

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

The Fine Art of Hiring, Reviewing, and When Necessary, Firing

How much attention do you pay to policies and procedures for hiring, reviewing, and firing employees? You may think that fairness and common sense are sufficient, but consider these sobering facts: a seemingly innocent question asked during an interview or placed on a job application can lead to a charge of discrimination; firing an employee and using the wrong procedures to do so can open you up to a lawsuit for wrongful termination—even if you had good reasons for the dismissal; failing to inform employees of their option to continue health coverage as prescribed by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) within a specific time after dismissal can lead to audits or large fines from the US government.

“Medical practices are subject to the same state and federal laws as other employers,” says labor and employment attorney William Tebbe, Esq., Musick, Peeler, and Garrett, in Los Angeles. “There are some situations that tend to occur more in practices, though, because a large percent of the staff is made up of females,” he adds. For example, medical practices tend to have more lawsuits concerning pregnancy and family leave as well as sexual discrimination and harassment. Many of these arise from actions taken while hiring, reviewing, and firing.

Safe hiring practices

Two important federal laws affect hiring practices. Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin. Titles I and V of the Americans with Disabilities Act of 1990 (ADA) prohibit employment discrimination against qualified individuals with disabilities. State laws can also regulate employer practices: they may give employees more protection than federal antidiscrimination laws, but they cannot provide less protection.

What do these laws mean when you are hiring an employee? To begin with, you should know what you can—and cannot—ask job applicants. This includes the well-known prohi-

bitions of age, creed, race, and birthplace, but also lesser known topics like the applicant's maiden name (see “The Job Interview,” page 7).

“The general rule is to avoid claims that you chose not to hire someone because of a particular characteristic, such as race or religion,” Tebbe says. “Before you ask an applicant any question, ask yourself whether it has any bearing on the person's qualifications or ability to perform the job. And never ask a woman a question that you would not ask a man, including ‘Are you planning to have a family?’”

On the other hand, there are a number of questions that you probably should ask each applicant: Is there anything that would keep you from maintaining the work schedule? Do you have transportation? Why are you interested in the job? What is your prior work experience? What were the circumstances of leaving those jobs? How would you describe your relationship with your prior supervisor? Questions like this can help identify potentially difficult employees.

Some questions depend on the preference of the employer. You may ask if the applicant has ever been cited in a malpractice suit, for instance, since this is public information. Whether or not to use a written job description is also a matter of preference. There are no requirements either way, notes

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Will Medical Practices Need Accreditation?

For more than 50 years, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been recognizing providers who meet its standards for delivery of high-quality health care. According to the agency, which has accredited almost 17,000 entities, including hospitals, nursing homes, assisted living facilities, and clinical laboratories, compliance with JCAHO criteria improves patient care while providing many benefits—for example, a competitive edge. The Accreditation Association for Ambulatory Health Care (AAAHC), a younger organization, bestows accreditation on ambulatory clinics and surgery centers that meet its quality marks. JCAHO will also certify eligible group practices, while the AAAHC will do likewise with single- and multispecialty group practices. Yet, pursuing formal recognition has not been a priority with private practitioners, probably because the effort and cost involved in the endeavor may be overwhelming.

However, some health care pundits believe that third-party payers may one day require physicians to meet certain benchmarks before they can be reimbursed for care. A provocative study sponsored by the Centers for Medicare and Medicaid Services (CMS) and entitled The Doctors Office Quality Project will attempt to measure the quality of care given by generalist physicians to patients with coronary artery disease, diabetes mellitus, heart failure, hypertension, major depressive disorder, and osteoarthritis. In tandem, strategies will be developed to “improve office-based preventive care and treatment.” Physicians taking part in the three-state pilot (California, Iowa, and New York) have been offered continuing medical education as an incentive. More attractive is the possibility that participation will lead to a reduced risk of medical liability and ultimately, lower insurance premiums. Participants will also help decide what kind of public recognition is merited. The study, scheduled for completion in July 2005, is currently running behind schedule, according to a CMS spokesperson, because the construction of a feasible Medicare drug benefit is presently a higher priority. Look for updates at cms.hhs.gov/quality/doq.

