



Rehab Report

The Practical Advisor on Reimbursement, Regulations & Business Strategies for Rehab Facilities

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In this issue

Patient Privacy

Don't Get Spooked By A Lawyer's Records Request **p3**

- ▶ Avoid violating HIPAA when lawyers pressure you for patients' confidential information.

IRFs

Claim Credit For Part A Patients' Short Stays — Here's How **p4**

- ▶ Expect eight tough hoops to jump through.

Clinical Rehab Roundup

Take This Approach To Treating Breast Cancer Patients' Lymphedema **p5**

- ▶ Active resistance exercise should be in your therapy bag of tricks, research reveals.

Reader Questions

Say Yes To At-Home Outpatient Treatment — Sometimes **p6**

Return Overpayments Immediately — Or Else **p6**

News

Bank On 2010's Pay Rate In 2011 **p7**

- ▶ New legislation pushes pay cut back to 2012.

Offer Therapy Mix For Veterans With Traumatic Brain Injuries **p7**

- ▶ Coordinated therapy could be the answer to re-wiring the brain after trauma.

Trends

4 Steps Get Your Practice Report-Card Ready To Prove Your Quality Care

Quality reporting is optional now, but don't expect that to last.

Think potential clients aren't paying attention to your therapy outcomes? Think again — and soon your results will be available to everyone.

“There's a lot of chatter at the Centers for Medicare & Medicaid Services making providers of all kinds more accountable” by providing proof of their quality on report cards like those already used by physicians, says **Michael Weinper, PT, MPH**, president of PTPN, a network of rehab professionals in private practice.

“The clear message from CMS and health reform legislation is that healthcare should move from paying for volume to paying for quality,” says **Ben Johnston, Jr., PT**, CEO of Knoxville, TN-based **Focus On Therapy Outcomes (FOTO)**, a company that provides evaluation tools and data management services to rehab providers.

Where Medicare goes, the rest of health care generally follows, Weinper points out. That means you can almost guarantee that if Medicare requires quality reporting, other payers will require it as well.

Now is the time to put the processes and procedures in place that will prepare you for extra quality scrutiny soon to come. Use these tried-and-true techniques to get started:

Step 1: Identify Your Outcomes

Challenge: The elusive component you must pin down if you hope to be report-card ready is your outcomes — the positive improvements your clients experience over the course of treatment.

Now more than ever patients are choosing their care providers — including rehab — based on the value they can expect from the relationship, Weinper says. They will look to outcomes like measured improvement, patient satisfaction, and efficiency (the number of visits/cost necessary to get the measured improvement) when determining who to give their business.

Action plan: You must flag and collect these outcomes, Weinper urges. PTPN currently tracks how well its therapists adhere to quality assurance, how many facilities meet credentialing standards, patient satisfaction, outcomes percentile and participation, and efficiency and outcome benchmarks, he shares with **Eli**.

Rehab providers can also prepare for report cards by affiliating themselves with a “valid and proven quality measurement and reporting process that is moving toward public reporting,” Johnston says.

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Step 2: Prove Your Therapy Works

Now that you've determined your outcomes, you must track and measure them just as you do for your processes and structures. This will provide proof that your training or certification and number of therapy sessions resulted in improved quality of life for your patients.

Action plan: You can start small when measuring outcomes, Weinper notes. A pre-treatment and post-treatment questionnaire allows patients to self-rate how successful their therapy was. You could also perform pre-treatment and post-treatment interviews or ask patients to evaluate their progress over the course of treatment.

The key is measuring results at different time points, Weinper says. "We recommend that practices measure results at the beginning of care, during care, and after treatment ends," he outlines.

Crucial: You must clearly define who is responsible for ensuring each outcome element is collected, Johnston notes. The information must be gathered consistently and maintained for future comparisons. Failing to gather even one component can throw off your results.

