

Radiology Administrator's

Compliance & Reimbursement Insider

Hello, bundle!

HOPPS favors wholesale packaging payments

The biggest change to the 2008 Medicare hospital outpatient prospective payment system (HOPPS) has major implications for radiology reimbursement—wholesale packaging.

This means your hospital will no longer receive many of the separate ambulatory payment classification (APC) payments previously received in imaging supervision and interpretation services and diagnostic radiopharmaceuticals.

CMS expands packaging

Despite comments from providers, industry leaders, and trade associations, expanded packaging is now the rule in the following hospital outpatient categories:

- Guidance services
- Image processing

- Intraoperative services
- Imaging supervision and interpretation
- Diagnostic radiopharmaceuticals
- Contrast media
- Observation services

With the expanded packaging logic, hospitals no longer see separate payment for several services for which they received payment in the past.

“This final rule appears to contain the most radical changes to HOPPS payment policy since its inception in August 2000,”

says **Jugna Shah, MPH**, president of Nimitt Consulting in Washington, DC.

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—*Jugna Shah, MPH*

Some changes are understandable regardless of whether they will be positive or negative for hospitals, Shah says. However, others raise questions about the outside pressures CMS faced that caused it to move forward with so many significant changes all at once, she adds.

CMS created a composite APC in the 2008 HOPPS that, in certain circumstances, provides a single payment to cover services across an entire patient encounter.

Through packaging, CMS hopes to:

- Improve the quality of services
- Improve outcomes for Medicare beneficiaries through the quality data reporting program
- Initiate specific payment approaches to encourage efficient delivery of services and control future growth of the volume of services

In the preamble to the 2008 HOPPS final rule, CMS says expanding various APC payment bundles will encourage

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HOPPS

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increased efficiency of outpatient care. In addition, increases in packaging provide hospitals the flexibility to manage resources more efficiently, CMS says.

Further, the effect of increased packaging is budget neutral because the payment for the primary procedure is being increased to reflect the cost of the packaged services.

Prepare for packaging confusion

Packaging is certainly an understandable and acceptable concept in any prospective payment system, Shah says. However, CMS' grand-scale introduction on the

outpatient side, in such a short time, is too much, she says. It left industry and providers wondering about the accuracy of the calculations, particularly in cases in which the logic doesn't seem quite appropriate.

For example, in 2007, a provider billed two line items and received two separate APC payments totaling \$1,500. This year, the same two billed line items receive only \$800 because one service is now packaged and included in the other service.

"It's pretty clear that providers are going to be unhappy and raise questions with respect to CMS' calculations related to its expanded packaging logic," Shah says. "The rapid movement and expansion of the packaging policy apparently reflects CMS' goals of controlling outpatient expenditures and volume," she adds.

The agency moved toward packaging to reduce costs rather than examining value-based purchasing or trying to streamline payment policies between hospitals and ambulatory surgery centers (ASC), she says.

One advantage is that the new packaging policies do not require changes to billing for radiology services, says **Jackie Miller, RHIA, CPC**, a senior consultant at Coding Strategies, Inc., in Powder Springs, GA. Hospitals will continue to submit charges on their Medicare claims for all of the services that are now defined as packaged, she says. They just won't receive separate payment from Medicare for those services.

Four major concerns

Radiology professionals should stay apprised and heed the following tips:

► **Don't stop billing for packaged services.** Hospital staff members may wrongly believe that they can't bill for packaged services and may stop entering charges for these services, says Miller. "That would cause the department's revenue to drop significantly," she says.

Additionally, reimbursement could lower if charges for packaged services are not entered on non-Medicare accounts (where those services will still be separately

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paid). "This sounds like a far-fetched scenario, but I do periodically run into people who have this mistaken belief, including the occasional compliance officer—who should know better," says Miller.

► **Watch for drops in reimbursement.** Administrators could be blindsided by drops in reimbursement for outpatient radiology services, says Miller. "This will be particularly important for outpatient interventional radiology services," she says.

Even though accounts receivable remain unchanged, if reimbursement for specific services drops, the hospital administration may be less willing to support expansion of specific services or new equipment.

