THE PHYSICIAN'S
CODING COMPLIANCE
ALERT™

December 2002

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

National Coverage Determinations Smooth Billing for Lab Services

A new set of 23 policies governing payment for clinical laboratory tests scrupulously defines the conditions under which the services, represented by 65 CPT codes, will be reimbursed. Some five years in the making, these national coverage determinations (NCDs) went into effect on November 25, 2002, and will be implemented on January 1, 2003, providing a brief extension of the one-year period during which Medicare carriers and fiscal intermediaries can make final preparations for handling pertinent claims.

The NCDs supersede local medical review policies (LMRPs) for the applicable tests, long a great source of frustration for physicians ordering tests and the laboratories performing them. Carriers and intermediaries will continue to create LMRPs for other tests and may still develop LMRPs to supplement the NCDs, but may not contradict them. "Laboratory groups, and to some extent physician groups, wanted NCDs because there was tremendous variability among carriers as to what was and wasn't covered," says a spokesperson for the Centers for Medicare and Medicaid Services (CMS). For example, inconsistencies existed among lists of diagnoses used to establish whether a certain test was medically necessary. Or, the lists devised by LMRPs were thought to be too narrow.

Concerned groups successfully lobbied the US Congress to change the situation. The Balanced Budget Act of 1997 directed the Secretary of Health and Human Services to employ a negotiated rule-making process in the construction of national uniform coverage and administrative policies for clinical laboratory services paid under Medicare Part B. The CMS source observes that it's a formidable task. "First, representatives of every group with a potential interest are interviewed to mark out the issues and see whether a workable rule can be developed. Once the report is filed," she continues, "there is a recommendation as to which groups should be represented in the negotiation. The goal is not to include every group, but to be sure that all interests are represented. Then the fun starts."

In this case, the endeavor required 10 three-day sessions in which the selected participants—notably, physicians, hospital representatives, laboratory experts, and coding specialists—pounded out the details for eight hours a day. Overall, the negotiating committee had delegates from the CMS and 16 organizations, including the American Medical Association (AMA), the American College of Physicians—American Society of Internal Medicine, and the American Clinical Laboratory Association. "Decision-making was by consensus," explains the CMS spokesperson. "The rule would only include those things to which everybody had agreed."

Salient points

The final NCDs are meticulously outlined in a 200-plus page document attached to a July 31, 2002, CMS Program Memorandum (Transmittal AB-02-110 is available at www.cms.hhs.gov/manuals/pm_trans/AB02110.pdf). Negotiators culled the tests, which represent an estimated 60% of Medicare Part B payments for lab services, from roughly 1,000 candidates. On the roster are blood counts, blood glucose testing, lipid assays, prostate-specific antigen testing, prothrombin times, and thyroid testing

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EDITORIAL

Feds Ever More Watchful of Coding Practices

The American government is stepping up its examination of your coding habits. For confirmation, look to the General Work Plan for fiscal year (FY) 2003, newly released by the Office of Inspector General (OIG) for the US Department of Health and Human Services (available at oig.hhs.gov/publications/workplan.html). In the section pertaining to Medicare physicians and other health care professionals, four of the dozen areas targeted for investigation concern coding. As in FY 2002, the OIG will explore whether physicians are correctly coding evaluation and management (E&M) services. This effort will include an appraisal of mechanisms used to find physicians with aberrant coding patterns—especially those "coding disproportionately high volumes of high-level" E&M codes. Another continuing area of interest is consultation coding. An associated study aims to establish the suitability of physicians' billings for these services, determine the financial burden of inaccurate claims, and find out why improper billings occur.

Also on the agency's agenda are two new coding issues: coding of Medicare physician services and coding of physician evaluation of dialysis. The OIG will test whether Medicare Part B carriers are successfully detecting and correcting billing errors with edits developed for Medicare's National Correct Coding Initiative (CCI). Edits are designed to locate claims bearing multiple CPT codes for each aspect of a procedure instead of a single complete procedure code. They also kick out claims that carry mutually exclusive codes; an example offered by the CCI is the reporting of female- and male-specific codes for a single patient. In short, the OIG wants to ascertain whether physicians have been improperly paid for claims that should have been rejected. In addition, claims for physician evaluation during dialysis will be reviewed to look for evidence of up-coding.

Note that the FY 2001 Work Plan scheduled no coding-related investigations, the FY 2002 Work Plan addressed two such areas, and the FY 2003 Work Plan includes four, indicating the government is resolutely pursuing improvements in coding compliance. To help you do the same, we've outlined other important developments: national coverage determinations for laboratory services, new advance beneficiary notice forms, and recent coding changes. All of it is information you'll most definitely need in the upcoming months.