In the meantime, our cover article is examining a nonclinical area that can prove traumatic for many physicians: the hiring and firing of employees. We also look at how poor care can lead to prosecution under the False Claims Act. Finally, we'll answer some billing questions. We hope you can put some of the information in this issue to use today!



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More Than Malpractice: When Inferior Health Care Becomes A Federal Case

Something about Dr. David Tremoglie's demeanor made the patient's wife suspicious. The absence of diplomas on the psychiatrist's walls reinforced her doubts. Equipped with the name of the hospital where he said he was on staff and the license number from a prescription written for her husband's worsening depression, the woman made some calls and learned something that had escaped Tremoglie's employers at the Bustleton Guidance Center in Northeast Philadelphia: He wasn't a licensed physician.

A class action suit was filed against Tremoglie, Green Spring Health Services, Inc., which operated the clinic, and Keystone Health Plan East, Inc. on behalf of the patient and others who, as participants in Keystone's managed care plan, were required to use Green Spring facilities for psychiatric care. This type of situation—a so-called credentialing failure—could trigger prosecution under the False Claims Act if an unqualified provider generates Medicare or Medicaid claims. Because the patient did not receive care from a legitimate physician, the resulting bill to the government is fraudulent. Similarly, a claim for services provided by any other type of unlicensed health care practitioner is false. Another example of a credentialing failure is the physician who writes prescriptions for controlled substances without possessing an authentic drug enforcement administration number.

Credentialing is an important quality-of-care focus, notes Jim Sheehan, JD, associate US attorney for the Eastern District of Pennsylvania (EDPA). The lead case in this area involves United Memorial Hospital in Greenville, Michigan, which was prosecuted by the US government. "United Memorial was indicted along with two physicians—one was the former chief of staff; the other was the

chair of the Professional Activities Committee," he explains. "A doctor was using the hospital to perform inappropriate pain management procedures, and those physicians allowed him to stay on staff. They also obstructed the investigation. If you are in a leadership position, you have certain responsibilities for quality, and if someone on the medical staff is clearly not doing a job, you have to make sure that person is out of there." The defendants pled guilty.

No charges of false claims were brought against Keystone. The managed care plan asserted that it learned of Tremoglie's bogus documents through a media report published eight months after he'd been suspended by Green Spring. Keystone then notified all relevant parties, including its members, the Centers for Medicare and Medicaid Services, and the US Attorney's Office for the EDPA, and cooperated in subsequent inquiries. A joint agreement between Keystone and the US Attorney's Office resulted in a model credentialing policy that offers guidance on the verification of providers' qualifications as well as mechanisms to ensure that these procedures have been carried out (see www.usao-edpa.com/Pr/2003/feb/keystone%20credentialing%20policy.pdf). Tremoglie, by the way, was sentenced to 37 months in prison.

Gunpowder and health care

An issue in false claims cases is whether the government is getting the goods or services for which it has paid. "The False Claims Act was created during the Civil War," explains William Maruca, JD, Chair of the American Health Lawyers Association's Fraud and Abuse, Self-Referrals, and False Claims Practice Group. "There was a rash of procurement scandals in which munitions manufacturers and vendors would sell barrels of sawdust to the government and charge for barrels of gunpowder. In the 1970s and 1980s, we had defense department scandals where the government was charged \$600 for a toilet seat or \$400 for a hammer. The False Claims Act applies to all claims for payment from the federal government, not just health care claims. However, the health care angle has gotten stronger in recent years."

