-

tices frequently hire workers as independent contractors, and there are definite benefits to doing so: the practice will have fewer employees in the retirement plan and avoid paying social security, Medicare, and unemployment taxes. In response to this common but illegal practice, the IRS has beefed up enforcement.

In fact, few workers actually meet the criteria used to describe an independent contractor. Consider this typical but risky scenario that plays out every day in medical practices: the practice hires a nurse practitioner (NP) or other health care professional to work regular hours on a part-time basis. The worker earns an hourly rate and does not receive medical insurance or other benefits. She is paid as an independent contractor and the practice does not withhold or pay taxes, but files a Form 1099-MISC for her. An audit by the IRS would most likely show that the NP is an employee and not an independent contractor, and the practice would be responsible for paying all past withholding taxes, late-payment penalties, and interest charges for that employee.

How can your practice avoid this costly error? The question you should ask yourself is, “How would the IRS classify this person if our practice were to be audited?” (Audits are done randomly by the IRS, but can also be ini-

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## The Who, What, and Where Aspects of Compliance

Two recent transmittals from the Centers for Medicare and Medicaid Services spotlight just how many details are involved in the business of medicine—and how costly it can be to miss those details. A March 2003 change to the *Medicare Coverage Issues Manual* (Transmittal 168) stresses that a physician must interpret the data accumulated during ambulatory blood pressure monitoring—though that interpretation can take place in any setting. In May 2003, a Program Memorandum (Transmittal B-03-043) emphasized that incident-to billing requirements need not be met when nonphysician practitioners provide diabetes outpatient self-management training. The main point: payment does not hinge on whether the physician is on the premises when training is supplied.

This issue of *The Physician's Compliance Alert* focuses on the fine points of employees' roles within the practice. One area that is often confusing to many small businesses in general, and medical practices in particular, deals with employment law. Much confusion exists as to which employees qualify for exempt status (salaried employees) and which ones qualify for nonexempt status (employees paid on an hourly basis). Our cover article discusses this area in great detail since employers may face stiff penalties for a mix-up. The piece also explores whether workers qualify as independent contractors or as employees; their official status affects both employee rights (ie, overtime) and the accurate reporting of Federal and State Withholding Taxes.

Another important article delves into reimbursement of nonphysician practitioners, specifically clinical nurse specialists, nurse practitioners, and physician assistants. If you employ these health care professionals, you should know how to best bill for their services. You must also know exactly what these providers are legally allowed to do—sometimes employees are so capable that the boundaries blur. The Office of Inspector General of the US Department of Health and Human Services is examining the services billed on behalf of these employees in an effort to find out whether they are billing for services they are not qualified to perform. We also answer questions from readers who are wondering how to bill when office visits, admissions, or discharges occur on the same day. We think all of these matters heighten the imperative for all-encompassing compliance programs in every medical practice.



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# Uncertainty Abounds: Billing for Services of Nonphysician Practitioners

Currently, the business of reimbursing nonphysician practitioners is like settling a wild frontier. New opportunities are pursued in uncharted territory. Since January 1, 1998, Medicare has permitted payment for work done by clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) in all settings. However, the rules directing payment remain unclear to many physicians and their nonphysician colleagues. At the same time, the US government has noted possible flaws in the system.

Prior to the Balanced Budget Act of 1997, Medicare covered the services of NPs and CNSs, when health care was delivered in rural areas and nursing facilities. Medicare also paid when NPs and CNSs assisted during surgery. The services of PAs were covered when their duties were carried out in hospitals, nursing facilities, or in physician offices in rural health professional shortage areas. In addition, payment was provided when a PA served as first assistant in a surgical procedure.

Today, NPs and CNSs can bill Medicare directly for their services—and be paid directly—as long as they meet certain qualifications (for example, as of January 1, 2003, NPs must hold a Master's degree in Nursing), provide care within their scope of practice, and work in collaboration with a physician. The doctor does not have to be in attendance when health care is given nor does that physician have to evaluate the patient separately. Rather, he or she handles treatment beyond the nonphysician practitioner's authority. In contrast, the PA's employer must bill Medicare for the practitioner's services and always receives the payment. Unlike the advanced practice nurse (APN), the PA must work under the supervision of a physician. That is, the physician oversees the PA's professional activi-

ties and makes sure that the care given is suitable. Unless state law dictates that the doctor be on hand when the PA treats a patient, he or she can be off-site and accessible by phone.