Step 3: Help Therapists Home In On Advantages

While patients will be in hot pursuit of therapy report cards, therapists may not be as excited at the prospect of being "judged" according to outcomes. "Therapists may fear that the service they provide isn't as good as they think it is or may fear punishment if their outcomes aren't as good as others' are," Weinper explains.

Action plan: Get therapists' buy-in by showing them how knowing their outcomes can improve future results. "The reality is that therapists may be good at something and not at others — but it's better to know so they can work on the weak areas," Weinper says. For instance, if your outcomes for shoulders are lower than your results for backs, you know it's time to beef up on shoulders.

The practice can offer inservices or seek out development opportunities that help therapists strengthen their weak areas. Or, a therapist who excels in a specific area can offer training for those whose results for that area aren't as strong.

And, as you ramp up your measurement efforts, skip discipline altogether, Weinper recommends. "Your focus should be on helping therapists improve," not penalizing them for needing to, he says. Your goal in the early stages is to figure out where you are and where you need to be.

Step 4: Act On All Measurement Results

Your therapists aren't the only ones that may end up with a low score initially. Your facilities or compliance may also falter.

Action plan: Start by looking at the areas where your facilities or therapists don't meet your expectations, Johnston suggests. Work on bringing those areas up to speed first, and then tackle the more-subtle issues.

"Report cards will distinguish providers who say they provide quality care from those who can prove it through external benchmark comparisons," Johnston asserts. Once you've accumulated some positive data, share it with existing clients, include it in your marketing efforts, and make it available to referral partners, he advises.

Final say: Though required reporting is still a few years away, the time will fly by. Getting started now will put you ahead

of the curve and show both patients and insurers that your therapists provide only top-notch results. □

Patient Privacy

Don't Get Spooked By A Lawyer's Records Request

Avoid violating HIPAA when lawyers pressure you for patients' confidential information.

Imagine it: An attorney calls your practice and demands that you turn over one of your client's medical records for use in a court case. He follows up the call with a faxed order for the information. You send it the info immediately, right?

Wrong. First, you must ensure that the attorney has authorization from the patient to release the personal health information (PHI), or has other legal documentation proving that you can send the information.

"Covered entities and business associates should exercise great caution when responding to such requests," advises **Abner Weintraub**, president of **The HIPAA Group Inc.**, a HIPAA training and consulting firm in Orlando, Fla. "The best advice here is to take your time, investigate, and be sure of what you are doing," he says.

"Law firms are often intentionally intimidating in their phone or written requests for documents and data," Weintraub says. "And while it may feel awkward not to respond immediately with the requested information, disclosing PHI to a law firm or attorney unlawfully can itself be a costly HIPAA violation. With the recently increased HIPAA penalties instituted by the HITECH Act, the consequences for unlawful disclosures can be devastating," he warns providers.

The following steps can help you determine when you should — and shouldn't — comply with an attorney's request for medical records:

Step 1: Check for Patient Release

Once an outside party asks you for access to a patient's records, you should check the patient's HIPAA release form to determine whether she has authorized you to share the records with the requesting party. In many cases, a patient will authorize you to share her medical records only with her spouse, children, or caregiver, and not any outside parties. In the absence of such a form, ask the requesting attorney if he has a signed HIPAA release form on hand.

"If the law firm represents itself as being the patient's law firm, it should provide [you] with a HIPAA-compliant authorization for the release of medical records executed by the patient," advises South Florida-based health care attorney **Deborah Green**. "Just to make extra sure, I would recommend

contacting the patient to find out whether it is actually the patient's signature. If so, keep the authorization in the patient's file and send the records," Green says.

Step 2: Determine Whether A Court Order Exists

If you don't have a release form from a patient, you should then find out whether the records request falls under a court order. "HIPAA imposes restrictions on the circumstances in which records can be released in a legal proceeding," says **Heather Cook Skelton**, a health care attorney in Charlotte, N.C.

A release is permitted if (1) it is pursuant to a court order and the provider only discloses what is specifically included in the order or (2) in response to a subpoena or discovery request that is not accompanied by an order if the provider receives 'satisfactory assurances' from the party seeking the information that reasonable efforts have been made to inform the patient of the request, Skelton says.