Catching those who are accountable depends heavily on whistleblowers, formally known as qui tam relators. "It takes somebody who has direct knowledge of what's going on and is able to bring a lawsuit on behalf of the government," Maruca points out. Depending on the case, the government may choose to take part in the proceedings. As incentive, the relator is entitled to receive up to 25% of the money recovered by the US government, adds F. Lisa Murtha,

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JD, vice president for audit compliance and chief privacy officer at The Children's Hospital of Philadelphia. If the US government does not contribute to the litigation, the relator can receive up to 30% of the money recouped. The financial consequences for violating the False Claims Act: three times the loss sustained by the government plus a separate penalty of \$5,500 to \$11,000 per false claim. In addition, the relator cannot be fired or otherwise penalized by the party under investigation.

"The False Claims Act makes it illegal not just to bill for something that you didn't do but also to bill for something that is supported by a fraudulent claim," Maruca says. "For instance, there was a case here in Western Pennsylvania where a durable medical equipment company was allegedly providing oxygen on the basis of falsified blood gas tests. They provided oxygen tanks they had billed for, but they falsified the medical necessity underlying the claim." Sheehan adds, "Creating a false record—either destroying what exists or adding something that was not originally in the record—is by itself a federal crime with respect to Medicare and Medicaid patients. Even if you don't give it to the government, you're liable, and that statute is used in quality-of-care investigations and prosecutions."

In healthcare settings, whistleblowers are often patients or their family members, Murtha says. They may question a service listed on an explanation-of-benefits form. Or, a health care provider may become aware of a problem and get no satisfaction when the matter is called to the attention of supervisors. Some organizations may uncover a problem through regular compliance auditing and report their findings to the government. "When that happens, you still have to pay

back any money you should not have received, but you tend to get much more positive treatment," she says.

Addressing quality

As already noted, quality-based false claims cases may involve credentialing failures. Another concern is whether a provider meets minimum standards of care. For example, is a laboratory billing for tests that are so poorly performed that they offer no useful information? More difficult circumstances to investigate are whether care is adequate among patients in nursing homes and hospitals. "Let's say we have a nursing home where patients have multiple bed sores that don't heal or patients are suffering from malnutrition or dehydration," Sheehan suggests. "The medical director and treating physician have a duty to monitor their patients and to take action if someone isn't getting proper care. If we see patient harm as a result of a quality issue and the allegation is that the physician was told on several occasions and paid no attention to the information, we've got to do something." Inappropriate use of physical restraints, regular administration of heavy sedation, or failure to treat delirium in nursing home residents are other poor-quality situations that could prompt a false claims investigation.

"Quality issues are chiefly a failure to provide necessary care," Maruca explains. "By accepting fees through a prospective payment system, a facility is representing that it will deliver adequate care for the dollar. Those investigating false claims are looking for some sort of systemic under-treatment; not an error in judgment."

To date, charges of false claims have primarily been leveled at institutions, but you should also consider shoring up your own quality compliance program. Sheehan suggests con-

ducting a diligent credentials check on any health care provider you hire. "If you're going to hold a physician out to a community, know that he or she is actually licensed and that the license is valid," he emphasizes. "If physicians represent themselves as board-certified, ensure that they have received the certification. Make sure a prospective employee isn't on probation for use of drugs or alcohol."

"I think a practice should have some sort of auditing and monitoring process in place, from both a clinical perspective and a billing perspective," Murtha advises. "Feedback on the services being provided and the quality of those services is important. Obviously, the depth and breadth of these compliance programs are dependent on the size and complexity of the practice." You should also have written protocols for clinical documentation of care and orders. Make sure training is available when needed. Offer opportunities to report problems without fear of reprisal. Conferences can be worthwhile, offering a lot of information in a concentrated period. "I also think it's helpful to occasionally hire a peer-review person with expertise in your area," she adds.

Again, false claims stemming from poor quality of care are different from errors. "What happens is that over a long period of time, conduct does not meet any kind of standard," Sheehan concludes. "In most cases, you want to give people the benefit of the doubt because mistakes can occur. But it's the evidence of intentional conduct or indifference that moves a case across the line. If you're making a good-faith effort to practice medicine in a competent way, this is not an issue you're going to see."

