

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

Prevent Practice Revenue From Vanishing Into Your Paperwork

It was like finding buried treasure. When a 38-member medical practice in Virginia hired Physician Management Group, Inc. (PMG) to assess the components of its billing and collection systems, the doctors learned that they were due additional earnings of at least \$800,000 per year. Some \$100,000 of that sum was traced to underpayments from a single insurer, yet nobody was aware of the shortfall, according to John W. McDaniel, president and CEO of PMG, which is based in New Orleans, La.

Significant amounts of money can be obscured in unpaid claims and other accounts receivable. The problem usually remains hidden until cash flow drops off. "That's when we get calls from physicians who do not understand why they are working

harder but earning less," McDaniel emphasizes. To avoid a similar situation, you need to shore up your revenue cycle. A solid billing compliance program is essential to that endeavor.

"Some people think that fulfilling compliance requirements is like being kept after school, but achieving good compliance is good business," McDaniel remarks. "When we develop a compliance program for a practice, we look for areas with the potential for financial improvement."

A coding compliance plan is the largest part of an overall billing compliance program. Other key elements that are sometimes overlooked are the advance beneficiary notice (ABN) and patient refunds. If you are going to provide a service that you do not believe is covered by Medicare, you are required to use the ABN to inform patients that they are likely to be responsible for payment, and you must ask for a signature. Otherwise, the beneficiary does not have to compensate you if the claim for that service is denied. In fact, McDaniel recommends that non-Medicare patients also be required to sign waivers stating that they will pay if the insurer denies reimbursement.

"Another big compliance issue pertains to patients with credit balances," he points out. "If patients are owed money, you are supposed to refund it within 60 days of discovery. What most

people do is deduct the surplus from the next service. That probably is the simplest thing to do, but it is not what the government wants you to do."

Put it in writing

How many of the routine billing decisions made in your practice are based on a written policy? McDaniel believes that, even in very small practices, all such decisions should stem from a carefully constructed plan. For example, you should have guidelines that describe how co-payments, deductibles, noncovered services, and bad debt are to be addressed. You should also consider—and record—the circumstances under which you will write off charges. For instance, you might decide that balances under \$20 will be set aside because the cost of billing surpasses the amount you are owed.

A common quandary is how to handle the accounts of patients who are unable to pay their balances. Provide these patients with a simple form that substantiates financial hardship; they can list monthly income and monthly expenses. You can then discuss whether some type of payment plan can reasonably be instituted. Or if necessary, you can choose to absorb the balance. Regardless of how you proceed, you must document the agreement you make with the patient and the reasons for it before you can

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The Ethical Imperative

The shaky financial dealings of people associated with a number of companies—including Adelphia Communications, Enron, HealthSouth, ImClone, Tenet Healthcare, Tyco, and WorldCom—have given students of business ethics plenty of new material to contemplate. Even those without any academic interest in such cases have been drawn to detail after detail as they are shared in the press. Highly publicized corporate scandals tend to rattle the public's confidence in our nation's business leadership, whether that leadership is responsible for a huge conglomerate or a smaller business in the community.

It is clear to me that physicians love treating patients—and they work hard to do what's right when it comes to the business aspects of their practice. But it requires an epic effort to stay on top of both clinical advances and the seemingly endless fine points tied to compliance programs. For instance, April 14, 2004, is the final deadline for health care providers, health plans, and health care clearinghouses to comply with the rules for disclosures to business associates. These require you to enter into a written contract with any person who performs a service for you that involves access to protected health care information. One such situation would be a consultant who audits your charts in order to check the accuracy of your practice's coding compliance. The contract, stipulated by the Standards of Privacy of Individually Identifiable Health Information associated with the Health Insurance Portability and Accountability Act of 1996, guarantees that business associates will handle privileged information with care.

