Two-Midnight Rule Pushes More Procedures To Outpatient Side, Alters the Incentives

CMS’s new two-midnight rule draws a line in the sand for procedures that are not emergencies or not on the Medicare inpatient-only list. The agency has been nudging hospitals in the outpatient direction for a while through policy and audits, but formalizing it is one way the 2014 inpatient prospective payment system (IPPS) regulation is expected to pack a big reimbursement punch.

“The rule says patients having procedures not on the inpatient-only list should be outpatients except in unusual circumstances,” says Steven Meyerson, M.D., vice president of the regulations and education group at Physicians Advisory Services. If patients require admission for a procedure, the documentation will have to be persuasive. For example, it won’t be enough to say that patients with chronic obstructive pulmonary disease (COPD) are expected to have post-op respiratory problems. The physician should explain why the hospital stay is expected to cross more than two midnights: it will be hard to extubate the patient, who may need aggressive respiratory therapy, monitoring of oxygen saturation and adjustment of medications post-op. “Then you have a case for admitting the patient,” Meyerson says. “But you will be seeing very few non-inpatient-only procedures done as an inpatient because the physician is no longer allowed to admit patients based only on the risk assessment.”

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Caveat Emptor: ‘Audit-Proof’ Electronic Medical Records Are Seldom Audit-Proof

Some electronic medical record (EMR) systems are advertised as audit-proof, which may give providers a false sense of security about their coding and billing compliance. Contracts with EMR vendors may tell a different story than the ads, because they typically state there is no guarantee the software is error-free and the vendor has no financial responsibility for overpayments, one lawyer says.

It’s tempting to invest in charge modules or other software applications marketed as “audit-proof” because EMR scrutiny is at full tilt, says Richelle Beckman, an attorney with the Forbes Law Group in Overland Park, Kan. A year ago, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius sent five hospital associations a letter warning that “law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided.”

Medicare administrative contractors are starting to downcode claims for evaluation and management (E/M) services because physicians copied and pasted notes from previous patient encounters (RMC 3/25/13, p. 1) and EMRs are on the OIG’s 2013 work plan.

But the phrase “audit-proof” is a red flag. Beckman has seen it used by more than one EMR vendor to describe some applications, and has watched some providers become more complacent about coding compliance as a result of relying on claims made by the vendor.

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According to the two-midnight standard in the 2014 IPPS, which takes effect Oct. 1, CMS generally will assume inpatient admissions that cross two midnights are medically necessary unless they are delayed on purpose or lack medical necessity for the second night in the hospital. Auditors will turn their attention to shorter stays unless they are for procedures on the inpatient-only list (RMC 8/12/13, p. 1). Hospitals face new certification requirements and other challenges under the regulation (RMC 9/16/13, p. 1, 9/2/13, p. 1).

The two-midnight rule has raised the ante for oversight of billing for procedures. Hospitals should review procedures that aren’t on the inpatient-only list before billing Part A, and whenever possible, convert them to outpatient cases using condition code 44, Meyerson says. “It’s much better than self-denying after discharge and rebilling under Part B,” he says. With condition code 44, hospitals cancel the admission order without all the fuss and muss of rebilling, although they have to work fast to get the treating physician and utilization review committee’s concurrence to change the patient status before discharge.

With Part A/B rebilling, there are more hoops to jump through, Meyerson says. Hospitals submit the Part A claim, but indicate it’s a no-pay/provider liable claim, he says. The Medicare administrative contractor processes the claim and sends a remittance advice to the hospital acknowledging it won’t be paid. Then the hospital encodes the services on two separate claims: preadmission services are submitted on a Part B outpatient claim and post-admission services are rebilled on a Part B inpatient claim (RMC 6/24/13, p. 1), with codes changed from ICD-9 to CPT, he says.