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This newsletter is published by Premier Healthcare Resource, Inc., Morristown, NJ.

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Learning Your ABNs: Revised Forms Can Cause Confusion

Many providers go astray when it comes to using advance beneficiary notice (ABN) forms, and the situation will probably get worse before it gets better since the use of a revised form, approved by the Office of Management and Budget this past June, went into effect on October 1, 2002.

ABNs advise beneficiaries, in advance of items or services being provided, that Medicare is likely to deny payment. If Medicare refuses to cover a service and the patient did not sign an ABN, the provider can't bill the patient for that service. The idea is to let beneficiaries decide whether they want to proceed with a service they may have to pay for out of pocket.

"Many beneficiaries believe that Medicare pays for anything that a physician orders," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, based in New Orleans, La. That, of course, is not the case, and ABNs inform beneficiaries ahead of time when they may have to pay for the service themselves.

The revisions were made for a number of reasons. "There was language that doctors found offensive, particularly the medical necessity section," points out a spokesperson for the Centers for Medicare and Medicaid Services (CMS). "We also wanted to make the forms more beneficiary-friendly and easier to read."

ABN forms now mandatory

The general use ABN (ABN-G) should be entered on form number CMS-R-131-G, a document appropriate "for all situations, including laboratory tests," according to a July 31, 2002, CMS Program Memorandum (PM), specifically, Transmittal AB-02-114. Another form, CMS-R-131-L, is reserved for ABNs that pertain to physician-ordered laboratory tests (ABN-L). English and Spanish versions may be found at www.cms.hhs.gov/medicare/bni/. These forms are mandatory and cannot be modified. The only exception, according to the PM, is that physicians or suppliers requiring more space can extend the blank boxes, and the form can be lengthened from letter size to legal size to accommodate that need, but it must remain one page in total. "Except for the headings and the empty boxes, the forms cannot be changed," says the CMS source. "It is not acceptable to make the form smaller or reformat it. Providers can fill out each form by hand, but most will probably make a template with the most common tests and services listed."

Included on the forms is a notice that Medicare will probably not pay for the services or tests being recommended. The name of the service and the reason Medicare will not pay is entered on the general form. Similarly, the lab form is filled out with the name of the test, and one of three reasons for nonpayment is selected: the patient's condition precludes payment, the test is repeated too frequently, or the test is experimental. Additional details are added in the appropriate space.

"Patients must check one of two boxes signifying either that they want the service or test anyway or that they have decided not to receive the service or test—and then sign the form. If patients refuse to sign, but still want the test or service, providers are probably well advised to ask them to reconsider and return when they decide to sign the form," says Picou.

There may be cases when you believe the service is medically necessary and furnish it, despite a patient's refusal to sign. Physicians should then note on the form that the patient refused to sign, describe the circumstances, and have the note witnessed. (You can write in the margins of the form.) In these cases, a "-GA" modifier should be used on assigned claims, and the beneficiary will be responsible for payment if Medicare denies the claim. When the claims are unassigned and the patient refuses a signature but demands the service, physicians must decide whether or not to provide it, considering that they will not be able to collect from the beneficiary in case of a denial. If the service is provided, note on the ABN that the patient refused to sign and include the "-GZ" modifier on claims. The "-GZ" modifier is also used when you provide services and later recognize that you should have given the patient an ABN first.

Where providers go wrong

ABNs should only be given to patients when you have "genuine doubt" a service will be covered, the PM states. "The biggest problem will

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When to Use ABNs

Knowing the common reasons Medicare will refuse coverage can help providers decide when to use an advance beneficiary notice. These include:

- More than one provider rendered the same services in the same period.
- Too many services were supplied within a certain period of time.
- More than one visit a day occurred.
- Too many visits or treatments were provided.
- More than one type of specialist provided the same services.
- Certain types of equipment or laboratory tests were used.
- Too extensive a procedure was performed.
- Treatments that have not proven effective were provided.
- More than one nursing home visit a month was made.

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be providers who use 'blanket' ABNs for all patients, which they should not do," says Charles E. Colitre, president of Med Management Group Inc., headquartered in Akron, Ohio. "It's up to them to determine whether Medicare may not pay for a specific service for a particular patient. Sometimes it's a guess, but they have to try."

The key is to know when an ABN is required (see "When to Use ABNs"). "It boils down to what will be covered and what won't, but each patient's situation will be different," comments Colitre.

ABNs are not needed for services that are never covered by Medicare, such as cosmetic or experimental procedures, explains Picou. And they are not required when the carrier's local medical review policies state that your patient's signs, symptoms, or diagnosis qualify an intended service for reimbursement. However, if the patient's complaint is not among those that deem a service eligible for coverage, an ABN is essential.

