



CHAMP legislation targets radiology reimbursement and accreditation

If passed, the Children's Health and Medicare Protection Act of 2007 (CHAMP) could mandate imaging center accreditation standards and nonphysician certification requirements for radiology professionals. The House approved the legislation in August. It will soon hit the Senate floor as part of the Congressional effort to reauthorize the State Children's Health Insurance Programs (SCHIP). Although many radiology officials support federally mandated quality measures for imaging services, there's plenty of financial and compliance details in the proposal to cause concern.

Proposal details

The House proposal would, among other items, condition Medicare Part B payment for diagnostic imaging services on accreditation and impose personnel

credentialing requirements. CHAMP calls for annual surveys and personnel certification for a large number of diagnostic imaging modalities.

The proposal would require those working with diagnostic imaging to obtain certification from a professional organization, licensure, or by another method. Although many states have begun to implement minimum requirements for radiology technologists and other nonphysician imaging practitioners, no standard, nationwide credentialing requirement exists. Further, CMS currently only requires nonphysician personnel to meet any credentialing standards if the imaging center is enrolled as an IDTF.

"[Because] imaging is a fast-growing Part B service, the likelihood is that it will be subject to large reimbursement reductions year after year under this policy."

—Orrin Marcella

Further, CMS currently only requires nonphysician personnel to meet any credentialing standards if the imaging center is enrolled as an IDTF.

Industry reaction

Despite general support for the legislation, some industry associations hope to convince Congress to change certain parts of the proposal.

CHAMP's current provisions act merely as an equipment certification requirement, says **Orrin Marcella**, assistant director of congressional affairs for the American College of Radiology (ACR).

"[Although] the framework of a good accreditation policy is there, [the proposal] is not [a true] accreditation, because language added in the final markup removes the physician component of facility accreditation," Marcella explains.

He believes the current language neglects to indicate whether technologist certification for accreditation applies. The ACR says it will advocate for full certification



IN THIS ISSUE

p. 4 Tips to hire techs
Use this advice from administrators in the field to help you navigate new hires.

p. 5 Sample questions
Adapt these sample questions to use during your next round of new hire interviews.

p. 6 MPFS affects imaging
Discover what steps you need to take to prepare for additional imaging cuts proposed in this year's Medicare physician fee schedule (MPFS).

p. 8 Ask the Insider
Accreditation is the buzzword of those attempting to curb imaging costs. Use this advice to get a jump start on the process.

CHAMP legislation

< continued from p. 1

requirements for all providers of advanced modalities as the bill moves forward in the legislative process, says Marcella.

The American Society of Radiologic Technologists (ASRT) says CHAMP should incorporate the educational and certification standards set forth in another bill—Consistency, Accuracy, Responsibility, and Excellence in Medical Imaging and Radiation Therapy (CARE).

The CARE bill sets out stronger educational and certification standards than CHAMP, according to ASRT. In an August 2 press release, the society also criticizes

CHAMP for failing to set standards for “all individuals performing medical imaging and radiation therapy in all healthcare settings instead of only setting standards for diagnostic imaging examinations and leaving out interventional and therapeutic procedures.”

The CHAMP and CARE bills differ in their definitions of radiation imaging, according to **Christine Lung**, director of government relations for ASRT. The CARE bill definition is more expansive than that in the CHAMP legislation. It applies to anyone who performs radiation imaging and therapy. CHAMP's definition excludes radiation therapy and interventional radiology.

Reimbursement changes

CHAMP also proposes the following reimbursement changes that might adversely affect radiology:

► **Pay cuts.** Although the bill would end global billing—a move the ACR supports—it also increases the discount from 25% to 50% for the technical component of multiple procedures performed in a single imaging session involving consecutive body parts.

Although the bill focuses on Medicare Part B payments and nonhospital services, the 50% reduction for contiguous body parts will certainly affect hospital-based imaging, says Lung.

Meanwhile, CMS has suggested sweeping imaging changes in proposed rules for the Medicare physician fee schedule (MPFS), outpatient prospective payment system, and inpatient prospective payment system, adds **Pam Kassing, MS**, senior director of economics and health policy for the ACR. “The provisions in the proposed legislation would be additive to whatever Medicare has proposed for these payment systems and the Deficit Reduction Act of 2005,” she says.

► **Separate conversion factors.** The CHAMP legislation could also affect future reimbursement for radiologists because it divides physician services into six categories with different conversion factors, according to the ACR.