In other words, Miller explains, there will be no decrease in the hospital's billings. For example, if the radiology department produced \$2 million in charges in 2007, it will still produce \$2 million in charges in 2008. However, the Medicare payment received for those charges will go down due to the packaging changes, says Miller.

Knowing that payment is decreasing, hospital administrators might decide not to approve purchases of expensive new imaging equipment, Miller says.

Many of the 2007 vs. 2008 reimbursement examples are quite significant. For example, payment for a four-vessel cerebral arteriogram dropped from \$5,119 to \$2,847 due to the packaging of imaging supervision and interpretation services. Although administrators can't do much about these drops in reimbursement, they must be aware of them, says Miller.

► **Pay attention to diagnostic radiopharmaceuticals packaging.** On p. 249 of the final rule, CMS finalized the decision to package all diagnostic radiopharmaceuticals, despite the comments it received against this proposal. The APC Advisory Panel recommended continuing separate payment for diagnostic radiopharmaceuticals

greater than \$200. However, CMS declined to heed this advice and adopted the package payment concept for all diagnostic radiopharmaceuticals. This change is likely to significantly affect hospitals that provide specific nuclear medicine procedures.

The one positive change for providers in this area is that CMS will implement edits in the Medicare outpatient code editor for nuclear medicine services furnished on and after January 1.

CMS will look for claims submitted without a HCPCS code or the charge for a diagnostic radiopharmaceutical. Shah notes that this will allow providers to fix their claims and ensure that CMS has complete data for future rate-setting.

► **Review reimbursement.** If you haven't paid close attention to your Medicare/Medicaid reimbursement, be sure to do so, says **Maurine Spillman-Dennis, MPH**, senior director of economics and health policy at the American College of Radiology (ACR). Give your reimbursement a much higher level of scrutiny, she says. Because the packaging concept is brand-new, there could be errors in reimbursement. (Use the chart from ACR on p. 4 to examine the packaging changes.)

Don't panic if you don't understand all the details, but be aware that changes have occurred; it will help you in your interactions with chief financial officers, says Miller.

Tip: The final rule includes changes in payment policy for ASCs, including some that affect payment for imaging services in ASCs. We'll keep you updated in future issues. ■

Administrators could be blindsided by drops in reimbursement for outpatient radiology services.

Questions? Comments? Ideas?

Contact Managing Editor **Melissa Varnavas**

Telephone **781/639-1872, Ext. 3711**

E-mail **mvarnavas@hcpro.com**

Insider sources

Maurine Spillman-Dennis, MPH, senior director, economics and health policy, American College of Radiology, 1891 Preston White Drive, Reston, VA 20191, 800/227-5463, Ext. 4559; msdennis@acr.org.

Jackie Miller, RHIA, CPC, senior consultant Coding Strategies, Inc., 5041 Dallas Highway, Suite 606, Powder Springs, GA 30127; jackie.miller@codingstrategies.com.

Jugna Shah, MPH, president, Nimit Consulting, Inc., 1740 18th Street NW, #103, Washington, DC 20009, 215/888-6037; [jugna@nimit.com](http://jugna.nimit.com).

Quick check**Use this table to analyze radiology packaging changes**

Code	Description	APC	Rate	Title
0144T	CT heart wo dye; qual calcium	0398	\$253.65	Level 1 cardiac imaging
0145T	CT heart w/wo dye funct	0376	\$306.31	Level II cardiac imaging
0146T	CCTA w/wo dye	0376	\$306.31	Level II cardiac imaging
0147T	CCTA w/wo, quan calcium	0376	\$306.31	Level II cardiac imaging
0148T	CCTA w/wo, strxr	0377	\$399.62	Level III cardiac imaging
0149T	CCTA w/wo, strxr quan calc	0377	\$399.62	Level III cardiac imaging
0150T	CCTA w/wo, disease strxr	0398	\$253.65	Level 1 cardiac imaging
0151T	CT heart funct add-on	0282	\$94.53	Misc computerized axial tomography

You can find a complete list of packaged HCPCS codes that fall into the packaged categories in Table 10 on p. 313 of the hospital outpatient prospective payment system (HOPPS) rule. View the final rule at www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/cms1392fc.pdf.

The table above indicates whether a code has a status N (packaged services) or Q (packaged services that are subject to separate payment under certain HOPPS criteria).