What that means: "'Satisfactory assurances' is defined as written confirmation that the requesting party has made a good faith attempt to notify the patient in writing, which should contain an explanation of the proceeding and a description of the protected health information that has been requested in enough time for the patient or his or her legal representative to object," Skelton says.

In absence of such satisfactory assurances, if a subpoena is coupled with a qualified protective order (QPO) that has been agreed to and presented to the court, or has been requested from the court by the attorneys seeking the records, then the attorney has the right to request the patient's records, Weintraub says.

Step 3: Only Disclose The 'Minimum Necessary' PHI

Even if an attorney has the legal authorization to request a patient's PHI, he may not have legal access to the entire patient record, Weintraub says.

When creating the HIPAA laws, the **Department of Health and Human Services** wrote, "A covered entity making a disclosure ... may of course disclose only that protected health information that is within the scope of the permitted disclosure." If a court order does not specify which parts of a patient's records you

(Continued on page 4)

should send to the attorney, you must “make reasonable efforts to limit the information disclosed to that which is reasonably necessary to fulfill the request,” the law states.

One last tip: If you have grounds to refuse to provide the attorney with medical records, you should also refuse any verbal requests that they might make. One provider says after she refused to send a patient’s medical records to an attorney, the lawyer asked her, “Well then can you just tell me if there is anything in the record about alcohol abuse?”

“Releasing PHI verbally is also a violation of HIPAA,” says attorney **Michael Schaff** with **Wilentz, Goldman and Spitzer** in Woodbridge, N.J. “Any disclosure of PHI which is unauthorized is a violation of HIPAA, even if a lawyer says it’s part of a lawsuit,” Schaff asserts.

Final say: “You’d need written authorization before you could release the information verbally, in writing, electronically, or otherwise,” Schaff confirms. □

IRFs

Claim Credit For Part A Patients’ Short Stays — Here’s How

Expect eight tough hoops to jump through.

Just because patients don’t receive five days of therapy doesn’t mean you can’t capture a rehab RUG for the care you provide.

Good news: You can use the Medicare short-stay assessment to meet the rehab RUG for Part A patients, according to CMS’ **Ellen Berry**. However, this optional assessment doesn’t come without its own set of rules — and it isn’t always your best fiscal move.

Start With The Basics

Medicare’s short-stay policy allows facilities to obtain a therapy RUG for patients discharged from Part A on or before the eighth day of the stay, Berry said in a recent webinar on RUG-IV.

Specifics: Patients who’ve exhausted their Part A benefits and those who’ve been discharged to the hospital (planned or planned), the community, or long-term care all qualify for the short-stay option, Berry noted.

Caveat: A patient falling into one of those categories doesn’t guarantee you can use the short-stay option. The patient must meet eight requirements, including the patient meeting the Rehabilitation or Rehabilitation plus Extensive Services groups.

In such cases, if the resident meets the criteria, you can combine a start of therapy Other Medicare Required Assessment (OMRA) with the five-day or readmission PPS assessment. Or you can complete the start of therapy OMRA as a standalone assessment after doing the five-day or readmission assessment.

Physical therapy, occupational therapy or speech language pathology services must have started within the last four days of the stay, Berry noted. The resident must continue to receive at least one discipline of rehab therapy through the last day of the Part A stay.

Critical: If the therapy start date is the first day of the resident’s stay, the stay can’t exceed four days. When the start of therapy

date (which is the date of the therapy evaluation) is the first day of the resident’s short stay, the short-stay assessment-generated rehab RUG will apply to the entire stay.