Editorial Advisory Board

Radiology Administrator's Compliance & Reimbursement Insider



Group Publisher: **Lauren McLeod**

Executive Editor: **Melissa Osborn**

Managing Editor: **Melissa Varnavas**

Larry Balmer

Radiology Incorporated
Mishawaka, IN

Thomas Bartrum, Esq.

Drinker Biddle Gardner Carton
Washington, DC

Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

Southeast Radiology Management
Stuart, FL

Mark B. Canada, MHA, CPC

Medical Practice Management
Richmond, VA

Alice Gosfield, Esq.

Alice G. Gosfield & Associates, PC
Philadelphia, PA

Thomas W. Greeson, Esq.

Reed Smith, LLP
Falls Church, VA

Stacy Gregory, RCC, CPC

Gregory Medical Consulting Services
Tacoma, WA

Mark B. Langdon

Arent Fox, PLLC
Washington, DC

Jackie Miller, RHIS, CPC

Coding Strategies, Inc.
Powder Springs, GA

Diane S. Millman, Esq.

Powers Pyles Sutter & Verville
Washington, DC

Melody W. Mulaik, MSHS, CPC, CPC-H, RCC

Coding Strategies, Inc.
Powder Springs, GA

Claudia A. Murray

Provider Practice Analysis, LLC
Baldwin, MD

Paula Richburg

QuadraMed
Columbia, MO

William A. Sarraille, Esq.

Sidley Austin Brown & Wood
Washington, DC

Michael F. Schaff, Esq.

Wilentz Goldman & Spitzer
Woodbridge, NJ

Jay Silverman, Esq.

Ruskin Moscou Faltischek, PC
Uniondale, NY

Edward Townley

Moncrief Cancer Center
Fort Worth, TX

Tobin N. Watt, Esq.

Smith Helms Murliss
& Moore, LLP
Atlanta, GA

Radiology Administrator's Compliance & Reimbursement Insider (ISSN: 1527-2338) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$249/year; back issues are available at \$25 each. • Postmaster: Send address changes to **Radiology Administrator's Compliance & Reimbursement Insider**, P.O. Box 1168, Marblehead, MA 01945 • Copyright 2007 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail customerservice@hcpro.com. Visit our Web site at www.hcpro.com. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the Marketing Department at the address above. • Opinions expressed are not necessarily those of Radiology Administrator's Compliance & Reimbursement Insider. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. **Radiology Administrator's Compliance & Reimbursement Insider** is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

"A separate service category with its own reimbursement calculation for imaging services is troubling for radiologists," says Marcella.

One of Congress's reasons for creating the six categories is to hold physicians accountable for growth in their specific service area. "[Because] imaging is a fast-growing Part B service, the likelihood is that it will be subject to large reimbursement reductions year after year under this policy," says Marcella. However, this strategy doesn't work for radiologists, who are consulting physicians dependent on referrals from others, explains Marcella. "ACR believes all physicians who order imaging services over the course of treatment for their patients should be responsible for the growth in volume of imaging."

Challenges to the bill

The final SCHIP reconciliation product may be quite different than the current CHAMP version. Congress might also put the matter aside until later in the legislative session. This would give the radiology industry more time to influence the final product. Regardless, Marcella expects Congress to continue its focus on accreditation and credentialing for radiology.

That's because private payers have already adopted facility accreditation standards, says Lung. The CHAMP bill confirms that Congress is paying attention to industry trends.

More and more insurers are requiring facilities to be accredited to perform MRI, CT, PET, and nuclear medicine studies. This means the equipment, technologists, and physicians must meet certain standards in order to receive payment, Marcella adds. So far, this is a quality measurement mechanism that imaging organizations support.

The most important concerns are education and credentialing standards, not only for patient safety, but also to ensure the proper performance of the imaging exam, says Lung. Administrators and practice managers should educate physicians about the potential impact of the CHAMP provisions, says Marcella. Facilities should either pursue facility accreditation now or build the costs for future accreditation requirements into upcoming budgets, says Lung. Also examine staff members' credentials to ensure they have the appropriate experience and qualifications to perform their current duties, she says. Make sure staff members have completed appropriate continuing education and competency requirements for the accreditation programs. ■

Insider sources

Pam Kassing, MS, senior director of economics and health policy, American College of Radiology, 1891 Preston White Drive, Reston, VA 20191, 703/648-8936; www.acr.org.