**New Rule May Have Unintended Consequences**

Procedures will present challenges on multiple fronts under the new IPPS. The different ways that hospitals and physicians approach the same procedures are an object lesson in how the two-midnight rule may have unintended consequences on their reimbursement and compliance. Some hospitals treat and release patients with uncomplicated non-ST segment elevation myocardial infarction (NSTEMI), a severe type of acute coronary syndrome, in less than 24 hours, Meyerson says. Patients will have emergency catheterizations and insertion of a stent, perhaps through the radial artery in the wrist, which means faster recovery than going through the groin. If the procedures are uncomplicated and the patients do well, they are discharged, he says. Other hospitals keep patients for two to three days, obviously as inpatients — and are paid significantly more money.

“The difference in length of stay is based on the hospital processes and the traditional approach to these patients,” Meyerson says. CMS has been pushing hospitals to perform procedures on an outpatient basis if they can be done safely and effectively, and is packaging payments for more outpatient services (RMC 9/16/13, p. 1). “Bundled payments encourage hospitals to be efficient and reduce length of stay,” he says.

But the two-midnight rule will muddy the waters, he says. After investing in processes to shorten observation stays, hospitals will wonder why they should bother anymore. After Oct. 1, there will be a financial incentive to keep patients in observation longer because there might subsequently be a medically necessary reason to admit them and observation counts toward the two-midnight stay.

CMS said it anticipates more inpatient admissions under the two-midnight rule because a greater number of observation cases will be converted to inpatient status than vice versa and in response will reduce MS-DRG payments 0.2%. “That prophecy may come true if hospitals lose the incentive to discharge quickly from observation. But CMS did not acknowledge there will be more patients placed in observation out of fear they won’t...
make the two-midnight threshold,” Meyerson says. So now there are conflicting incentives, he says. There are fewer rewards for treating and releasing patients quickly from observation because hospitals could admit patients who will cross two midnights.

Hospitals with a higher proportion of short-stay admissions will feel more pain from the two-midnight rule, says Peter Dressel, a managing director of FTI Consulting in Washington, D.C. “It creates a significant budgetary impact because our data analysis indicates there isn’t a large outpatient population” to replace the short-stay admissions that are considered medically necessary Oct. 1, he says. The final rule says that 360,000 inpatients will become outpatients in fiscal year 2014 and 400,000 outpatients will become inpatients, “but in reality, a lot more inpatients become outpatients,” he says. CFOs and compliance officers have their work cut out for them as both the reimbursement and compliance landscape changes. Dressel suggests that hospitals do risk profiles to identify what types of patients might be outpatient to inpatient and vice versa now that CMS has set up a “strict time-based measure.” Are they the same types of diagnoses? Same types of complications?

Speedy Recoveries Will Draw Auditors

Hospitals also face uncertainty with respect to inpatients who recover fast and are discharged before staying two midnights. CMS has said these cases are billable under Part A if the physician expected the patient to cross the two-midnight threshold and documentation supports the expectation (e.g., order and certification) as well as the medical necessity of the admission, Meyerson says. But “these cases will be highly subject to audit,” he says. For example, the physician may believe a pneumonia patient requires three to four days in the hospital but the patient responds well to treatment and goes home after one night. As long as documentation supports the reason for the admission and the two-night expectation — for example, in addition to respiratory treatment and IV antibiotics, the patient has marginal control over her diabetes, making it harder to get the infection under control — the admission should pass the medical-necessity test, he says.

Hospitals are in a pickle, however, when it comes to patients who are placed in observation on a Friday evening but the tests or treatments they need are not available until Monday. Often it’s too risky to send patients home over the weekend, but physicians can’t always say a two-midnight stay is medically necessary. “This is an example of a clarification that is needed because there are a lot of patients in this situation,” he says. He doesn’t advise admitting patients only because they are waiting for tests or treatments unless physicians document that the patient needs ongoing hospital care.

Meanwhile, CMS officials said in a Sept. 17 open-door forum they will publish manual provisions and answers to frequently asked questions about the two-midnight rule this fall.

Contact Meyerson at smeyerson@accretivehealth.com and Dressel at peter.dressel@fticonsulting.com.

Tips for Navigating the Stark Nonmonetary Compensation Rule

When a hospital wanted to give all board members iPads so they could receive documents electronically, it ran into the wall of the Stark law. One of its board members is a referring physician so he has a financial relationship with the hospital. Because the $500 iPad fell outside the Stark law exception for nonmonetary compensation, which allows hospitals to bestow up to $380 worth of non-cash gifts on each physician annually, the hospital took another route: the fair-market value compensation exception.