Reported and written by Cynthia Starr, editor. More information on compliance programs is available on our Web site (see page 8).

How Should I Bill For Venipuncture Performed During A House Call?

Q: *What CPT code should be used when blood is drawn at the patient's home and then taken back to our office for analysis? Would it be correct to bill with both 99001 and 36415?*

A: The CPT code 99001 is designed to bill for handling and/or conveyance of a specimen for transfer from the patient in other than a physician's office to a laboratory, and it could be used in combination with 36415 when billing insurers unrelated to Medicare because these are two different services, says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., based in New Orleans, La. However, she notes, Medicare does not cover the transport of the blood sample. In addition, the code G0001 should be used to identify routine venipuncture for collection of specimens on Medicare claims. A program memorandum issued on November 8, 2002 (Transmittal AB-02-163), explains that for 2003, the code 36415 was modified from "routine venipuncture or finger/heel/ear stick for collection of specimen(s)" to "collection of venous blood by venipuncture." The code 36416 was added to indicate collection of a capillary blood specimen, whether by finger, heel, or ear stick. Nonetheless, the Centers for Medicare and Medicaid Services states that it "must undertake further efforts before implementing codes 36415 and 36416." Clearly, this is an issue worth watching.

Q: *If a patient presents with specific signs and symptoms and a physician orders laboratory tests or*

x-rays to explore the complaint, should the codes for the signs and symptoms be entered on the claim form or is it proper to wait for the test results and use the resulting diagnosis code? For example, the patient complains of chest pain and dyspnea and an EKG indicates acute myocardial infarction (MI). Would I use the signs and symptoms code as a first diagnosis and the MI code as a second diagnosis?

A: Physicians—and nonphysician practitioners—ordering a diagnostic test are expected to provide the testing facility with an ICD-9-CM code or a corresponding narrative diagnosis. When a suspected diagnosis is confirmed by testing, use the corresponding diagnosis code on the resultant claim, Picou urges. If the patient has some signs or symptoms that are not likely associated with the established diagnosis, you can report the codes for these as additional diagnoses. Now assume the test comes back and the results are normal or inconclusive, she continues. Instead of coding for the suspected or working diagnosis, enter the codes for the complaints that triggered testing. Tentative diagnoses should not be reported. In situations where screening tests are ordered for apparently healthy patients, use the screening code as your primary diagnosis unless the insurer has other guidelines. Specifically, when billing for screening colonoscopy or sigmoidoscopy in Medicare patients, the screening code is used if the test results are normal. But if testing reveals an abnormality, the code for the particular lesion or growth becomes the primary diagnosis.

Q: *If a patient with a documented chronic condition such as diabetes mellitus or hyperlipidemia comes in for a blood test that is performed by the nurse, can we charge a level one nurse's visit if we record what was done and why the service was necessary?*

A: "The code 99211 has been a controversial subject because little direction has been given regarding the requirements for its use," Picou explains. "It is my understanding that this code should be used for evaluation and management (E&M) services provided to patients as incident to the physician's care." The blood draw and subsequent documentation would not merit a 99211 code. In addition to performing the venipuncture and documenting that it was done, you would need to spend a few minutes providing typical E&M services, such as reviewing the patient's history and current course of treatment.

Q: *If I perform surgery on a patient and that patient presents within the global period for a different problem, can we bill for care of the later situation and still expect reimbursement for it?*

A: "All the care required during recovery is included in the surgical fee, and the length of the global period is defined by the insurance carrier," Picou emphasizes. "Nonetheless, if an unrelated problem occurs during this phase and is treated by the same physician, it should be billed and reimbursed as it would at any other time." *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.*

Tebbe, but there are advantages and disadvantages to each approach. A written description gives employees a clear, objective outline of their duties, but may lead to complaints of “that wasn’t in my job description.”

