



Audit Hot Spots for Your Revenue Cycle

Including Strategies for Reviewing Your Emergency Department
Coding and Charging Practices

Audit Hot Spots for Your Revenue Cycle

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 - Issues Under Review - Past & Present Target Areas
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About OPTUM

- Optum is a health services business dedicated to making the health system work better for everyone.
- We are comprised of three market-leading business segments—OptumHealth, OptumInsight and OptumRx.
- We are dedicated to building and enabling Sustainable Health Communities. For a health community to be truly sustainable, it must be connected, intelligent and aligned.
 - *Connected*: giving people the insights they need at the right times so they can make decisions that improve the quality of care and facilitate fair and efficient transactions.
 - *Intelligent*: applying information and analytics to improve clinical, financial and administrative decisions and workflow at critical points in the health system.
 - *Aligned*: supporting the delivery of high-quality, efficient, patient-centered care and by guiding the development of integrated, accountable health systems.

OPTUM At-A-Glance

- With a combined workforce of 30,000 people, Optum serves the entire health ecosystem, including nearly 250,000 health professionals and physician practices; 6,200 hospitals and facilities; more than 270 state and federal government agencies; over 2,000 health plans; two of every five FORTUNE 500 employers; more than 400 global life sciences companies; and one in every five U.S. consumers.
 - OptumHealth specializes in population health management solutions that address the physical, mental and financial needs of organizations and individuals.
 - OptumInsight specializes in improving the performance of the health system by providing analytics, technology and consulting services that enable better decisions and results.
 - OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products.

CMS Audit Landscape

- The primary goal of each CMS contractor is to “Pay it Right”
 - pay the right amount
 - to the right provider
 - for covered and correctly coded services
- Improper Payment Elimination and Recovery Act (IPERA)
 - Signed by the President on July 20, 2010
 - Defines “improper payment” as:
 - payments that should not have been made, or payments made in an incorrect amount (including overpayments and underpayments)
 - payment to an ineligible recipient,
 - payment for an ineligible service,
 - any duplicate payment,
 - payment for services not received,
 - payments for an incorrect amount

CMS Audit Landscape

Comprehensive Error Rate Testing (CERT) National Medicare Fee-for-Service Error Rates by Year 1996 - 2010

Year	Error Rate	Total Dollars Paid	Total Improper Payments
1996	14.2%	\$168.1 B	\$23.8 B
1997	11.8%	\$177.9 B	\$20.9 B
1998	8.4%	\$177.0 B	\$14.9 B
1999	8.6%	\$168.9 B	\$14.5 B
2000	9.4%	\$174.6 B	\$16.4 B
2001	8.8%	\$191.3 B	\$16.8 B
2002	8.0%	\$212.8 B	\$17.1 B
2003	6.4%*	\$199.1 B	\$12.7 B*
2004	10.1%	\$213.5 B	\$21.7 B
2005	5.2%	\$234.1 B	\$12.1 B
2006	4.4%	\$246.8 B	\$10.8 B
2007	3.9%	\$276.2 B	\$10.8 B
2008	3.6%	\$288.2 B	\$10.4 B
2009	12.4%	\$308.4 B	\$35.4 B
2010	10.5%	\$326.4 B	\$34.3 B

* These entries have been adjusted to account for the high provider non-response rate in 2003. Had the adjustment not been made, the improper payments would have been \$21.5 B and the national paid claims error rate would have been 10.8%.

CMS Audit Landscape

• Causes for Improper Payment

- Most improper payments occur when providers submit claims that do not comply with Medicare’s coding or medical necessity policies and rules