“If you have a board member who is a referring physician, I suggest a simple contract for services between the hospital and the physician,” says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. Crafted to comply with the Stark exceptions for fair market value or personal services arrangements, the contract is written for a discrete purpose: to provide a physician with tangible benefits, such as an iPad, meals or a retreat, in exchange for a service, such as serving on a board. It also could be used when a CEO consults a physician over dinner. Wade calls it the “will-work-for-food contract” (see p. 5) and says it could be an escape hatch for other...

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goodies subject to the $380 cap under the nonmonetary compensation exception.

Compliance with the nonmonetary compensation exception “is not always black and white,” Wade says. In fact, it may be more flexible than hospitals think, but they should pay close attention because exceeding the cap could mean returning Medicare reimbursement for services referred by physicians who received more than $380 in nonmonetary compensation.

“Hospitals have to establish a process to identify items given to physicians, such as meals and sporting tickets, that need to fit into the nonmonetary compensation exception,” he says. They should track the items to ensure the aggregate doesn’t top the annual cap, which CMS increases every year.

For CEOs skeptical that the government cares whether free football tickets went beyond the cap, Wade notes that some of the settlements to come out of the CMS self-referral disclosure protocol include violations of the nonmonetary compensation exception, and there have been civil monetary penalty settlements with the HHS Office of Inspector General over this as well.

Here is Wade’s advice on applying the nonmonetary compensation exception to some typical freebies:

◆ Newspaper advertising: When photos of referring physicians appear in an ad for a hospital without their names, the benefit is solely for the hospital. Even if their names are printed, “I still don’t think we are getting there in terms of allocating a portion for the expense of the ad because the point is to promote the hospital,” Wade says. But when the doctor’s name and contact information are presented, it is joint advertising, which is considered compensation and must meet a Stark exception, he says. That includes the placement of the ad and the cost of developing it. Because the allocated cost to the M.D. may surpass $380, another Stark exception could be required.

◆ Lab coats with the physician’s name and logo: “You can get a little creative,” Wade says. Either account for the value of the lab coat under the $380 cap or push it into the Stark law’s medical staff incidental benefit exception if the hospital requires the physician to wear the lab coat while there, on the grounds that it costs less than $32 a day to rent the lab coat. Hospitals may give medical staff members unlimited goods or services if they are used or consumed while inside the hospital, such as cafeteria meals, as long as each doesn’t cost more than $32 (this year’s per-benefit cap).

◆ Golf tournaments: Suppose the hospital pays $10,000 to sponsor a foursome at a charity golf tournament and two of the players are referring physicians. The actual value of the golf game and any food and drinks consumed should be allocated to each physician rather than dividing the $10,000 by four, Wade says. He recommends calling the golf course and asking the cost of a round of
golf, then estimating the cost of the food and drinks and putting it in each doctor’s $380 column.

- **Expensive dinners:** The CEO takes a nonemployed physician to the Ruth Chris Steak House so they can discuss operations of the orthopedic department. Wade says either half the cost of the bill or the actual cost of the meal and drinks consumed by the physician must be allocated to the physician. However, if the physician is employed, and the hospital finds it went above the $380 cap, Wade says it can make the argument the business meal was an employee benefit.

- **Flowers to congratulate the opening of a new practice:** The cost — maybe $150 — can’t be divided among the number of physicians in the practice because the gift itself isn’t really divisible, Wade says. The entire amount must be allocated to every physician in the practice.

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**Will Work for Food: Service Agreements Under Stark**

This is an example of a contract that could carve out goods and services from the nonmonetary compensation exception under the Stark law, says Bob Wade, an attorney with Krieg DeVault in Mishawaka, Ind. It would allow the hospital to pick up a physician’s tab for goods or services (e.g., dinner, an iPad) in return for the physician’s expertise (e.g., serving on the board). The remuneration would fall under the fair-market value or personal services arrangements exception, Wade says (provided the other terms of the exception are met), which means it doesn’t count against the $380 annual cap on nonmonetary compensation under Stark.