Our cover article spotlights other important areas of billing compliance. For example, did you know that if you waive a patient's insurance co-pay because of his or her inability to pay, your benevolence could be mistaken as an inducement to use your services? Another article discusses the fiscal year 2004 Work Plan drawn up by the Office of the Inspector General of the US Department of Health and Human Services. The agency is taking a closer look at a number of important issues, several of which involve your coding habits. Finally, we look at the importance of updating the office superbill, a chore that too often is overlooked. If there are aspects of compliance that you would like to see covered in future issues, please do not hesitate to contact us by e-mail.



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OIG's Work Plan Provides a Draft for Your Compliance Program

Every October, at the start of the US government's fiscal year (FY), the Office of the Inspector General (OIG) of the US Department of Health and Human Services (HHS) discloses its Annual Work Plan. The document describes areas scheduled for investigation in subsequent months, and inevitably, some portion of the agency's resources is directed at claims for physicians' services. If you use the Work Plan as a guide to the OIG's billing-related concerns, you can better focus your practice's compliance efforts.

Organized into four chapters, the Work Plan lays out all inquiries scheduled for each of the key units of HHS: the Centers for Medicare and Medicaid Services (CMS), public health agencies, and the Administrations for Children, Families, and Aging. It also discusses endeavors that are not confined to a particular division. The section most relevant to physicians' practices—Medicare Physicians and Other Health Professionals—is within the CMS chapter. A glance at the 12 anticipated studies indicates that physicians' employment of codes continue to be of great interest to the OIG (a copy of the FY 2004 Work Plan is available at: oig.hhs.gov/publications/workplan.html#1).

While eight of the scheduled investigations are new to the roster, four began in previous years. According to Donald B. White, a spokesperson for the OIG, "Studies are sometimes held over until the next year because other priorities come up. That does not reflect any kind of focus; it's just a matter of scheduling. There are lots of variables as to when these studies actually get done."

All of the analyses undertaken by the OIG are intended to reduce waste, fraud, and abuse in HHS programs. The agency has met with considerable

success and notes that in FY 2003, taxpayers saved "a record \$23 billion" as a result of OIG examinations. In addition, a total of 3,275 people and companies were excluded from Medicare and Medicaid reimbursement. The OIG also obtained 576 criminal convictions and 243 civil actions.

Use of modifier "-25"

In one new study, the OIG plans to find out whether modifier "-25" is being applied correctly. Use of this modifier is reserved for occasions when a physician provides a significant, unrelated evaluation and management (E&M) service to a patient who has undergone a procedure or received another service on the same day. Inspectors will try to determine whether the roughly \$1.7 billion in claims for E&M services billed with modifier "-25" in 2001 were accurately billed and paid. All told, Medicare spent more than \$23 billion on E&M services in 2001.

Modifiers with NCCI edits

The CMS's National Correct Coding Initiative (NCCI) is designed to prevent payment for Medicare claims that have been incorrectly coded. Every quarter, the CMS provides Medicare Part B carriers with NCCI edit files containing HCPCS code

pairs that should not ordinarily be billed together for the same person on the same day. A classic example: The edits should kick out claims when a physician bills for components of a procedure rather than using a single comprehensive procedure code. They also block payment for services considered to be mutually exclusive.

Depending on the situation, however, one of 35 modifiers can be utilized to sidestep the edits when payment for each of the services in a code pair is warranted. The OIG will investigate whether these modifiers are being used properly. There is much incentive; in 2001, Medicare shelled out \$565 million to providers who used pertinent modifiers when submitting code pairs that would be picked up with NCCI edits.

Still, the program appears to be working. A September 2003 report (OEI-03-02-00770) on an investigation detailed in the OIG's FY 2003 Work Plan found that the edits thwarted reimbursement for 98% of claims that met criteria for denial when a provider billed for more than one service for the same beneficiary on the same date of service. In addition, a closer look at the data suggested that the majority of payments seemingly made in error might actually have been justified.