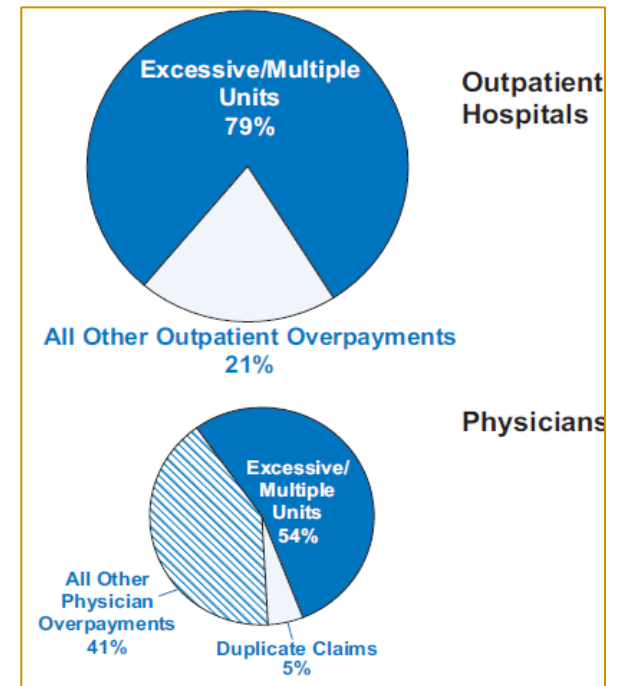
Appendix E Overpayments Collected by Error Type and Provider Type

Table E1. Overpayments Collected by Error and Provider Type (Net of Appeals):
Cumulative Through 3/27/08, Claim RACs Only
(Percent of Total)

Error Type	Inpatient Hospital	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Out-patient Hospital	Physician	Ambulance/Lab/Other	Durable Medical Equipment	Total Overpayments Collected
Medically Unnecessary	34.50	5.63	0.26	0.47	0.00	0.00	0.00	40.86
Incorrectly Coded	30.48	0.00	0.62	2.44	1.05	0.06	0.00	34.66
No/Insufficient Documentation	6.63	0.44	0.48	0.11	0.00	0.00	0.09	7.76
Other	12.57	0.00	0.41	1.22	1.44	0.45	0.63	16.72
Total	84.19	6.07	1.76	4.25	2.50	0.51	0.72	100.00

Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.

Source: THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM:
An Evaluation of the 3-Year Demonstration, June 2008



CMS Audit Landscape

• AHA RACTrac Survey Results through March 2011

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 1st Quarter 2011

Survey participants were asked to rank denials by reason, according to dollars impacted.

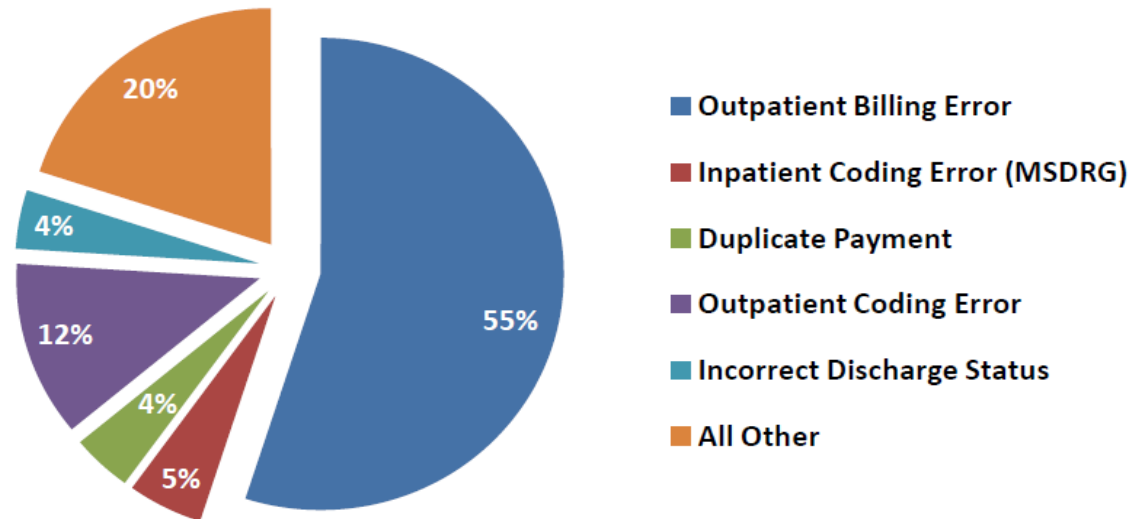
AHA RAC Trac Definitions

Outpatient Billing Errors – These denials may include but are not limited to the following:

- units or charge errors
- misuse or incomplete billing modifiers

Examples include ... incorrect billing of the drug or ... units billed incorrectly

Outpatient Coding Errors - This reason code denotes an error in HCPCS code or other outpatient coding related error.