Contact Wade at rwade@kdlegal.com.

THIS SERVICE AGREEMENT ("Agreement") is made and entered into as of this ______ day of ______, 20__ ("Effective Date"), by and between ________________ ("Company") and ________________ ("Contractor").

NOW, THEREFORE, Company and Contractor agree as follows:

1. **Services.** Company hereby engages Contractor to __________________________ (the "Services").

2. **Compensation.** In consideration of the time spent by Contractor performing the Services, Company agrees to pay Contractor __________________________. The parties believe this amount to be fair market value for the Contractor’s services.

3. **Term.** The term of this Agreement shall be for one (1) year from the Effective Date. This Agreement shall automatically renew for additional one year terms unless otherwise terminated by the parties. The parties acknowledge and agree that they shall not enter into an arrangement the same as, or substantially similar to, the one described in this Agreement for one (1) year after the Effective Date unless this Agreement is renewed on the same terms and compensation. Either party may terminate this Agreement at any time without cause by providing the other party with ten (10) days prior written notice of such termination.

4. **Sanctions or Debarment.** Contractor represents and warrants that he has never been sanctioned by the Office of the Inspector General ("OIG") of the Department of Health and Human Services, barred from federal or state procurement programs, or convicted of a criminal offense with respect to health care reimbursement. Contractor shall notify Company immediately if the foregoing representation becomes untrue, or if Contractor is notified by the OIG or other enforcement agencies that an investigation of Contractor has begun which could lead to such sanction, debarment, or conviction.

5. **Master List.** Company maintains a master list of contracts that is updated centrally and available for review by the Secretary of the Department of Health and Human Services upon request. The master list is maintained in a manner that preserves the historical records of contracts. If Company and Contractor have entered more than one (1) arrangement that meets the requirements of the personal service arrangement exception noted in 42 C.F.R. §411.357(d), the master list maintained by Company is intended to conform to the requirements of 42 C.F.R. §411.357(d)(ii).

6. **Miscellaneous.** This Agreement contains the entire understanding between the parties concerning the subject matter of this Agreement and no modification, amendment or waiver of any of the provisions of this Agreement shall be effective unless in writing and signed by both parties. Contractor may not assign any rights, duties or obligations under this Agreement in whole or in part without the prior written consent of Company. This Agreement and performance hereunder shall be governed by and construed in accordance with the laws of the State of ___________. If any provision of this Agreement is or becomes invalid, illegal or unenforceable in any respect, it shall be ineffective to the extent of such invalidity, illegality, or unenforceability, and the validity, legality, and enforceability of the remaining provisions contained in this Agreement shall remain in effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement to be effective as of the Effective Date.

**COMPANY**

By: __________________________

Name: __________________________

Title: __________________________

Date: __________________________

**CONTRACTOR**

By: __________________________

Name: __________________________

Title: __________________________

Date: __________________________
Hyperlinks to physician practices from the hospital website: Wade says hospitals may list members of the medical staff under the medical staff incidental benefits exception, which he would extend to hyperlinks.

Food for the medical executive committee: If the meal is in the hospital cafeteria, it fits within the medical staff incidental benefits exception. Outside the walls of the hospital, the hospital has to apply the nonmonetary compensation exception unless it uses the will-work-for-food contract, Wade says. If restaurant food is eaten outside of the hospital and the hospital picks up the tab, the Stark cap applies — even if the money comes out of medical staff accounts. “Some compliance officers don’t think they have to review what the medical staff spends its accounts on, but they usually use the tax ID of the hospital and as long as the account is tied to the hospital tax ID, you are using hospital funds although they may be restricted funds,” Wade says.

Contact Wade at rwade@kdlegal.com.

Richelle Beckman, an attorney with the Forbes Law Group in Overland Park, Kan., says providers may want to ask the following questions when entering into relationships with electronic medical record (EMR) systems vendors.

What warranty disclaimers and limitations on liabilities are in your EMR vendor contract?

What training will the EMR vendor provide, specifically related to the charge module, prior to, during, and following implementation?

Will you have the ability to manage settings for the charge module after implementation?