Cardiac CT and coronary CTA

CMS will pay for cardiac CT and coronary CTA in the hospital outpatient setting. However, CMS placed these procedures in nuclear medicine ambulatory payment classifications (APC) instead of CT and CTA payment categories.

The American College of Radiology (ACR) requested that CMS place these procedures in the new technology APC in order to gather correct pricing data and then determine their appropriate APC designation.

PET and PET/CT

CMS moved all PET codes into regular APCs, pricing them at \$862.29. Medicare placed PET/CT in a new technology APC priced at \$950. This allows for a \$100 payment differential between PET/CT and PET at the 2007 rate of \$862.29. CMS allows for the collection of a full year's worth of data in order to accurately price PET/CT. FDG is paid separately.

Other radiology procedures

CMS says CT and CTA procedures' rates are comparatively consistent and accurately reflect hospitals' resource costs. Therefore, CMS made no further effort to investigate why CTA payment rates at \$298.44 are the same for CT at \$297.54.

The ACR calculated an additional \$125 difference in clinical time, supplies, and equipment on the Medicare physician fee schedule side and holds that a similar difference in costs and resource use exists in the hospital outpatient setting.

These low pricing rates will have a severe effect when implemented under the Deficit Reduction Act in the office setting.

CMS has decided to move magnetoencephalography (MEG) into regular APCs for 2007 based on what it believes is an adequate amount of hospital cost data. The code 95965 (MEG spontaneous) is in APC 0038 at \$3,270.35. Codes 95966 (MEG evoked, single) and 95967 (MEG evoked, each additional) are in APC 0209 at \$687.26.

CMS says it will not pay separately for computer-aided detection (CAD) for chest x-rays or MRIs. At this time, CMS says it considers the costs of lung CAD and MRI CAD as part of the base procedure. ■

*Source: The American College of Radiology, www.acr.org.
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Lessons learned

Patient left in PET/CT shows need for safety protocols

Adapt these three steps to prevent safety breaches

With so much of the imaging industry focused on MRI safety, don't overlook the more obvious areas when it comes to safety procedures. Ensure that your center trains staff members to never leave patients while they are in a scanner and, as a backup, establish end-of-day closing procedures. It may seem improbable, but if your imaging center leaves a patient in a scanner or locks a patient in a clinic, you had better prepare for potential litigation, including the possibility of a false imprisonment lawsuit, says attorney **Michael F. Schaff, Esq.**, a healthcare attorney with Wilentz, Goldman & Spitzer, PA, in Woodbridge, NJ.

Woman trapped in scanner

Believe it or not, this scenario happened in fall 2007. An Arizona imaging center mistakenly left a woman inside a PET/CT scanner after the imaging center was locked up and staff members went home for the night.

Arizona Oncology would not comment to **RACRI** about the incident due to the possibility of future litigation, although a representative noted that the center completed a thorough evaluation of the event and established new procedures.

Lesson learned

Such an alarming incident offers a lesson for staff members in radiology departments and freestanding facilities everywhere. Use the following steps to ensure this nightmare doesn't happen to you.

1. Train technicians to follow through with patients. Nuclear medicine and radiologic technologists must receive extensive training specific to their fields. However, regardless of training or specialty, assigned staff members should follow through with their patients from beginning to end. This means staff members must:

- Gather the patient's pertinent medical history
- Make sure the patient suffers no medication contraindications

- Explain each step of the procedure and interpret the images
- Walk the patient out

Use the following model language we've created, based on advice from our experts. You can include this policy in your employee manual:

Postscan care: Technicians shall never leave the room or walk away when a patient is in a scanner. After a scan, the technician or designee should walk each patient out of the procedure room and into the dressing room. Ensure that the patient is feeling well and not dizzy, and ask if he or she needs water or time to sit down before leaving.

2. Set closing procedures. Check all rooms in a clinic before closing. Review with staff members how a physical indicator, such as a sign on a door, can show that a room has been checked. When changing shifts, staff members should make some type of handoff communications.