Christine Lung, director of government relations, American Society for Radiologic Technologists, 15000 Central Avenue SE, Albuquerque, NM 87123, 800/444-2778, Ext. 1308; cjlung@asrt.org; www.asrt.org.

Orrin Marcella, assistant director of congressional affairs, American College of Radiology, 1891 Preston White Drive, Reston, VA 20191, 703/648-8936; www.acr.org.

Questions? Comments? Ideas?

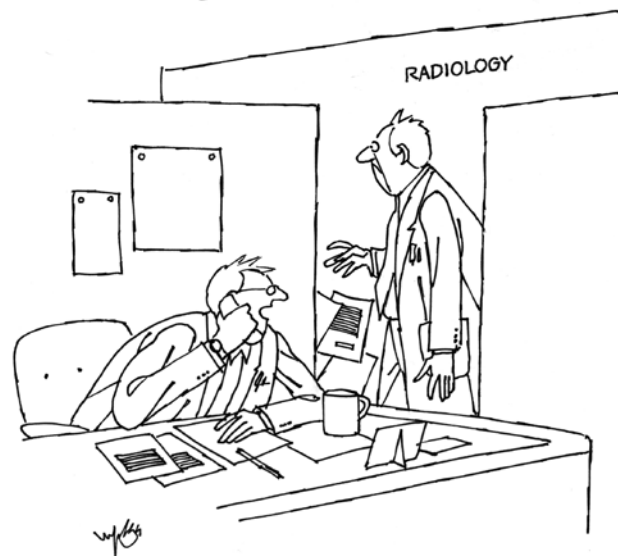
Contact Managing Editor
Melissa Varnavas

Telephone 781/639-1872, Ext. 3711

E-mail mvarnavas@hcpro.com

Illustrated by

David Harbaugh



"Center City Hospital? Hi, I need to pick somebody's brain in radiology about their credentialing process."

Don't settle when hiring technologists

Directors share their experience and advice

Demand for radiologic technologists and technicians will grow faster than the average demand for all occupations through the year 2014, according to the U.S. Department of Labor's *Occupational Outlook Handbook*. However, the supply side of the staffing equation appears unable to satisfy that demand.

In such an atmosphere, it's tempting to subscribe to the old adage that "any warm body will do." But such hiring methods can eventually harm even a well-run radiology department, says **Jay Mazurowski, CRA, FAHRA**, director of radiology services for Concord (NH) Hospital.

"When I first came to this department, we had what I would call a 'warm body' approach to hiring. If a candidate had a pulse and could start right away, [we hired him or her]. This led to high turnover, low satisfaction, and many associated costs—financial and otherwise," he says.

Approaches to candidate selection

Many department managers believe it's best to post open positions internally before seeking external candidates from traditional avenues (e.g., newspaper advertisements and job boards), says **Alicia Vasquez**, administrator for Arcadia (CA) Radiology Medical Group.

"Once the qualifications are clearly defined, we look in-house to give existing technologists the opportunity to move to another modality if they have the capability to do so," says Vasquez. If that is not an option, she broadens her search to radiology technologist schools in the area, and then to online and print advertisements.

Applicants at Advanced Medical Imaging Center in San Antonio often seek available positions through the center's Web site, says **Mary Lou Jew, RT(R)(M)**, director of outpatient imaging. After HR reviews an application, it goes on to the hiring manager.

Regardless of how the candidate's resume comes to you, complete a thorough investigation of his or her

experience, credentials, and personality in a straightforward, nondiscriminatory way.

Ask probing, multipart questions that force candidates to describe a past situation or challenge they faced, says Mazurowski, who takes a behavioral-based approach to interviewing potential employees.

"Behavioral-based interviewing is based on the premise that past performance or behavior is the best predictor of future performance," he says. For example, he might ask a potential technologist to explain how and why he or she chose a particular action in response to a specific challenge that technologists frequently face. Mazurowski then inquires about the outcome of the applicant's behavior and whether he or she would do it differently next time.

Such anecdotal information offers insights into how an employee might conform to your department's compliance and organizational structures. It also offers you valuable information about how the candidate could fit with the rest of your radiology team. To ensure a good fit, candidates typically meet a cross-section of current department employees after an HR screening. Mazurowski then asks his staff members for feedback. "This is essential, in that existing staff get to weigh in on hiring decisions and also take responsibility for outcomes," says Mazurowski. "It builds both trust and accountability."