Does the charge module apply 1995 or 1997 evaluation and management services guidelines? Can this setting be changed? Do any of your payors apply guidelines different from the coding guidelines used by the charge module to determine your levels of service? Which set of guidelines have your providers been trained on?

How does the charge module determine what services (history, exam, and decision making) are related to the presenting problem? For example, a Medicare patient presents for ear pain, but as a part of the visit the provider performs the breast and pelvic exam that are due. Does the charge module count the genitourinary system on exam towards the level of E/M service?

How frequently is the charge module logic updated?

Does the charge module capture HCPCS codes for Medicare screening services? Are Medicare’s minimum documentation requirements to bill those codes incorporated into the charge module’s coding logic? Is the charge module updated when requirements for these codes change?

Are progress and visit notes set to automatically document certain information, such as the patient’s past medical, family, social history, allergies, medications, etc.? If so, does the charge module “count” those items of documentation towards the level of service? What is the procedure to remove this documentation from the note (not from the chart itself) if these items are not relevant or are not reviewed?

How does the module calculate medical decision-making levels?

(1) How does the EMR distinguish between new and established problems, problems that are worsening vs. stable, problems with additional or no additional workup? They may affect the number of diagnoses and treatment options and the overall risk of the visit.

(2) If labs or X-rays are billed separately, does the charge module also give credit for ordering labs/X-rays in the amount of data to be a reviewed component of medical decision making?

(3) Are there any settings that contradict the guidance of your local Medicare administrative contractor?
intelligence. “When we review coding levels for clients that have charge modules, the levels of service may not be the most appropriate for what was done,” Beckman says. While the physician checked the right boxes for the elements of the patient exam and the history of present illness, and the EMR calculator seemed to map to the right code, “the nature of the visit was not as complex as what the charge module represents. Charge modules may overestimate and overcalculate the complexity of the service.”

Suppose a patient comes in with ear pain. The physician documents (by checking boxes) that the pain is in the right ear, is severe, has persisted for three days and is worse in the morning. The patient has a history of otitis media but no fever, congestion, sneezing allergies or trouble hearing. Then the physician takes vital signs, examines the patient’s ear, nose and throat and listens to his heart and lungs. The EMR charge module may assign a level four E/M visit based on the number of elements checked off for the exam and history, but the level of service could be skewed because the medical decision making to treat an ear infection is straightforward or low. “It may be more appropriate to code a level three or level two visit,” Beckman says. “Evaluating complexity is very subjective and very difficult to reduce to an algorithm.” That lack of nuance may result in upcoding, she says.

Also, when physicians open a new note in the charge module, it may automatically display information about the patient, such as medications and history. That may be useful clinically, but it frequently counts toward the level of service, and thus may contribute to upcoding if not actually reviewed or relevant to the encounter.

If they make a mistake, providers shouldn’t expect to fall back on the audit-proof promise from EMR vendors, Beckman says. Contracts typically leave liability in the provider’s lap in the event Medicare or other payers deny claims or downcode the level of service. “Despite all the great marketing on how accurate their charge modules are, the contract typically has warranty disclaimers,” she says. They essentially say that the EMR vendor makes no promise that the product will work as intended. That contradicts a “default assumption in the law” called “fitness for a particular purpose,” which holds that products will do what they are supposed to do when sold by companies that hold themselves out as experts, such as EMR vendors, Beckman says.

She cited one common example of software contract language that could disclaim the accuracy of the charge module: “Except as expressly set forth above, and to the maximum extent permitted by applicable law, [the EMR vendor] does not warrant the hardware or software system will be error-free. [The EMR vendor] does not make any warranties, whether express, implied, statutory or otherwise, with respect to the software system, hardware, services or any other materials provided by [the EMR vendor] under this agreement, including without limitation, the implied warranties of merchantability, fitness for a particular purposes or non-infringement. All such warranties are hereby expressly disclaimed.”

Beckman says contracts also may state that EMR vendors can’t be held responsible if their coding is wrong. “The EMR vendor is canceling out the claim of being audit-proof,” she says.