You may also ask potential employees to be drug tested, but you should discuss any such plans with an attorney. The laws covering drug testing are specific and complex. For example, you must test everyone if you test even one employee or candidate.

If a job candidate is disabled, you do not have to hire that person if you believe he or she will be unable to do the work. If the person needs only reasonable accommodation, though, you may be open to a lawsuit if you appear unwilling to make the adjustments, Tebbe says. For instance, if a person who applies for a clerk’s job cannot lift items higher than five feet because of disability, “ask yourself if this person could be easily accommodated.”

Some employers opt to hire all employees on a 90-day probation basis. “This is a smart thing to do,” observes Nikki McLaughlin, vice president of client relations for Employer Benefits Solutions, LLC, a Baton Rouge, La.-based company that specializes in employee benefit plans. “It allows you to see whether an individual has the skills needed to do the job.” Another option is to use a temporary agency to find an employee, which lets you sample potential employees without commitment.

Once the individual is hired, provide a manual detailing the practice’s policies and procedures, a Medicare compliance handbook, and information on the Health Insurance Portability and Accountability Act (HIPAA) privacy notices, says McLaughlin. COBRA and HIPAA are becoming more regulated, and employees should be educated on these two issues. Have new employees

date and sign a form stating they have received and read the materials.

“We recommend that even small medical groups have an employee manual that includes all policies and procedures,” says McLaughlin. Include everything that is expected of the employee, such as hours of operation and dress code. “We advise our clients to include employee benefits as well,” she comments. Remember, however, that employers must also follow the policies in their manuals. “You don’t want a terminated employee to have substantial evidence that you do not follow the rules yourself or that you do not hold your staff accountable,” McLaughlin adds.

Performance reviews

Another potentially dangerous area involves employee reviews and disciplinary practices. The main goal for these is to use objective criteria, says Tebbe. This means giving as many concrete examples of what you expect as possible during reviews.

“Typically, evaluations should be done on an annual basis by the direct supervisor,” comments McLaughlin. “And your policies must be the same for all employees.” Most employers evaluate the person’s knowledge and his or her interactions with staff and patients in addition to qualifications. Inform new hires that this is your procedure; you may also include this in the manual. Write-ups should be placed in the personnel files. “Keep all certificates, licensing, and continuing education documentation in the files as well,” she says.

As for tying financial rewards to performance, nothing prohibits an employer from rewarding employees with raises or bonuses, says Tebbe. Again, though, this should be based on objective criteria. Otherwise, an employee who feels he or she did not get a raise because of gender, race, or

another protected characteristic may have a case against you. Conversely, you can never use financial punishments for infractions (except to pay for property damage that the employee may have caused). You may suspend an employee without pay.

Disciplinary policies

“When there is a problem, tell the employee specifically what you don’t like, then what you expect, and finally, what will happen if there is no change in behavior,” says Tebbe. This will make your actions more defensible in court if an employee sues for wrongful termination.

“You may want to use pink slip notices and a policy that three notices will lead to termination,” suggests McLaughlin. The notices should describe the transgression, when it occurred, and any action plan on how the employee can improve. “Let the person respond to the notice directly on the form and then give a copy to the employee,” she says. Keep all documentation in the personnel file.

If you suspect a particular employee of an infraction, tread carefully. “For example, if money, blank prescriptions, or drugs are missing, you must confront everyone who has access,” emphasizes Tebbe. “Don’t single out one person, and avoid being confrontational.” Calmly ask each person whether he or she knows anything about the situation. “Often, the person will crack and tell all,” he says. You can then decide what action to take.

Fire with care

If you do have to fire an employee, it’s crucial to follow certain procedures. All states are legally allowed to use “at-will” employment. This means that employers can hire or fire for any reason they choose—or even no reason—except those characteristics protected by federal law. “We advise employers

to have a written at-will policy," Tebbe says. This can protect you from claims that you agreed to retain the employee for a specific period of time.