At Advanced Medical Imaging, hiring managers interview and check references, after which Jew completes any needed second interviews. Applicants must also pass a drug screening and background check, she adds.

The importance of patient care

Finding new staff members with the appropriate competencies and skill sets who also care about patients and coworkers is the ultimate goal, says Vasquez.

"You can pay anyone to work, but you can't pay someone to care. That is the difference between a good employee and a great employee," she says.

Jew once hired a former mentor as a technologist. As an instructor for 14 years, he came to Jew's organization with certifications in MRI, CT, mammography, and quality management.

"He came to us with not only experience as an instructor but also as a technologist with the highest commitment to patient care and ethics. He has since worked his way to being a very successful manager who today leads his team by example," she says.

Unfortunately, some employees do not work out well no matter how good they look on paper, says Jew.

Vasquez tries to avoid such circumstances with a test run. "We ask potential employees to come and spend a few hours with us," she says. "They see very quickly [whether] they are a good fit for our organization."

Sometimes the job is simply not what the candidate

expected. Recently, an applicant interviewed for a full-time technologist position in a specific modality but ultimately turned down the job.

"The time and money invested was costly for us, because this person did not really understand what [he or she] wanted to do," says Vasquez.

The organization cannot fit the person, Vazquez says, "the person has to fit us, or it will be a negative experience for all involved."

Jew echoes that sentiment. Experience in patient care is as important as imaging experience and credentials, she says. She suggests technologists remember the reason they chose the healthcare field—patient care.

"If you only have 20 minutes to spend with a patient, make them the best 20 minutes you can possibly give [him or her]," says Jew. ■

Sample interview questions

The right inquiry makes all the difference

Ask the following questions when interviewing potential candidates.

Notice they are not hypothetical. Instead, they seek specific examples of previously demonstrated behavior as a means to determine future success.

Before you start asking questions, clearly outline the key attributes and skill sets necessary for both the specific position and your facility's overall mission.

The words in brackets describe the skill set the inquiry should reveal.

1. Tell me about the last time you broke the rules to serve a customer in need. [flexibility, judgment]
2. How have you used humor to defuse a tense situation? [fun]
3. Give me an example of how you dealt with a difficult coworker. [adaptability, collaboration, conflict resolution]
4. Tell me about a time when you made a serious mistake with a customer or coworker. How did you reconcile it? [adaptability, flexibility, growth]

5. What do you love most about your current job? [dedication, priorities]
6. If you were not a radiology technologist, what other profession would you consider? [honesty, flexibility, potential]
7. Tell me about a time you thought you did excellent work but a doctor questioned it. [collaboration, teamwork, adaptability, communication]
8. Tell me about the last time you took on additional responsibilities when there was no guarantee for success? [ambition, collaboration, team work, adaptability]
9. What traits do you like in a supervisor? [adaptability, collaboration, willingness to learn]
10. Tell me about a situation in which you were asked to complete a menial task? [time management, deference, teamwork] ■

Source

These questions are adapted from HCPro, Inc.'s *Radiology Manager's Handbook: Tools and Best Practices for Business Success*. For more information, visit www.hcmarketplace.com or call customer service at 800/650-6787.

Examine the impact of MPFS proposals

Beware of possible Stark changes

By now, you're probably wondering why you became a radiology administrator in the first place. If private payer regulations, new accreditation mandates, and reimbursement cuts to technical component (TC) and contiguous body part scans didn't cause you to question your career, the proposed Medicare physician fee schedule (MPFS) probably did. Facing cuts from regulations left, right, and center, those managing the business of radiology now also confront a number of financial and compliance concerns relating to MPFS.

Decoding the proposed rule's language

The MPFS proposed rule that CMS released July 2 offers an update of -9.9% for 2008. However, that's the least of imaging's worries. The proposed rule also attempts to close what CMS considers Stark law loopholes, including:

- "Per-click" payments for space and equipment leases
- "Set-in-advance" percentage-based compensation
- Burden of proof
- Anti-markup
- In-office ancillary services exception

The proposed MPFS also includes new standards for IDTF enrollment in Medicare, which attempt to increase the quality of imaging services.

Medicare first presented IDTF enrollment changes in its *Medicare Program Integrity Manual Transmittal 187*, released January 26. But CMS withdrew its proposed requirements prior to implementation following an industry outcry. (**RACRI** subscribers can read more in our online archives at www.hcpro.com/pub-2977.html.)