Payment rules: For the short-stay assessment, RUG-IV pays on a prorated basis for therapy based on the average daily therapy minutes the resident received, Berry noted, as follows (the x stands for classification based on the ADL score):

RLx — 15-29 minutes

RMx — 30-64 minutes

RHx — 65-99 minutes

RVx — 100-143 minutes

RUx — 144 or > minutes

Consider Short-Stay The Exception, Not The Rule

Though sometimes useful, the short-stay assessment option isn’t likely to end up on the most-popular assessment list. “The challenge with the short-stay is that there are eight very specific, non-negotiable requirements to qualify, which are going to be fairly difficult to achieve,” says **Glenda Mack, MSPT**, senior director of clinical operations for PeopleFirst Rehabilitation in Louisville, Ky.

Doing the short-stay assessment “is going to be the exception rather than the rule for the vast majority of residents,” predicts **Pauline Franko, PT, MCSP**. That’s because the assessment will likely be for medically unstable patients who are discharged too early from the hospital. The patients will be admitted to an inpatient facility, but then will wind up readmitted to the hospital shortly after, she says.

Third option: You can avoid needing the short-stay assessment for therapy by allowing the resident to stabilize medically. Those who stabilize will go on to need standard treatment and those who don’t will return to the hospital — eliminating the need to find a way to capture the short stay, Franko suggests.

And if your patient is only admitted for five or six days, facilities should begin therapy on day one to get in five days of therapy during the stay. Most facilities are set up for weekend

therapy, so the onus is on them to start immediately in order to meet the requirement, Franko advises. □

Clinical Rehab Roundup

Take This Approach To Treating Breast Cancer Patients' Lymphedema

Active resistance exercise should be in your therapy bag of tricks, research reveals.

Effect of Active Resistive Exercise on Breast Cancer-Related Lymphedema: A Randomized Controlled Trial. Kim do S, Sim YJ, Jeong HJ, Kim GC. Arch Phys Med Rehabil. 2010 Dec;91(12):1844-8.

Patients suffering from lymphedema related to breast cancer should take an active role in combating the condition — especially when it comes to exercise.

After investigating the differences between the effects of complex decongestive physiotherapy with active resistance exercise and without it, researchers have found that patients with breast cancer-related lymphedema (BCRL) could benefit from a sticking to the active type, according to “Effect of Active Resistive Exercise on Breast Cancer-Related Lymphedema,” a study published in the *Archives of Physical Medicine and Rehabilitation*.

The study was conducted on 40 patients in an outpatient rehab clinic who were diagnosed with BCRL. Researchers randomly assigned patients to either the active resistance exercise group

or non-active resistance exercise group. Those in the active group participated in active resistance for 15 minutes per day, five days per week, over the course of eight weeks. The non-active resistance group only performed complex decongestive physical therapy.

To determine results, researchers measured the circumferences of the upper limbs for volume changes and supplied participants with a quality-of-life questionnaire at pre-treatment and post-treatment.

Outcome: Not only did active resistance exercise not cause additional swelling, patients who were prescribed this type of treatment saw significant reduction in proximal arm volume. Those in the active group also reported higher quality of life scores.

Takeaway: Incorporating active resistance into your treatment plan for patients with BCRL could decrease swelling — and that alone can help your patients better perform the activities of daily life, which leads to improved quality of life. □

Development

Get The Most Out Of Your Next Conference

Use these strategies to turn conferences into goldmines for your practice.

Attending a conference is a great opportunity for rehab providers to glean the latest information and make new professional contacts who can share what works well in their practices or facilities.

To achieve these goals, experts suggest these strategies.

1. Do your homework. “If you chose a conference, there’s something about the agenda that appeals to you,” says **Kurt Haas**, former Ohio survey agency chief and currently CEO of **Nursing Home Perspectives**. “So look at the agenda and prepare questions. Speakers may not be able to answer the questions but they will likely be able to point you in the right direction.”

2. Capture the highlights. Haas recommends taking some notes rather than just relying on the handouts. “When you

take notes, you’re writing what ‘speaks to you’ about the information which is probably something you don’t know or haven’t thought about. There’s always going to be a significant portion of the information that you know. It’s the exceptions that you want to focus on.”

Organize your materials: Many conferences have stopped providing notebooks, but you can take one with the printed handouts in it. Include a section or few pages to jot down novel ideas or specific answers to questions you have.