(Continued on page 4)

Capitated care

Physicians treating Medicare beneficiaries who require maintenance dialysis for end-stage renal disease receive a monthly capitation payment for all related services provided during the month, whether dialysis is performed at home or at an outpatient facility. The OIG will be looking at the value assigned to the physician work component of the fee to determine whether or not it is a true measure of the number of physician services regularly provided to these patients.

Place-of-service errors

The OIG will be looking for claims from ambulatory surgical centers (ASCs) and hospital outpatient departments that wrongly designate the site of care. For example, when physicians who are hospital employees see patients in an off-campus outpatient setting, those visits should be coded as having taken place in an outpatient hospital department rather than in a physician's office. Note that Medicare pays more for physician office services than it does for care provided at the other two locations.

Care plan oversight

Medicare payments to physicians who coordinate the treatment of beneficiaries in home health care or hospice programs nearly tripled in just one year, soaring from \$15 million in 2000 to \$41 million in 2001. Investigators will scrutinize claims for care plan oversight—the ongoing supervision of complex or multidisciplinary courses of therapy—and assess their merit with regard to Medicare regulations.

Billing for diagnostic tests

At issue is the medical necessity of nerve conduction studies, a service for which Medicare paid out \$186 million in 2001 compared with \$136 million in 2000. Sharp increases in

the use of these electrodiagnostic studies of the peripheral nerves tend to inspire doubts among payers. The OIG will comb through claims to establish the cost of testing that was medically unnecessary and improperly paid.

Radiation therapy services

A review of payments made by one Medicare carrier to physicians who provide radiation therapy management services uncovered “a high percentage of overpayments,” according to the OIG. Now the agency will analyze nationwide reimbursements to this group. A reminder: Every five sessions of treatment equals one billable unit of service.

Ineligible physicians

A study to be completed this year will explore whether Medicare Part B has paid for services ordered by physicians who are excluded from federal health care programs and if so, the amount disbursed to caregivers who are prohibited from treating Medicare beneficiaries. The OIG suspects this could recur significantly.

Ongoing analyses

An issue that has been on the docket since the FY 2002 Work Plan is the accuracy of claims for physician consultations and the fiscal repercussions of improper payments. Consultations are frequently confused with referrals, and the result can be an incorrectly coded claim. In short, consultations, which are billed at a higher rate than referrals, occur when one physician sends a patient to another physician for assessment. The consulting physician provides written findings but sends the person back to the original physician for treatment. A referral takes place when one physician sends a patient to another physician, who then treats the patient for a particular ailment.

Perhaps the most important topic on the Work Plan is coding of E&M services. The OIG wants to know how well the mechanisms put in place to track down physicians billing excessive volumes of high-level E&M codes are working—and how effective carriers are at spotting these practitioners.

The OIG will also continue to review the reliability of long-distance claims, such as those for face-to-face encounters from physicians whose practice location is a significant distance from the patient's address. Finally, the agency also has plans to conclude its examination of conditions under which physicians bill “incident-to” services provided by allied health care professionals under their direct supervision.

No doubt some of these subjects will prove more applicable to your practice than others. It is a good idea to read through other parts of the CMS segment of the Work Plan as well as you may find other sections of interest to you and your practice. For example, additional OIG investigations will explore the medical necessity of allergen immunotherapy given to Medicare beneficiaries, the costs and charges reported by ASCs, recent trends in rural health clinic locations and billings, and the appropriateness of prescriptions written for oxycodone.

Many compliance officers undertake an annual review of the practice's compliance program when the Work Plan is released. This affords an immediate opportunity to identify current risk areas and to conduct a benchmark audit to determine their level of compliance in those areas. It is a tactic well worth adopting.

Reported and written by Charles E. Colitre, President, Med Management Group, Inc., headquartered in Akron, Ohio. More information on the subjects discussed in this article is available on our Web site (see page 8).