Incorporating the changes in the MPFS is just another way for CMS to control escalating imaging costs, says **Adrienne Dresevic, Esq.**, an attorney with Wachler & Associates in Royal Oak, MI, who spoke July 8 at the American Healthcare Radiology Administrators annual meeting in Orlando.

CMS will likely publish the final rule soon. It will be effective for services performed on or after January 1, 2008. (*Editor's note:* Although CMS did not issue the final rule by presstime, look in future issues of **RACRI** for further analysis.)

There is no proposal to grandfather existing arrangements or otherwise delay the effective date of the proposed change. So, anyone attempting to comply with the rules as proposed could undergo a significant business disruption as they restructure existing partnerships and legal arrangements prior to the January 1, 2008, MPFS implementation date.

The MPFS proposed rule's comment period closed August 31. To view the proposed rule, visit www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-P.pdf.

Differentiating Stark details

Radiology facilities and hospitals enmeshed in any number of business plans should pay particular attention to "under arrangement" and "per-click" agreements.

➤ **Under arrangement.** Services between hospitals and referring physicians are impermissible when referring physicians own an interest in the entity performing the designated health service (DHS). Facilities must restructure these deals.

Unfortunately, the MPFS proposed changes leave numerous questions unanswered, says attorney **Thomas Bartrum, Esq.**, partner in the healthcare group in the Washington, DC, office of Drinker Biddle Gardner Carton.

For instance, he says, in expanding the definition of "entity" to include those performing DHS, CMS leaves unanswered what exactly constitutes "performing" DHS.

Under the current Stark law, the entity is simply whoever submits the bill to Medicare, according to **Robert Wade, Esq.**, an attorney with Baker & Daniels, LLP, in South Bend, IN. So hospitals have physicians provide services, then submit the bill under the hospital's provider number. By doing so, the physician or

physician group does not have to be in compliance with Stark, just the hospital.

If the proposed MPFS changes make it into the final rule, the entity is no longer just who submits the bill. It's who submits the bill and who provides the services. The hospital and the physician must both be in compliance.

"A lot of hospitals have abandoned this [under-arrangement] approach," Wade says. "Hospitals that are considering this type of arrangement are getting cold feet."

"Clearly, an under-arrangement provider performs the DHS, but what about an entity that furnishes equipment or management services?" Bartrum asks. "The expansion of 'entity' [has an effect on] a number of legitimate arrangements around the country." Additionally, despite the changes to the definition of entity, the IDTF standards would still affect certain shared space and equipment arrangements.

"If implemented as proposed in the final regulations, IDTFs will need to unwind any block lease or shared space arrangements," says Bartrum.

► **Per click.** The proposed change would require facilities to also restructure arrangements under which referring physicians lease equipment or space to hospitals on a per-click or per-use basis. Instead, they must base these arrangements on daily or hourly fair market value rates.

"A lot of arrangements are set up on a per-click basis," says **Jim Kopf**, president of Healthcare Oversight in New Canaan, CT. Under the proposal, "you can't do that, and all of those arrangements have to be restructured."

Historically, entities could handle this arrangement with split billing, or one entity could handle it with global billing.

The billing entity paid on a fair market value, per-click, or per-use basis for the part of the exam that the other entity provided, says **James C. Dechene**, partner in the Chicago firm of Sidley Austin, LLP.

Although some per-click arrangements are potentially abusive, others simply facilitate efficient billing and collection under managed care contracts, he explains.

Reducing imaging reimbursement

Although some might see imaging services and other diagnostic services as commodities to either purchase or provide, the reality is that imaging services and their interpretation are medical services, says Dechene. "If not done by skilled professionals with an eye on quality, there can be substantial malpractice risks to the practice billing for the service."

Essentially, the proposed rule seeks to remove the profit element from services that quality radiology personnel do not directly perform, says Dechene.

Under the proposal, physicians who perform the professional component but purchase the TC cannot mark up the TC, says Dechene. Similarly, the opposite would also be true under the proposal. The rule would also make it harder for those who refer patients for imaging service to bill for services without taking on the burden and risk of actually performing the technical or professional components.

Under the proposal, those who employ radiologists on a full-time basis and own imaging equipment can bill for imaging services. However, in this situation, the entity now assumes the risk associated with the imaging services.