Always tell employees why they are being dismissed. Many employers avoid this because it may make them uncomfortable, but there are important legal reasons to do so. "Suppose you tell an employee their work is no longer needed, but you actually want to replace the person," says Tebbe. "What happens if the individual sees an ad for the job or learns that you hired someone else? The person could conclude that the actual reason for the discharge was gender or race. Not only would the lie come up in court, but you would also have to defend why you fired the person in the first place."

Complying with COBRA

"One common source of liability stems from employers who fail to follow the COBRA laws," observes McLaughlin. These allow employees to continue their health care coverage for 18 months after they leave employment. COBRA applies to all employers with 20 or more employees, whether or not all 20 employees are in the benefits plan.

The laws state that COBRA employers must notify the employee of their option to elect COBRA within 30 days of termination. Failure to comply could result in fines and other liabilities. McLaughlin recommends either sending the notice "return receipt requested" or having the employee elect during the exit interview. You must also inform the employee of the amount of the premium and due dates. (You can add a 2% administrative fee.) You may also want to advise exiting employees that any changes in the group plan will affect them and if the business terminates benefits or closes down, their participation in COBRA will cease.

The Job Interview

There are a number of questions you may not ask job candidates. Prohibited topics include:

- Race
- Gender-specific areas (such as whether the applicant plans to become pregnant)
- An applicant's disability, past medical problems, or previous workers' compensation claims
- The number of children the applicant has or questions about child-care arrangements
- Marital status or the spouse's occupation
- The applicant's ethnic origin, birthplace, nationality, or native language
- Whether the applicant is a citizen of another country
- The applicant's maiden name
- Religion or religious holidays that the applicant observes
- Date of birth, graduation dates, or age
- Arrests, veteran status, discharge status, or branch of service

You may inquire as to whether applicants are in the country legally, if they can speak English or other languages, if they are over 18 or 21 years of age (depending on requirements), if they have any prior convictions, if they have a disability that would prevent them from performing the duties of the job (but not about details of the disability itself), and if they can perform essential job-related functions. You are also allowed to ask about applicants' training and education, including any training received in the military. References from previous employers may be requested.

Another trouble area is the final paycheck. "In some states, you have to pay the employee within a certain period," says McLaughlin. You should therefore know the local laws. Final paychecks should include vacation time, sick time, and severance pay.

The exit interview

Whenever employees leave, a formal exit interview can prevent a number of potential problems. "We recommend using an exit interview form," says McLaughlin. This provides a checklist for the procedure, including:

- State the reason for the discharge
- Note that the decision is final and that all factors were considered
- Give the date of termination
- Review the benefits due
- Provide the final paycheck
- Obtain all company IDs, keys, and

credit cards

- Wish employees good luck and express confidence in their future.

You should also ask employees why they are leaving (if they resigned); how they would describe their working relationships; whether any working conditions were detrimental or beneficial. This feedback can be invaluable in the event of a lawsuit.

Finally, even the most conscientious employers can be sued. To fully protect yourself, be sure your malpractice and professional liability insurance is up to date. "Professional liability insurance provides coverage in the event you are sued for hiring or firing actions," says McLaughlin.

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

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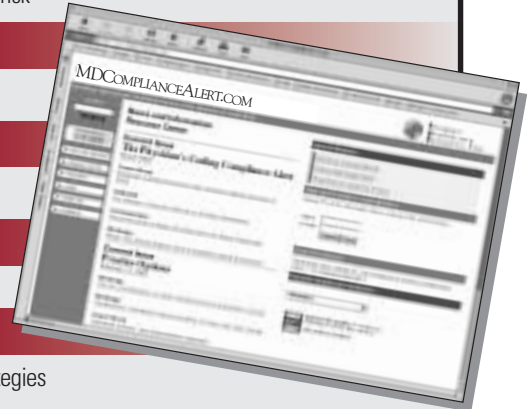
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