Schedule Periodic Examinations for Your Office Superbill

Are you setting yourself up for rejection? If you do not regularly update the diagnosis and procedure codes on your superbill, a significant number of insurance claims may go unpaid, according to Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Physician Management Group, Inc., based in New Orleans, La. "Make sure you add relevant new codes to your billing system and remove deleted codes from your printed superbill," she advises. However, obsolete codes should remain accessible for 12 months or more in case you need to re-bill services from the previous year. If you have an electronic billing system that will accommodate it, an ideal solution would be to attach a warning to an outdated code to prevent its use in a current claim.

"Review all changes in CPT-4, HCPCS, and ICD-9-CM codes,"

Picou says. "Sometimes there are new ICD-9-CM codes, or a new digit has been added to an existing code. One of the biggest reasons that claims are kicked back is because the ICD-9-CM code is not as specific as it needs to be." A case in point: As of October 1, 2003, the correct ICD-9-CM code for prophylactic vaccination and inoculation against influenza is V04.81 rather than V04.8. People also tend to forget about HCPCS codes. "I have reviewed superbills that do not include them, but if you are trying to bill Medicare screening services using CPT-4 codes instead of HCPCS codes, your claims will be denied," she warns.

An important change to note is the imminent disappearance of the 90-day grace period that traditionally has been granted to providers. New ICD-9-CM codes become effective on October 1 of each year, but old codes have been

accepted through December 31. Similarly, when changes in CPT-4 and HCPCS codes are annually implemented on January 1, physicians have had until March 31 to stop using discontinued codes. However, when the new ICD-9-CM codes go into effect on October 1, 2004, you must begin using them immediately; the same is true when the new procedure codes become active on January 1, 2005. New codes introduced during the year will also have to be used without delay. The 90-day buffer has been terminated because the Health Insurance Portability and Accountability Act of 1996 requires that services be billed with the codes that are valid on the day of service.

While you are reviewing your superbill, remember that another significant mistake is to omit lower levels of service from the charge form. "For example, under consultation codes, the physician will be offered the two highest code levels instead of all five, and you can get into serious trouble that way," Picou says. In situations like these, it appears that physicians are being directed to charge based on reimbursement rather than on the level of care provided.

Some revised diagnosis code titles appear in the accompanying table. More information on changes in ICD-9-CM and HCPCS codes is available at: www.cms.hhs.gov/medlearn/icd9code.asp.

Reported and written by Cynthia Starr, editor. To learn more about coding, visit our Web site (see page 8).

Selected Revised Diagnosis Code Titles

Code	Description
491.20	Obstructive chronic bronchitis, without exacerbation
491.21	Obstructive chronic bronchitis, with (acute) exacerbation
493.00	Extrinsic asthma, unspecified
493.02	Extrinsic asthma, with (acute) exacerbation
493.10	Intrinsic asthma, unspecified
493.12	Intrinsic asthma, with (acute) exacerbation
493.20	Chronic obstructive asthma, unspecified
493.22	Chronic obstructive asthma, with (acute) exacerbation
493.90	Asthma, unspecified, unspecified
493.92	Asthma, unspecified, with (acute) exacerbation

Source: Centers for Medicare and Medicaid Services

legitimately surrender fees from insured patients.

Suppose you choose to waive a long-time patient's insurance co-pay because he is suddenly out of work. Or you decide not to bill a Medicare beneficiary who has signed an ABN for an excluded test. Without written evidence of your rationale, these transactions might be viewed as an inducement to attract patients—and make you the subject of an investigation. “You are supposed to be diligent in trying to collect your money from all patients, including Medicare patients,” McDaniel advises. “It is accepted that most Medicare patients are on fixed incomes.” A reasonable, written payment policy and documentation pertaining to individual cases supports your actions. Your office manager can also refer to printed office procedures when trying to determine whether bills should be sent to a collection agency. By the way, you should also place patient payment notices prominently in your waiting room, letting patients know that you expect to be paid at the time of the visit unless other arrangements have been made with the office staff.

Of course, a coding policies and procedures manual should also be on hand. Consider developing a patient screening reference manual that outlines major aspects of each insurance company or managed care contract. This provides a good reference for employees who process insurance information and determine co-pays as well as for physicians, who might need to quickly track down details such as how laboratory work is to be processed.