Finding room for improvement

Many industry experts suggest the rule isn't perfect. CMS' proposals lack clarity at best and, at worst, are incomprehensible, says Bartrum. It is unclear whether CMS has the authority to expand the payment limitation to purchased professional components. Further, it is unclear how the new markup provisions apply to services that part-time employees furnish. ■

Insider sources

Thomas Bartrum, Esq., partner, Drinker Biddle Gardner Carton, 1500 K Street NW, Washington, DC 20005, 202/230-5196; thomas.barton@dbr.com.

James C. Dechene, partner, Sidley Austin, LLP, One South Dearborn, Chicago, IL 60603, 312/853-7275; jdechene@Sidley.com.

Adrienne Dresevic, Esq., Wachler & Associates, 210 East Third Street, Suite 204, Royal Oak, MI 48067, 248/544-0888; www.wachler.com.

Jim Kopf, president, Healthcare Oversight, 467 Laurel Road, New Canaan, CT 06840, 203/966-5528; jkopf@healthcareoversight.com.

Robert Wade, Esq., Baker & Daniels, LLP, 205 West Jefferson Boulevard, Suite 250, South Bend, IN 46601, 574/239-1906; bob.wade@bakerd.com.

Ask the Insider

Prepare for accreditation mandates

Q What can radiology departments/facilities do to prepare for accreditation?

► **Start early**—getting accredited typically takes six to eight months from the time you apply.

► **Be flexible**—most sites have to make at least some minor changes in their routine practices (such as imaging protocols or quality control procedures) to meet the accreditation standards.

► **Be confident**—you will be successful, even if you experience some unanticipated difficulties. Although the process is difficult, remember that you have a team of professionals doing what they do best to help you complete your accreditation. Don't be shy about asking lots of questions—of your staff members, of the accreditation program support staff members, of your physicist, and of your equipment vendor—especially if this is your first experience with accreditation.

Make sure you have a good team in place going into the process. A designated lead person—either a manager or a senior/chief radiology technologist (RT)—should coordinate accreditation activities and collect all of the necessary materials. The RT has the greatest direct involvement of anyone in the practice. After a facility obtains accreditation,

the RT maintains primary responsibility for quality control as he or she goes about his or her daily activities.

Notify your physicist as soon as you decide to apply for accreditation. If you don't have one, now is a good time to find one. The medical physicist occupies a central role in the process. Often, the physicist is best situated to understand the "big picture" in an accreditation effort. He or she regularly serves as a central point of contact for technologists, physicians, and administrators in navigating the process. ■

Editor's note: Dozens of legislative and regulatory motions suggest voluntary accreditation for radiology departments and freestanding facilities may soon become a luxury of the past. In January, UnitedHealthcare announced that radiology facilities that perform particular studies must obtain accreditation by March 2008 in order to receive reimbursement for those services from the insurer. The above information is excerpted from the RACRI special report "Imaging Accreditation: FAQs to Help You Through New Payer Requirements," available to subscribers online at www.hcpro.com/content/71716.pdf.

Insider source

David W. Jordan, PhD, senior medical physicist, West Physics Consulting, 4339 Oakdale Vinings Circle SE, Smyrna, GA 30080, 770/435-9186; dave@westphysics.com.

RACRI Subscriber Services Coupon

Start my subscription to RACRI immediately.

Options:	No. of issues	Cost	Shipping	Total
<input type="checkbox"/> Print & Electronic 1 yr	12 issues of each	\$249 (RACRIPE)	\$24.00	
<input type="checkbox"/> Print & Electronic 2 yr	24 issues of each	\$448 (RACRIPE)	\$48.00	
Order online at www.hcmarketplace.com. Be sure to enter source code N0001 at checkout!		Sales tax <small>(see tax information below)*</small>		
		Grand total		

For discount bulk rates, call toll-free at 888/206-6554.



*Tax Information

Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV. State that taxes products only: AZ. Please include \$27.00 for shipping to AK, HI, or PR.

Your source code: N0001

Name _____

Title _____

Organization _____

Address _____

City _____

State _____

ZIP _____

Phone _____

Fax _____

E-mail address

(Required for electronic subscriptions)

Payment enclosed. Please bill me.

Please bill my organization using PO # _____

Charge my: AmEx MasterCard VISA

Signature _____

(Required for authorization)

Card # _____

Expires _____

(Your credit card bill will reflect a charge to HCPro, the publisher of RACRI.)

Mail to: HCPro, P.O. Box 1168, Marblehead, MA 01945 Tel: 800/650-6787 Fax: 800/639-8511 E-mail: customerservice@hcpro.com Web: www.hcmarketplace.com