If providers can’t persuade the vendor to delete the provision, the next best thing is to redouble compliance reviews of automated coding assignment.

For more information, contact Beckman at rbeckman@forbeslawgroup.com.
NEWS BRIEFS

- North Arkansas Regional Medical Center, a rural health clinic (RHC) in Harrison, Ark., agreed to pay $395,591 in a civil money penalty settlement with the HHS Office of Inspector General over “incident-to” billing. In November 2012, the medical center self-disclosed that during a three-year period, it had improperly billed Medicare separately for “incident to” services that were included in the rural health center payment. RHCs, which are clinics located in rural, medically underserved areas, are paid an “encounter rate,” which is an all-inclusive rate covering services provided by a physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse, and related services and supplies. The clinic did not admit liability in the settlement.

- In recent weeks, CMS posted five new settlements under its Stark self-referral disclosure protocol. An Ohio hospital paid approximately $235,000 because of noncompliant arrangements with certain physicians for EKG interpretations, medical director services and vice-chief of staff services and for the donation of electronic health record items. A North Carolina hospital agreed to pay $87,110 for problems with arrangements for medical director services, medical coding and consulting services and the lease of office space. A Texas hospital paid $54,108 because arrangements for case management physician advisor services did not fall into any exception. A physician group practice in Louisiana self-disclosed that arrangements for “incident to” services did not meet the requirements of the in-office ancillary services exception and agreed to a $13,572 settlement payment. Finally, a nonprofit community hospital in Minnesota paid $9,570 for problems with arrangements for the rental of office space and the provision of support services. Visit http://tinyurl.com/bt6sy9z.

- Hutchinson Regional Medical Center, Inc., in Wichita, Kan., has settled allegations that it submitted false claims to Medicare for hyperbaric oxygen wound therapy services that were not medically necessary or that lacked adequate documentation of medical necessity, the Department of Justice said Sept. 17. The claims allegedly resulted from kickbacks between the hospital, at least one of its physicians and the company that supplied the chambers. The hospital will pay $853,651, in addition to the more than $1.7 million it previously refunded to Medicare. It also is functioning under a five-year corporate integrity agreement with the HHS Office of Inspector General. Visit http://tinyurl.com/13te2sn.

- Five Pensacola, Fla., radiation oncology centers and two physicians have agreed to pay $3.5 million to the federal government and Florida to settle allegations of improper claims submitted to Medicare, Medicaid and TRICARE. In the Sept. 13 press release, the Department of Justice alleged that the providers, over a five-year period, billed the health care programs for radiation oncology services that were not properly supervised by a physician. In fact, according to the allegations, some of the services were performed while the supervising physician was on vacation. The providers also allegedly billed for services not indicated in the medical record, billed twice for the same services and misrepresented the level of service provided to increase reimbursement. In addition to the payment, the medical center and one of the physicians entered into a three-year corporate integrity agreement with the HH5 OIG; the other physician agreed to a three-year integrity agreement. The settlement closes a 2012 whistleblower case — United States ex rel. Koch v. Gulf Region Radiation Oncology Centers Inc., et al., No. 3:12-cv-00504 (N.D. Fla.). Visit http://tinyurl.com/nxrpnnv.

- A new CMS publication explains how to submit a denied Part A claim for payment under Part B. The Medical Learning Network article (SE1333) details the process for admissions on or after Oct. 1 that are denied for lack of medical necessity. The article also explains the effect of an appeal on such a claim. The policy authorizing Medicare to pay for services rendered to an inpatient that would have been payable under Part B if the patient was an outpatient was finalized in the 2014 inpatient prospective payment system final rule, published Aug. 19 in the Federal Register. Visit http://tinyurl.com/mhs6492.

- On Sept. 20 — the eve of the Sept. 23 deadline for compliance with the omnibus HIPAA/HITECH rule — the Office for Civil Rights released three guidance documents addressing drug refill reminders, student immunizations and decedents. These follow OCR’s release one week earlier of models for the revised notice of privacy practices. OCR also announced a delay in enforcement of the NPPs for CLIA and CLIA-exempt labs. Go to “What’s New” in the right column at www.hhs.gov/ocr/privacy.
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