While variations are likely to exist from state to state, the duties that CNSs, NPs, and PAs may perform are generally similar and can include "services that traditionally have been reserved to physicians," according to Part 3, Chapter 2, of the Centers for Medicare and Medicaid (CMS) *Carriers Manual*. These may include physical examinations, minor surgery, casting of simple fractures, and interpretation of x-rays. In fact, if state regulations allow, these nonphysician practitioners can provide any level of evaluation and management (E&M) service and diagnostic tests. Payment for the services of each of these nonphysician practitioners, made on an assignment-only basis, is 85% of the Medicare Physician Fee Schedule (MPFS) or 80% of the actual charge—whichever is less.

That may sound fairly straightforward, but keep in mind that work done by nonphysician practitioners may also qualify for billing as incident to the physician's services, thus earning 100% of the reimbursement set out by the MPFS. "There is a lot of misunderstanding among physicians regarding what nonphysician practi-

tioners can and cannot do and how to bill for their services," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. Further complicating matters is the variety of nonphysician practitioners who can contribute their expertise. For example, practices may have a certified nurse-midwife (CNM), a dietitian, or a physical therapist on staff. "I think the biggest problem is that there are multiple variables that are not completely clear," she adds. These include state laws, carrier rules, and special aspects of the Medicare program, such as guidelines for practice in underserved areas.

## Targeting a weakness

*Medicare Coverage of Non-Physician Practitioner Services*, a report published in June 2001, noted that Medicare paid for 5.2 million services billed for CNSs, NPs, and PAs in 1999 versus 1.2 million services in 1997, more than a fourfold increase. Not surprisingly, the associated payout rose steeply as well, from \$55 million in 1997 to \$202 million in 1999 (see [oig.hhs.gov/oei/reports/oei-02-00-00290.pdf](http://oig.hhs.gov/oei/reports/oei-02-00-00290.pdf)).

By far, most claims stemmed from health care given in the office. CPT code 99213, an office or outpatient

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visit for an established patient, was the most common service billed, accounting for 12.4% of total services. Overall, eight of the top 10 procedures were E&M services. Although most E&M services were of low complexity, some 8% of claims from nonphysician practitioners reported high-complexity E&M services.

Because an unknown portion of total claims had likely been billed as incident-to services before 1997, it was impossible for the agency to calculate how much of the increase was traceable to real growth and how much could be attributed to a change in billing practices. A significant concern was that the states' scopes of practice for these practitioners are too general to permit carriers to construct reimbursement guidelines. More importantly, it is difficult to discern whether nonphysician practitioners are being paid for treatment they are not qualified to administer. As a result, the OIG concluded that the situation "creates potential vulnerabilities, both from payment and quality-of-care standpoints."

Further investigation is scheduled for this year. The OIG's work plan for 2003 indicates that the agency will be studying trends in the billings of nonphysician practitioners. Of special interest is whether CNSs, NPs, and PAs are billing for procedures that are not within their particular scopes of practice. A report is slated for release in fiscal year 2004. This is not unwelcome news to many physicians. In July 2000, the American Medical Association announced that it had petitioned the Health Care Financing Administration—now the CMS—along with 49 other medical organizations. The petitioners wanted the agency to ensure that Medicare payment went to NPs and CNSs only when they worked in collaboration with physicians and supplied health

care that was within their state's scope-of-practice requirements. A February 2003 policy statement from the American Academy of Pediatrics also addresses scope-of-practice issues related to nonphysician practitioners (available at [www.aap.org/policy/060013.html](http://www.aap.org/policy/060013.html)). The organization maintains that PAs should stay under the supervision of a physician and NPs should remain in a collaborative relationship; independent practice by NPs is discouraged.

### Getting practical

Physicians confused about billing for the services of midlevel providers may forgo incident-to billing when it is reasonable or worse yet, relinquish all reimbursement for care provided by APNs or PAs. "Several practices that I have been to never bill a midlevel service as incident-to, but rather bill under the midlevel provider's provider identification number (PIN)," Picou remarks. "So the practice is taking a 15% loss because employees don't understand the incident-to guidelines and they don't want to risk a mistake." In the same way, many practices never bill CPT code 99211 for the lowest-level office visit or outpatient visit. "You can bill 99211 for nurse's services," she points out. "But physicians are afraid to bill them. Nurses are providing services, and the practice isn't charging when they have the right to do so. Again, that's money walking out the door."