3. Expand your circle of contacts. If you know just one person at a reception or other networking event, you’ve got a connection, says **Maribeth Kuzmeski**, author of *The Connectors: How the*

(Continued on page 6)

World's Most Successful Businesspeople Build Relationships and Win Clients for Life. Walk up to that person and chat for a while, Kuzmeski tells **Eli**. Then ask the person: “Who here does your marketing or your quality assurance or who sets your therapy goals” and ask to be introduced to that person.

Tip: “If you don’t know anyone at all, lingering at the refreshment table as you get some food and beverages is a good place to strike up a conversation,” Kuzmeski advised. “Or get a plate of food and look for someone sitting alone or a group at a table with empty chairs and ask if they mind if you join them.”

Reader Questions

Say Yes To At-Home Outpatient Treatment — Sometimes

Question:

A few of our Part B clients have asked to receive their outpatient treatment in their homes. We would like to accommodate their request, though our practice is not a home care provider. Can we set up this arrangement and bill the visit as outpatient?

Answer:

Yes, “the Medicare program allows you to treat patients in their homes as outpatients,” says **Rick Gawenda, PT**, president of **Gawenda Seminars & Consulting** in Detroit.

Providing therapy to patients in their homes is a “highly valuable service to the community,” says **Tom Howell, PT, MPT** of **Howell Physical Therapy** in Eagle, Ind. At-home treatment is especially marketable for patients with acute severe back or neck pain that keeps them from leaving the house, he notes.

Not so fast: If patients are under a home health agency plan of care, you can’t receive separate reimbursement, Howell says. For these cases, work with the agency to get the discharge done (and in writing) so that you can begin therapy.

If the agency is still treating the patient — such as for clients who aren’t homebound but need nursing services at home — you can set up a contract with the agency that pays you out of their Part A reimbursement. However, this arrangement is tricky and can often leave therapists high and dry when it comes to payment, Howell warns.

Remember that Medicare doesn’t reimburse for your travel time. Howell suggests scheduling at-home therapy for early morning or late afternoon sessions so your therapists can work with them on the way to or from work. And therapists should always carry a “travel kit” that includes everything they might need so that no one is traveling back and forth unnecessarily.

Important: While Part B pays for at-home outpatient therapy, you should still thoroughly document your reasoning for working with patients at home, Howell advises. You can simply jot down the problem, whether it’s that a client doesn’t have reliable transportation, is in severe pain that limits mobility, or another factor.

Consultant **Rena Shephard** may “strike up conversations” with people around her before or after a session, she says. “Drawing the speaker into that discussion can be really helpful if you can do that,” says Shephard.

4. Develop a standard format for reporting on conferences.

You can do oral presentations for staff as part of meetings or inservices. But providing a concise (one page or so) written format can help you share the highlights and any insights. □

Bottom line: As always, check with applicable state laws and your conditions of participation, Gawenda stresses. If they say you’re clear for at-home outpatient treatment, you can begin seeing patients in their homes immediately. Those using the 1500 claim form will simply choose place of service code 12 to signify the location. □

Return Overpayments Immediately — Or Else

Question:

We’ve discovered that a patient overpaid us on her copay. We collected \$50, which was the last copay we had on record. It turns out that the patient’s plan changed but is still under the same payer. Her copay is now only \$10 for an office visit, however. Can we just credit her account or do we need to issue a refund?

Answer:

You do need to issue a refund to the patient, but how you do that is up to the patient. As soon as you discover that a patient has overpaid you, your practice should notify the patient.

You cannot hold onto the money indefinitely.

You can credit the patient’s account, but only if the patient agrees to that. If the patient will be returning your office you can suggest that you apply the overpayment as a credit toward the next visit. If the patient doesn’t want to apply it toward a future visit, however, you must return the overpayment.

You should offer two options:

- » A credit on the patient’s account that you will apply to future services
- » A refund of the overpayment.