Adopt the following model language we've created, based on advice from our experts, to ensure your facility is checked at closing time:

Closing procedures: The staff member closing the clinic is responsible for ensuring that all rooms are checked before closing. Staff members should always check each scanner to make sure it is empty and properly shut down. After a staff member has checked a room, he or she shall post a designated sign to show that a room has been checked. At closing, all rooms should have signs, which staff members should then remove in the morning.

3. Remind staff members of procedures. Once you have procedures in place, remind staff members of their importance and follow up with regular training. ■

Insider source

Michael F. Schaff, Esq., Wilentz, Goldman & Spitzer, PA, 90 Woodbridge Center Drive, Woodbridge, NJ 07095, 732/855-6124; schaff@wilentz.com.

Radiology to bear brunt of Stark II, Phase III implications

Make sure your radiology group is up to speed about Stark changes. The Stark II, Phase III final rule took effect December 4, 2007. Imaging personnel need to examine the effect on relationships with referring physicians, says **Thomas W. Greeson, Esq.**, a healthcare attorney with Reed Smith, LLP, in Falls Church, VA.

The Stark Law generally prohibits a physician from referring Medicare patients to receive certain designated health services (DHS) from an entity with which the physician has a financial relationship, such as a radiology group, unless an exception under the law applies, says **Ellen Kessler, Esq.**, a healthcare attorney with Ruskin Moscou Faltischek, PC, in Uniondale, NY.

In other words, Stark limits a physician's ability to profit from his or her referrals of certain health services covered by federal health plans, including certain diagnostic testing services, unless the referral is made consistent with a Stark exception, says Greeson. The law also affects radiology groups as DHS providers.

Final rule highlights

The following are some highlights of changes in the final rule that could have an effect on your radiology group and steps you can take to prepare:

1. Review arrangements with physician groups under "stand in the shoes" rule. CMS added a new provision that requires physicians to "stand in the shoes" of their physician organizations. This means a significant number of compensation arrangements involving physician practices, which previously qualified under the less-stringent "indirect compensation" exception, will now be reclassified as direct compensation relationships, says Greeson. You should review such arrangements and possibly restructure them to meet the requirements of an applicable exception for direct compensation relationships, such as the exceptions listed under equipment rental and personal services, he says.

For example, suppose an orthopedist hires a radiologist as an independent contractor to read images for

the group practice, says Kessler. Under the final rule, this now puts every physician in the orthopedic group, "standing in the shoes" of his or her group and, therefore, in a financial relationship with the radiologist who interprets the exam. Thus, the contract between the group is deemed to be a contract for each physician in the entity.

The referring orthopedic physician has a direct relationship with the radiologist and will need to meet a compensation arrangement under the Stark Law. Each orthopedic physician in the group will have to sign a contract with the radiologist or, at least, an adherence agreement to the master agreement between the orthopedic group and the radiologist. Alternatively, Kessler says, the radiologist could try to structure the agreement under the personal services exception.

In order to implement the "stand in the shoes" requirement, CMS created a new definition to describe the types of entities subjected to collapse of physician ownership for purposes of establishing a direct compensation relationship, says Greeson.

The types of entities that will be subject to the new provision are physician organizations, defined as:

- A physician (including a professional corporation of which the physician is the sole owner)
- A physician practice
- A group practice that complies with Stark requirements

Although this expands the definition of a physician organization, Greeson notes that it does not include:

- A limited liability company
- A limited partnership
- A corporation that may be owned by physicians, but which does not function as a physician practice

Thus, for many radiology arrangements, the rule will have a limited effect, he says.

Tip: CMS grandfathered certain existing agreements. If an arrangement was in place prior to September 5, 2007,

and satisfied the “indirect compensation exception,” the new “stand in the shoes” rule need not apply during the original term or current renewal term of the arrangement. However, upon expiration of the current term of such a preexisting arrangement, the “stand in the shoes” rule would apply, and the arrangement would have to satisfy an exception.

2. Review independent contract arrangements.

If a radiologist in your group acts as an independent contractor for another physician's group, interpreting images or performing other tasks, review those arrangements.

CMS clarified the definition of “physician in the group practice” to provide that “an independent contractor physician must furnish patient care services for the group under a contractual arrangement directly with the group practice,” says Greeson.

CMS requires this direct contractual relationship in order for a referring group practice to bill for designated health services. In order to fit within the definition of “physician in the group practice,” an independent contractor must have “a contractual arrangement with the group practice,” states CMS.