Charles E. Colitre, president of Med Management Group, Inc., based in Akron, Ohio, has seen self-audits of practices turn up two related problems. "In one case, the physicians were losing money because no one was billing for the PAs' services at all," he recalls. "In the other, the PAs were billing for procedures that were not within the scope of their state licensure. The practice identified the

claims and made a repayment to the carrier." He recommends that physicians know what their employees are qualified to do and that they give them the appropriate level of supervision. Some states have fairly detailed regulations while others are relatively vague. Consider posting a list of duties within the scope of practice for each nonphysician practitioner employed in your practice.

You should also become familiar with the rules pertaining to incident-to billing. Basically, the nonphysician practitioner must be legally able to provide the service under state law, and the physician must supervise the practitioner and be immediately available, according to Thomas Loughrey, MBA, CCS-P, chairman and CEO of Economedix, LLC, a physician training and consulting company located in Orange, Calif. "If the physician is on-site, is personally available, has reviewed the chart, and has made certain that everything else that's required has been done, then it is appropriate to use incident-to billing," he observes. "The only time something should be billed under the nonphysician practitioner's PIN is when the physician is not immediately available."

Picou suggests that you also take note of which practitioners can provide incident-to services. "Some physicians believe that only the services of CNMs, NPs, and PAs can be billed as incident-to, but the services of others, such as clinical psychologists, clinical social workers, occupational therapists, and physical therapists, may be eligible as well," she concludes. "In this time when it's so hard for physicians to make a profit, you certainly want to make sure you're collecting where you should."

*Reported and written by Cynthia Starr, editor. More information on incident-to billing is available on our Web site (see page 8).*

# Patients Come, Patients Go: How Should These Transitions Be Billed?

**Q:** *Can a physician working in an urgent care facility charge for seeing the patient in the office as well as for the subsequent admission to the hospital on the same date of service?*

**A:** “If you admit a patient on the same day he or she is evaluated in the office, the hospital admission code is the only evaluation and management (E&M) code that should be billed that day,” says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., headquartered in New Orleans, La. “However, the time and work required to evaluate the patient in the office should be rolled into your admission code level of service.” Depending on the purpose of hospitalization, you would choose from CPT codes 99218 to 99220 (initial observation care for new or established patient) or codes 99221 to 99223 (initial hospital care for new or established patient). As always, be sure to document what you’ve done to support the selected level of service.

As an aside, it should also be noted that urgent care centers are not to use the E&M codes for emergency department (ED) services—even when billing for care of true emergencies. To be considered an ED, the facility must meet certain criteria. For example, it must be hospital-based and open 24 hours a day.

**Q:** *Can a physician bill for a hospital discharge and admission to a nursing home for the same patient on the same day? If so, what codes or modifiers should be used?*

**A:** You can bill individually for the hospital discharge and the nursing home admission, regardless of whether the patient is entering the facility for the first time or returning after a hospital stay, Picou notes. If patients are discharged after observation, use 99217; otherwise, use 99238 (the entire process takes you 30 minutes or less) or 99239 (discharge requires more than 30 minutes). When patients are admitted to the hospital and discharged on the same day, Picou suggests reporting 99234, 99235, or 99236. These codes encompass observation and inpatient care. You can then use one of the codes for comprehensive nursing facility assessments—99301, 99302, or 99303—to bill for admission or readmission. Remember that these codes are also used to describe admission or readmission to other types of convalescent, rehabilitative, or long-term care establishments, including psychiatric residential treatment centers—essentially, residential facilities where medical services are provided.

**Q:** *Most of the charges generated by our growing multi-practice group are for outpatient care and chemotherapy. Recently, two hospitalists joined the practice, and in the course of their work, they have posed billing questions I can’t answer. First, if a physician in the ED calls the hospitalist in to evaluate one of the practice’s established patients and the hospitalist decides not to admit the patient, do we bill the encounter as a consultation or a visit to the ED? Or, if the patient is admitted and the hospitalist runs a central line for that patient later on the same day, can*

*the practice charge for subsequent hospital care?*

**A:** Situations like these can be perplexing. Two physicians can’t bill for providing the same services to the same patient at the same time. Therefore, if both the ED physician and the hospitalist see the patient in the ED, the ED physician bills for the visit with one of the E&M codes for ED services, Picou points out. However, if the ED physician shifts care of the patient over to the hospitalist before the patient leaves the ED, then your colleague will bill for the encounter, using the appropriate E&M code for office or other outpatient services. Now assume that the ED physician asks the hospitalist to come to the ED, evaluate the patient, and provide an opinion on how treatment should proceed. In this case, she says, the hospitalist has acted as a consultant and bills with a code designating an office or other outpatient consultation—even though the patient is part of your practice. If the hospitalist admits the patient and must insert a central line either during the admission process or later on the day of admission, he or she can use an E&M code to charge for the admission plus the appropriate procedure code. The modifier “-25” should be attached to the pertinent E&M service code. This indicates that a significant and separately identifiable service has been carried out.