Tip: You may find it easier to just send the overpayment amount back to the patient with a letter explaining the situation, rather than notifying the patient and discussing options. Follow whichever process works best for your practice.

Bottom line: You cannot keep an overpayment — from a patient or a payer. That practice is illegal. □

Industry News

Bank On 2010's Pay Rate In 2011

New legislation pushes pay cut back to 2012.

Worried about the 25-percent cut to Medicare rates set to take effect Jan. 1? Relax — you have a one-year reprieve.

On Wednesday, Dec. 15, President Obama signed the Medicare and Medicaid Extenders Act of 2010, a one-year “doc fix” bill that averts the rate cut. Lawmakers drew funds for the fix from other parts of the health care reform law’s provisions instead of other Medicare providers’ reimbursement rates.

Important: The legislation extends the therapy cap exceptions process, which affects patients receiving outpatient therapy

from home health agencies under Part B. (Patients receiving therapy under a home health plan of care are not affected by the \$1,860 cap.)

Bottom line: “Providers of therapy services will be reimbursed at the same rate in 2011 as they were in 2010” except for the negative impact (4- to 6-percent pay reduction) that will result from the Multiple Procedure Payment Reduction policy, says **Rick Gawenda**, president of **Gawenda Seminars & Consulting** in Detroit. □

Offer Therapy Mix For Veterans With Traumatic Brain Injuries

Coordinated therapy could be the answer to re-wiring the brain after trauma.

Patients who’ve suffered traumatic brain injuries (TBI) may seem “normal” on the outside, but they often struggle to complete daily tasks — and that’s where therapy should come in.

Case in point: Rather than offering a single type of therapy, the **SHARE Initiative**, a program designed to help veterans and soldiers heal from TBI, is finding tremendous success with a combination of physical, speech and occupational therapy, coping skills and psychological counseling, reports *ProPublica* and *NPR*.

Based out of the **Shepherd Center for Brain and Spinal Cord Injury** in Atlanta, the SHARE Initiative administers an intensive evaluation to understand patients’ cognitive needs and then develops a treatment plan that brings together therapists from different fields. The therapists coordinate their goals and strategies so that treatment is seamless.

Put it to work: Assign OTs to work with TBI patients on accomplishing tasks, overcoming memory problems, and handling frustration. They could accompany patients to the grocery store or work with them on running errands. PTs can help patients learn to manage lingering pain and restore balance. SLPs can work with patients to interpret the subtleties of conversation as well as restoring clear speech.

Bottom line: The goal is to offer cognitive therapy that re-trains the brain or helps it compensate for things it can no longer do. After the closely coordinated therapy, patients who started out “unable to do basic tasks ... can function independently,” **Bonnie Schaudé**, one of the speech pathologists working with the program, told *NPR*.

Resource: Learn more about the SHARE Initiative at www.shepherd.org/patient-care/care-for-us-service-members. □

Add “Check Exclusion List” To Your Hiring Policy

Spot and report exclusion mistakes before the OIG comes knocking.

If you forget to check the **HHS Office of Inspector General’s** exclusion list when you hire new employees, you could wind up in the same expensive boat as **American Senior Communities** in Indianapolis.

The nursing and rehabilitative care provider ponied up \$376,000 in civil money penalties to the OIG for employing seven excluded individuals, the OIG says in a release.

ASC might have gotten off lighter if it had discovered and reported the problem itself. “Providers self-disclosing such

violations will ultimately pay lower settlement amounts,” **Lewis Morris**, Chief Counsel to the OIG, says in a release. “But in cases initiated by the government — such as this one — providers will, as a matter of course, be required to pay more to resolve the matter.”

Remember contractors: “Providers need to check their employees and contractors on the OIG excluded list,” urges consultant **Tom Boyd** with Rohnert Park, Calif.-based **Boyd & Nicholas**. The exclusions list applies to contractors too, the OIG reminds providers. □

Rehab Report

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Rehab Report and reimbursement* to the Editor indicated below.

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