The agency interprets this to require that the contractual arrangement be directly between the group practice and the independent contractor physician, and not between the group practice and another entity, such as a staffing company.

For example, suppose your radiology group enters into an arrangement with a physician group and agrees to provide professional interpretation services. Each interpreting radiologist must now have a direct contract with the physician group, says Greeson. It is not enough for

your group to sign a professional service agreement with the physician group.

In responding to comments, CMS says it considers an independent contractor physician a “physician in the group practice” only when he or she is performing services in the group practice's facilities and, thus, has a “clear and meaningful nexus” with the group's medical practice.

CMS says the term “physician in the group practice” is central to the definition of a group practice and significant for purposes of two important exceptions of the Stark Law: the physician services exception and the in-office ancillary services exception.

These exceptions enable physicians to make referrals for DHS within their group practices, provided certain requirements are satisfied. Thus, the strong nexus with a group practice created by the requirement that an independent contractor physician practice in a group practice's facilities ensures that the physician is truly practicing in the group.

Suppose an orthopedic group uses a radiologist for reads and takes reassignment, meaning that he or she will bill for those services. The radiologist must complete his or her analysis or interpretation of the images in the orthopedic group's office, says Kessler.

Some orthopedic groups send films to radiologists, bill for services, and pay the radiologists as independent contractors. This violates the final rule if the orthopedic physicians made the referral and then bill for the services, says Kessler, because the orthopedic group would be unable to satisfy either the physician services exception or the in-office ancillary services exception.

But separate billing of the professional component by the off-site radiology group is permitted, say Greeson and Kessler.

3. Review arrangements for shared use of diagnostic imaging centers. Review any leasing arrangements your group may have. CMS addressed common lease arrangements in which groups of physicians share a diagnostic testing facility on an as-needed basis, says Greeson.

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Stark II

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For example, several individual physicians may share an imaging suite for x-rays or ultrasounds and may share the costs and administration of the facility rather than enter into separate leases with the facility for set periods of time.

CMS didn't make regulatory changes to the in-office ancillary services exception to the self-referral rule. However, it clarified the matter somewhat, offering a shared expense model that allows simultaneous use of the shared facility. The model will not comply with the "same building" requirements of the in-office ancillary services exception to Stark unless the referring physician leases the facility on a block-time basis, says Greeson.

CMS states that "irrespective of whether the office-sharing arrangements . . . are common, both the statute and our regulations require that the lessee have exclusive use of the leased space or equipment when the lessee uses the space or equipment."

Thus, the law requires space and equipment leases be for established blocks of time, CMS says.

For example, says Greeson, physicians can sign up for specific time blocks, such as 9 a.m. to noon, on a specific date, and schedule appointments then.

Historically, Stark Law enforcement activities were limited, says Greeson, but this could change with the increased regulation. The basic sanction under Stark Law is nonpayment for DHS referred by a physician with an improper

financial relationship with the DHS group, he says. In addition, such an entity cannot bill for the DHS if it is referred pursuant to an improper financial relationship, and if the entity collects payment based on a prohibited DHS referral must refund all collected amounts on a timely basis.

CMS expands safe harbor for good-faith compliance


In Phase II, CMS added a safe harbor to permit a DHS entity to receive payment for its services furnished during no more than a 90-day period of noncompliance if:

- The financial relationship in question had been in full compliance with an exception for at least 180 consecutive days immediately preceding the date on which the relationship became noncompliant
- The financial relationship fell out of compliance for reasons beyond the entity's control, but the entity promptly moved to address the noncompliance
- The financial relationship does not violate the federal Anti-Kickback Statute and complies with all other applicable federal and state laws ■

Insider sources

Thomas W. Greeson, Esq., Reed Smith, LLP, 3110 Fairview Park Drive, Suite 1400, Falls Church, VA 22042-4536, 703/641-424; tgreeson@reedsmith.com.

Ellen Kessler, Esq., Ruskin Moscou Faltischek, PC, East Tower, 15th Floor, 1425 Rex Corp. Plaza, Uniondale, NY 11556, 516/663-6522; ekessler@rmfpc.com.

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