How to use an ABN

Using the forms correctly is also critical. "Often, they are not completed properly," says Picou. It is not enough to say this EKG may be denied; you also have to tell why.

Not surprisingly, physicians worry about their financial liability. "It's important to explain to patients why a procedure or service is medically necessary, and that the denial is only due to Medicare reimbursement guidelines," urges Picou. Physicians can choose to challenge the denial by submitting the ABN along with an explanation of why the service or test is medically necessary. "In fact, this is generally how changes to the guidelines occur, when enough physicians challenge denials," she observes.

Practices should review the new documents and establish policies for evaluating the ABNs that are given to beneficiaries. "They should be audited periodically to ensure they are complete and that they are given to the patient to sign before the service is provided," says Picou. Check that the correct dates of service, types of service, and reasons for denial are included. "Practices should have a monitoring process to check for these elements, and the person who does the monitoring should not be the person who fills out the forms initially," she adds.

Become familiar with the modifiers. "If the correct modifier is not attached to a claim and payment is denied, the provider may have difficulty collecting from the patient," Picou notes. Another point to remember: correct and consistent use of modifiers can help you avoid the appearance of abusive or fraudulent billing. For example, the "-GA" modifier, which indicates a waiver of liability statement is on file, should be entered on all claims that correspond to a signed ABN. Appropriate use of the "-GZ" modifier on a claim lets Medicare know that you don't have a signed ABN but are aware one was necessary. You aren't likely to get paid, but you won't get into trouble, either.

The "-GY" modifier indicates an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. This is useful when seeking a quick denial so that a patient can then submit the claim to a secondary payer.

"When the ABN comes from the lab, practices should review these as well because they will be responsible if there is a problem," says Picou. Some labs will bill the physician if payment for the test is denied and an ABN was not obtained.

Above all, be prepared. "Pull out the top 20 services for your practice, and the reimbursement polices for these. Then see if the codes used most often for those services are payable," says Picou. "If not, don't substitute codes that are payable," she warns, adding, "That could cause your utilization pattern to get skewed and result in bigger problems."

Reported and written by Deborah Epstein, in West Milford, N.J. For a copy of Transmittal AB-02-114, go to: www.cms.hhs.gov/manuals/pm_trans/AB02114.pdf. More information on Medicare procedures is available on our Web site (at www.Coding-Compliance.com).

New ICD-9-CM Codes for 2003 Already in Use

More than 140 new ICD-9-CM codes went into effect on October 1, 2002, a number of them reflecting grim medical scenarios that most American physicians would have shrugged off as highly improbable less than 18 months ago. Recently implemented V codes and E codes detail a chilling variety of health crises stemming from terrorism.

For example, V01.81—one of four new codes related to bioterrorism—denotes contact with or exposure to anthrax, while V71.82 corresponds to observation and evaluation for suspected exposure to anthrax. Terrorism-related external causes of injury include E979.1, terrorism involving destruction of aircraft; E979.2, terrorism involving other explosions and fragments; E979.5, terrorism involving nuclear weapons; and E999.1, late effect of injury traceable to terrorism. Another new E code offers a less appalling sign of the times: E885.0 pertains to a fall from a nonmotorized scooter. Paintball guns are also newly recognized as sources of external injury.

For the most part, this year's coding changes strive for greater specificity in conveying what has occurred, explains Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, based in New Orleans, La. "For example, there are several new codes for cystic fibrosis (CF)," she says. "CF with pulmonary manifestations is designated with 277.02; CF with gastrointestinal manifestations, 277.03; and CF with other manifestations, 277.09."

Explicit codes also allow the government to more closely follow morbidity and mortality due to particular diseases, Picou points out, adding that better surveillance "helps determine how available healthcare dollars can best be spent." From that perspective, West Nile fever now has its own code: 066.4. Previously, it was categorized with more esoteric illnesses, such as Bwamba fever and o'nyong-nyong fever, as 066.3, a catchall classification for "other mosquito-borne fever." The causative virus was unknown in the United States before the summer of 1999, yet as of October 2, 2002 some 2,530 human cases had already been reported for the year. Another infectious disease, toxic shock syndrome, has also been given a specific code (040.82) this year.

Overall, the new codes cover an assortment of medical issues, including aftercare for healing traumatic fractures, aftercare following surgery for a neoplasm, diseases of newborns, ectopic pregnancies, heart failure, laboratory findings, neurologic and muscle diseases, systemic inflammatory response syndrome, and vascular disorders. A selection of new codes appears in the accompanying table. The entire list can be found at: cms.hhs.gov/medlearn/icd9code.asp.