*Editor’s note: Readers of The Physician’s Compliance Alert are invited to visit our Web site (see page 8) and submit their questions. Members of our Advisory Board will offer their expert opinions in response.*

tiated by a disgruntled employee who files a complaint.) To categorize workers, the US government uses a checklist of 20 questions (see “When Is a Worker an Employee?” on page 7).

“There is no set definition, and the IRS generally makes a determination based on how the majority of the checklist questions are answered,” says David Sherman, Esq., tax attorney for Chehardy, Sherman, Ellis, Breslin, Murray, and Recile, located in New Orleans, La. Some of the 20 items carry more weight than others, he notes, and the most important queries relate to control: Who controls the work and the manner in which it is done? Does the hiring person have the right to direct the individual who performs the services, not only in terms of the results of the work, but also in the details and means by which those results are accomplished? If so, the person is almost certainly an employee. “I have seen many instances of this in my legal practice, including a number of medical groups in which all the doctors and nurses were treated as contractors, when they were actually employees,” observes Sherman.

The IRS also gauges what is conventional for the individual’s field, says Lawrence B. Goodman, CPA, president of Lawrence B. Goodman & Co., PA, in Fair Lawn, NJ. By convention, plumbers are outside contractors, and physicians and nurses employed by doctors are not, he says. Yet like Sherman, he also finds that in many practices, doctors and nurses are paid as independent contractors rather than as employees.

“In my experience, physicians prefer to treat all part-time workers as independent contractors,” Goodman says, “And that’s risky because they are almost always employees based on the government’s criteria.” He cites the physician who paid an employee of 30 years as an independent contractor.

“When she retired, she filed for social security benefits, but was not on record: she had never paid social security withholding taxes, and the doctor had to pay 30 years of back withholding taxes, which totaled thousands of dollars,” Goodman recalls.

Practices may also be responsible for more than back taxes in these cases. If you offer benefits to your employees, you could owe that independent contractor, who is really an employee in the eyes of the IRS, for all unpaid medical and retirement benefits as well. Any employee who works more than 1,000 hours a year is eligible for any benefits you offer.

Another wrinkle concerning benefits concerns malpractice and liability insurance. “If your practice has malpractice insurance that covers the practice and its employees, you may think it covers everyone. But if you treat doctors and nurses as independent contractors, they may not be covered by your policy,” counsels Sherman. That could be a real problem for both the worker and the employer in the event of a lawsuit.

### **Avoiding the pitfalls**

There are ways to be certain you are complying with the law in terms of your employees. First, know the 20-point checklist used by the IRS to differentiate between an employee and an independent contractor. “Very few people are truly independent contractors,” comments Goodman. “A per diem nurse, for example, is not independent. Many practices think they can pay them as outside contractors, but they should not.”

“A simple rule of thumb is that if the person’s schedule is set by the practice, that person is an employee,” Sherman adds. “If you hire someone and give them hours and a regular salary and supply the tools and equipment needed for the job, the worker is

your employee.” Part-time office workers and cleaning staff, for instance, are employees, unless they actually work for another company that pays their wages and liability insurance and withholds their taxes.

“To be safe, ask any independent contractor who works for you to sign a letter indicating that they are responsible for paying their own payroll taxes,” suggests Goodman, adding that you should also have the contractor obtain a federal identification number if he or she does not already have one. This number is designed to prove that the worker is truly an independent contractor and not an employee, says Goodman.

### **Salaried versus hourly: The overtime minefield**

Another important issue that can get employers into serious trouble is when they should pay their workers overtime, observes Patricia E. Pannell, Esq., labor attorney for the aforementioned New Orleans law firm. Many assume that salaried workers are never eligible for overtime pay, but this is not the case.