Think about using a corner of your office as a library so that such important resources as practice policies, payer manuals, and information system instruction books are readily available to all employees. You should also include a master file listing, by

physician, of all managed care contracts and provider numbers. Conduct regular training sessions so that employees become well-versed in relevant billing procedures. Office employees would concentrate on front-desk transactions, including ABNs, while physicians would focus on coding, documentation, and other pertinent issues.

Check your work

A brewing financial dilemma cannot evolve into disaster if you set benchmarks related to billings and collections and conduct regular audits to see whether you are reaching those yardsticks. An easy standard to monitor involves over-the-counter (OTC) collections. “Let’s say that your patients’ average co-pay is \$20 and you see roughly 40 patients a day,” McDaniel explains. “At minimum you ought to collect about \$800 daily—that’s your benchmark. It does not include deductibles, noncovered services, or outstanding balances. If you are not getting even that absolute minimum figure, then something is wrong.” For the average primary care practice, as much as 20% can come from these transactions,” he adds. Specialty practices probably get 10% to 15% of their income from OTC collections.

It is also crucial to set performance benchmarks aimed at reducing the number of denied claims. “Have the office manager review the reasons for denials on a monthly basis,” McDaniel says. “Then errors can be corrected and prevented from recurring. Rejections are an issue from both a cash flow and a compliance standpoint.”

Chart audits should be performed every three months. Examine a sampling of charts to ensure that you have used the appropriate codes to capture your charges and that you have documentation to support all diagnoses

and the medical necessity of subsequent courses of therapy. You should also go over your most commonly used CPT-4 and ICD-9-CM codes and determine the frequency with which you use them. If you are repeatedly using the highest code levels to bill insurers, you could well be audited.

Track business goals as well as compliance efforts. For instance, McDaniel recommends that you conduct a monthly review of accounts receivable and set objectives for improved follow-up. In addition, monitor the performance of the collection agency that pursues your aged accounts receivable. “The collection percentage should be between 6% and 10%,” he counsels. “If they’re getting back more, then you’re not working those accounts sufficiently.”

Keep track of how long it takes office staff to re-bill rejected claims and bill secondary payers—make certain that outstanding charges go out every 30 days. Shan McDaniel (no relation to John McDaniel), CFO of MedData Service Bureau LLC, a division of Medtron Software Intelligence Corp., headquartered in Covington, La., suggests a period of 45 days because “many carriers are pushing for monetary penalties for duplicate claims.”

Review the status of any outstanding accounts older than 60 days and determine whether you need to contact a primary insurer, bill a secondary insurer, or change an account to self-pay. “A recent mandate by carriers is that providers must file an appeal within 60 days of receiving the explanation of benefits,” says Shan McDaniel. “Filing timely appeals is something that a lot of practices get tagged on because by the time that supporting documentation such as notes, pre-certifications, and letters of medical necessity are gathered to supplement an appeal, the time allowed may have expired. Many staff mem-

bers don't realize that challenging a payer's disposition is the practice's right when undisclosed bundling or medical necessity issues are used as a reason for denial." Before you shrug such claims off, learn how much money you are conceding.

Charge validation studies are valuable, too. "Take your 10 most common CPT-4 codes, and sample your 10 top payers to see how much they have been reimbursing you," John McDaniel explains. "We do these all the time, and the number of errors is phenomenal. Typically, the person who receives the check sees that the insurer paid \$48 of a \$100 charge and that employee investigates no further." Shan McDaniel adds, "Load the carrier's contracted fee schedule into the practice management software system and appeal any incorrectly paid amount because, as often as not, the carriers may pay incorrect amounts and their mistakes cost you!"

Avoiding rejection

More than 90% of rejected claims are the result of misinformation, according to John McDaniel. "It's not because of coding errors, but because the patient's address was wrong, the insurance card expired, or no pre-authorization was requested," he remarks. "Tell your receptionists to ask patients for a copy of their driver's license and their current insurance card. Most people don't mind being asked for those items."