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

Selected New ICD-9-CM Codes

Code	Description	Code	Description
357.82	Critical illness polyneuropathy	443.21	Dissection of carotid artery
414.12	Dissection of coronary artery	443.24	Dissection of vertebral artery
428.21	Acute systolic heart failure	445.01	Atheroembolism, upper extremity
428.22	Chronic systolic heart failure	445.02	Atheroembolism, lower extremity
428.31	Acute diastolic heart failure	459.11	Postphlebitic syndrome with ulcer
428.32	Chronic diastolic heart failure	459.12	Postphlebitic syndrome with inflammation
438.6	Alterations of sensations	795.31	Nonspecific positive findings for anthrax
438.7	Disturbances of vision	813.45	Torus fracture of radius
438.83	Facial weakness	823.42	Torus fracture, fibula with tibia
438.84	Ataxia	998.31	Disruption of internal operation wound
438.85	Vertigo	998.32	Disruption of external operation wound

Source: Centers for Medicare and Medicaid Services

The Pertinent Tests

- Alpha fetoprotein
- Blood counts
- Blood glucose testing
- Carcinoembryonic antigen
- Collagen crosslinks, any method
- Culture, bacterial, urine
- Digoxin therapeutic drug assay
- Fecal occult blood
- Gamma-glutamyltransferase
- Glycated hemoglobin/glycated protein
- Hepatitis panel/acute hepatitis panel
- Human chorionic gonadotropin
- Human Immunodeficiency Virus testing (Diagnosis)
- Human Immunodeficiency Virus testing (Prognosis, including monitoring)
- Lipids
- Partial thromboplastin time
- Prostate-specific antigen
- Prothrombin time
- Serum iron studies
- Thyroid testing
- Tumor antigen by immunoassay—CA 125
- Tumor antigen by immunoassay—CA 15-3 (or CA 27.29)
- Tumor antigen by immunoassay—CA 19-9

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(see table, this page). Aside from being commonly used, tests selected for NCDs were considered mainly because payment was directed by conflicting local coverage policies.

Descriptions of each test are accompanied by the covered CPT codes, indications for testing, and limitations on coverage. In addition, three categories of ICD-9-CM codes are set forth: diagnoses for which the test will be covered by Medicare (medical necessity is presumed), diagnoses guaranteeing denial, and diagnoses that don't appear on either list. While tests in the last group usually aren't covered, limited exceptions may be reimbursed if additional documentation fortifies an assertion of medical necessity. Then again, the effort may fail. For that reason, physicians or laboratories should get an advance beneficiary notice (ABN) when the diagnosis spurring the test falls into the third group (see "Learning Your ABNs: Revised Forms Can Cause Confusion," page 3). Every section also contains general coding guidelines, specific coding guidelines, documentation requirements, and reasons for denial.

The regulation creating the NCDs also laid out administrative policies that pertain to all clinical diagnostic laboratory tests paid under Medicare Part B, regardless of where they are performed. For example:

- Physicians ordering laboratory tests need not sign the requisition. But they must be able to make documentation available proving that the test was ordered. Those submitting claims for specimens drawn in the office or for tests carried out in the office must enter an ICD-9-CM diagnosis.
- Labs submitting a claim can assign an appropriate diagnosis code to a physician's narrative diagnosis even if the code description and the narrative do not precisely match.
- Tests characterized as a "screen" or "screening" by the relevant CPT codes may be covered if they are used to diagnose or treat signs or symptoms of an ailment. Analyses done when the patient has no signs, symptoms, complaints, personal history of disease, or an injury are not paid for unless a statutory provision clearly states otherwise.
- The date of service is the date the specimen is collected. If the collection process lasts more than 24 hours, use the date that the collection began. Or, if the test is performed on a stored specimen, the date of service is the date that the specimen was retrieved from storage.
- The person collecting the specimen must provide the date of service to the laboratory.
- The CMS or the local contractor must publish information about reasonable test frequency before payment can be denied on the basis of over-utilization.

All Medicare carriers, fiscal intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans must abide by the NCDs. As necessary, the significant CPT and ICD-9-CM codes will be updated.

A practice run

It's a good idea to download a copy of the NCDs and review the requirements for tests you order on a regular basis. While the information is too copious to be distilled into a single article, it is possible to offer a glimpse of what you'll find. For example, the NCDs specify four CPT codes to be used for urine culture: 87086, culture, bacterial; quantitative, colony count, urine; 87088, culture, bacterial; with isolation and presumptive identification of isolates, urine; 87184, susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents); 87186, susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration or breakpoint), each

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multi-antimicrobial, per plate.