“There are only three types of employees who are exempt from overtime pay—executives, administrators, or professionals,” she says, and these are employees who have considerable responsibility on the job. In medical practices, they are the doctors, nurses, and office managers. “All other salaried employees, including clerical staff, should receive time-and-a-half overtime pay for all work exceeding 40 hours in any consecutive seven-day period,” says Pannell. Employees’ hourly wages are computed based on the weekly or biweekly salary they earn. At some companies or practices, the overtime policy states that salaried workers are paid only half time for extra hours. This also complies with the law because employees

are receiving additional compensation. It's also important to know that the laws on exemption will probably soon change. The DOL has proposed revisions on how exempt employees are classified, and if these changes are enacted, fewer employees will be exempt. This would result in increased overtime payroll costs for employers, and the DOL estimates that health care services would be among the hardest-hit industry sectors, to the tune of \$85 to \$163 million each year in new payroll costs.

With or without the proposed changes, though, the important lesson for medical practices is that they could find themselves at the center of a DOL audit, which is usually initiated in response to a worker's complaint. If a DOL investigation of the practice's records shows that employees were not paid overtime when they should have been, the department will generally hold the employer responsible for paying all past overtime wages to the employee. In addition, employees can sue their employer for past overtime owed to them and have two years in which to file a lawsuit. The law allows for filing after three years, however, if it is found that the employer willfully withheld overtime pay, Pannell says. "A lawsuit can be very expensive, especially if a group of workers sues for overtime over a period of time."

As for hourly-wage earners, most practices comply with overtime regulations, paying workers time and a half for work exceeding 40 hours in any consecutive seven-day period. In fact, some practices actually pay more than required. "A number of our clients pay their nurse employees an hourly wage because of custom and because there is a nursing shortage," says Pannell. They could hire them as professional salaried employees, but in that capacity they would then be exempt from overtime.

Knowing these ins and outs for han-

## When Is a Worker an Employee?

The Internal Revenue Service uses a 20-point checklist to determine whether a worker is an employee. If most of the answers to these questions are "yes" (except questions 17 and 18, which would generally be answered "no" for an employee), the IRS classifies the individual as an employee. It's therefore important to know these criteria to properly handle payment to the worker.

1. Is the person required to comply with instructions on when, where, and how to work?
2. Is job training provided to the worker?
3. Is the work performed integrated into the business?
4. Are services rendered personally?
5. Is the employer responsible for hiring, supervising, and paying assistants for that worker?
6. Is the work relationship a continuing relationship?
7. Are there set hours for the worker?
8. Is full-time work required?
9. Is work done on the employer's premises?
10. Does the employer set the sequence or order in which the work is done?
11. Are the workers instructed to report in for instructions or assignments?
12. Is payment made by the hour, week, or month?
13. Does the employer pay business and/or traveling expenses?
14. Does the employer furnish tools and materials for the work?
15. Is a significant investment made by the employer in licensing and other costs for the worker?
16. Does the employer have control over how many hours the worker works and how much is earned?
17. Does the worker work for more than one employer at a given time?
18. Are the worker's services available to the general public?
19. Does the employer have the right to discharge the worker without breaking a contract?
20. Does the employer have the right to terminate the relationship without breaking a contract?

Note: For help from the IRS on determining whether or not a particular worker is an employee, fill out and file IRS Form SS-8, Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding.

dling employee status is just the beginning for avoiding IRS and DOL woes. "The laws are fairly complicated, and they change," says Pannell. She therefore strongly recommends that every practice arrange a yearly meeting with their administrators and a labor attorney to review pertinent issues; a similar meeting with a tax attorney is also a good idea. "Defending yourself in an

investigation and possibly having to pay back taxes and payroll, as well as penalties, can be costly for a practice," she concludes. The key is to avoid problems in the first place by ensuring compliance with IRS and DOL regulations regarding worker status.

*Reported and written by Deborah Epstein, in West Milford, NJ. More information on these issues is available on our Web site (see page 8).*

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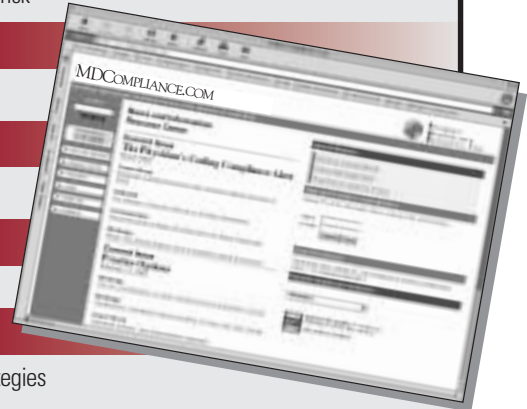
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