Sometimes, significant changes occur with relatively little notification. One carrier has changed its major claims processing address five times in four years, Shan McDaniel remarks. Failing to notice modifications like these can wreak havoc on a practice. "If you don't make the change, your claims may be going into a deep hole, and the burden is on you to provide proof of timely filing

and adequate follow-up for resolution," she remarks.

Many errors occur each year when new coding changes go into effect. Practices must alter the office superbill to reflect additions, deletions, and modifications (see *Schedule Periodic Examinations for Your Office Superbill*, page 5). "We check these all the time, and I'll bet that only one out of every 20 we review is perfect," says John McDaniel. "If you submit old stuff, you're not going to be paid."

Staff members processing claims in your office should make note of any idiosyncrasies they find when dealing with a particular insurer. For example, some insurers handle modifiers better than others, Shan McDaniel stresses. If a patient has two facial moles and a physician removes one and biopsies the other, it would be appropriate to use modifier "-59," denoting a distinct procedural service. But without that modifier or a written explanation, a carrier might interpret the two charges as being bundled. "The Health Insurance Portability and Accountability Act of 1996 is not just about privacy," she says. "A goal of the Centers for Medicare and Medicaid Services was to make sure all carriers receive and digest information in the same manner. Yet it's being interpreted very differently by carriers and within different environments. The physician practice is still plagued with having to know each carrier's interpretation and requirements."

PMG urges clients to create a summary of charges, collections, adjustments, and aged trial balances for your practice's most common insurers, a strategy that allows you to identify reliable payers. "Your adjusted charge collection percentage should always be in the 90th percentile," John McDaniel says. "If it's under 80%, that's low. Either they're paying at rates that are different from those contracted, or

they are delaying payments. If an insurer appears to be hanging on to a number of claims beyond two months, call the representative and find out where these claims stand."

All of this is easier if you maintain a cordial relationship with insurers' representatives. PMG suggests that physicians schedule quarterly meetings with major third-party payers to discuss any payment or administrative issues that arise. "We encourage our clients to be nice to them because nobody is nice to these folks," John McDaniel notes. "Develop some relationships with them, because these actions do go a long way. This whole business is about relationships."

He also recommends that physicians look for ways to accomplish business tasks with less effort. Search out opportunities to transmit and receive information such as pre-authorizations via computer rather than telephone. Buy software that improves efficiency. For example, you might be able to purchase a billing edit enhancement module that flags incomplete or incorrect claims before they go to the insurer. Bill your patients on a cyclic basis. "Instead of sending all your statements out on the first day of the month, you might split them up by alphabet," John McDaniel says. "That evens out your cash flow over time, but it also simplifies things for the staff. The phone rings constantly for the three days after the bills go out." This method diffuses the call volume.

"This body of business and compliance knowledge is huge," he concludes. "It's hard for us to keep up. What if we were also seeing 100 patients a day and had a staff of 20 to manage? I don't see how physicians do it. It's a tough business."

Reported and written by Cynthia Starr, editor. For more information on billing and coding compliance, go to our Web site (see page 8).

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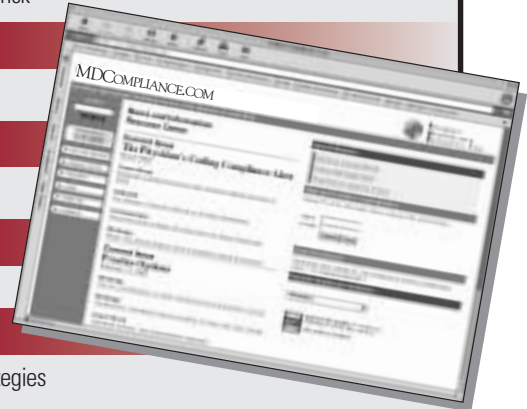
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