Among other reasons, you might perform such tests for patients with an abnormal urinalysis, clinical signs and symptoms suggestive of a urinary tract infection (UTI), suspected urosepsis, or a scheduled surgery of the genitourinary tract. The NCDs catalog more than 60 ICD-9-CM codes supporting medical necessity (for a sampling, see table, this page). Several limitations are denoted. For example, CPT code 87086 can be used one time per encounter and is not to be used concurrently with CPT code 87088. Another restriction: While testing for asymptomatic bacteriuria during pregnancy is medically appropriate, it's also considered screening and is therefore not covered by Medicare.

Specific instructions help steer code selection. For example, CPT codes 87184 or 87186, which can also be used for isolates from sources other than urine, are to be used when susceptibility testing of significant microbes is performed along with identification. The number of units of service then corresponds with the number of isolates. Or consider that ICD-9-CM code 780.9—the covered diagnosis of other general symptoms (altered mental status, chills, generalized pains)—is only to be entered when elderly, immunocompromised, or neurologically impaired patients with no overt manifestations of UTI have increasing debility, declining functional status, acute mental changes, changes in awareness, or hypothermia that can't be connected to a co-existing condition.

Broad-spectrum advice

As noted, the NCDs also offer general guidance on coding and denials. Every claim for tests included in the NCDs requires an appropriate ICD-9-CM diagnosis or equivalent narrative diagnosis. When a diagnosis has yet to be determined, use codes that convey signs and symptoms. These bolster your rationale for ordering a test to rule out or confirm a diagnosis. Use all digits in a code, including those related to subclassifications. Three-digit codes are only acceptable when there are no additional subdivisions. For example, ICD-9-CM codes 220 (benign neoplasm of ovary) and 226 (benign neoplasm of thyroid gland) are three-digit diagnoses covered under the NCD for thyroid testing.

Code the patient's condition to the "highest degree of certainty" for the encounter. If you don't have a diagnosis, note the reasons the patient came to see you, such as signs, symptoms, aberrant test results, or possible exposure to an infectious disease. The NCDs point out that "diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule-out,' or 'working diagnosis' should not be coded as if they exist."

Document thoroughly to provide ample evidence of medical necessity. Heed particular documentation requirements when included in an NCD. For example, if blood glucose testing is ordered, the patient's record must indicate that a preceding history and physical revealed manifestations of abnormal blood glucose levels, prompting the evaluation. All patient records should also indicate that the test was ordered.

At this point, there are no plans to explore NCDs for the other 40% of tests covered by Medicare Part B. "This was a very long process, but an open one," says the CMS spokesperson. Providers got a better sense of what needed to be taken into account when developing these policies, and the CMS got a better sense of the reasons why a physician might require a particular test."

Robert J. Mills, Senior Public Information Officer for the AMA, is optimistic. "We hope that physicians will agree that the final product more appropriately reflects the way lab work is ordered," he says. "It should be an aspirin that alleviates one headache of dealing with Medicare."

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

Selected ICD-9-CM Codes Supporting Urine Culture

Code	Descriptor
038.0-038.9	Septicemia
276.4	Metabolic acidosis/alkalosis
306.53	Psychogenic dysuria
580.0-580.9	Acute glomerulonephritis
583.0-583.9	Nephritis and nephropathy, not specified as acute or chronic
592.0-592.9	Calculus of kidney and ureter
595.0-595.9	Cystitis
599.0	Urinary tract infection, site not specified
600.0-600.9	Hyperplasia of prostate
616.10-616.11	Vaginitis and vulvovaginitis
625.6	Stress incontinence, female
724.5	Backache, unspecified
780.6	Fever (hyperthermia)
788.0-788.9	Symptoms involving urinary system
V72.84	Pre-operative examination, unspecified

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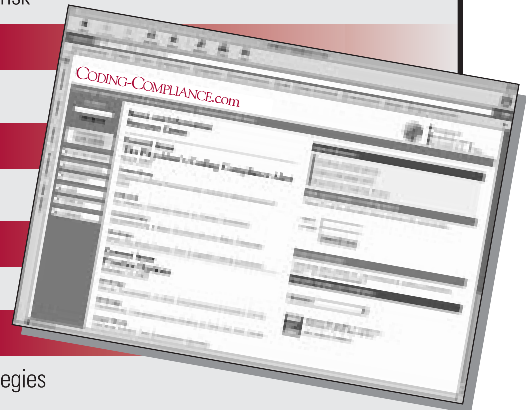

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December 2002

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