Source: AHA. (May 2011). RACTrac Survey
AHA analysis of survey data collected from 1,960 hospitals: 1,580 reporting activity, 380 reporting no activity through March 2011. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Emergency Department (ED) Target Areas



Issues Under Review - Past & Present

- **Emergency Department (ED) Coding and Billing Issues Identified During RAC Demonstration**
 - Demonstration RACs were not looking at E/M services
 - Incorrect level of physician E/M codes were excluded claims from the demonstration program
 - RACs could review E/M services to look for other types of errors such as duplicate payments, violations of Medicare's global surgery rules, definition of new patient, etc.
 - Very few of these types of claims were selected for audit by the demonstration RACs
 - Hospitals were being audited on a number of procedures including infusion services, a common service in the emergency department

Issues Under Review - Past & Present

- **ED Coding Issues Identified**

- OIG FY2004/FY2010 Work Plans

- The OIG is worried about the 'excessive' number of diagnostic tests being performed in the ED. For FY2008 the emphasis was on diagnostic radiology services in the ED.
- The OIG is investigating the correlation of coding between the physicians and the hospital. The E/M codes do not need to match, but other codes should generally match
 - Need to carefully separate *Professional* from *Technical* component
 - E/M Level development is completely different for physicians versus hospitals
 - Medical/Surgical procedures should be coded the same way

- OIG reports: www.oig.hhs.gov/reports.html

Issues Under Review - Past & Present

- **OIG Reports**

- Outpatient **infusion therapy services** provided as part of a surgical procedure and therefore were not separately payable by Medicare (A-03-10-10005, 07-28-2010)
- Billed Medicare for more than one **infusion therapy service** per visit, and nonchemotherapy infusion therapy services provided during outpatient surgical procedures. These infusion therapy services were not separately billable by the provider or payable by Medicare. (A-03-10-10001, 07-09-2010; A-03-10-10004, 06-24-2010; A-03-10-10002, 07-09-2010)
- 3-year-long “Operation Vampire” project uncovered hospitals submitting separate and distinct Medicaid payment claims for **blood transfusions** on bills that had more than one unit per day (OIG Semiannual Report to Congress (Apr-Sept. 2008))
- Medicare paid \$97.6 million for **E/M services** that were included in eye global surgery fees but not provided during the global surgery periods in calendar year 2005. Global surgery fees include payment for a surgical service and the related preoperative and postoperative E/M services provided during the global surgery period, which extends from the day before the surgery to 90 days after the surgery (OIG Semiannual Report to Congress (Apr-Sept. 2009))

Issues Under Review - Past & Present

- Top ED-Related CERT Errors Reported (2008)
 - “No Documentation” Errors- 99284 – 1.6%
 - Incorrect Coding - Emergency dept visit (99285) 5.4%
 - Underpayment Coding Error- Emergency dept visit (99285) 5.4% and ED visit (99283) 2.3%
 - One-level E/M error - Emergency dept visit (99285) 4.9%
 - One Level E/M Error Emergency Dept visit (99283) 3.4%

Source: *Improper Medicare Fee-For-Service Payments Report - May 2008 Report*

Issues Under Review - Past & Present

- **Current Emergency Department Audit Risks**

- CMS

- Targets providers that don't have consistent charging methodology for Evaluation and Management (E/M) visit levels

- OIG

- Capturing the drug that is provided with IV and infusion therapy is not enough. Correct accounting of all associated administrative charges is necessary

- Focused search for missing administrative charges on IV and infusion therapy

- RAC

- IV/Hydration and blood transfusions are low hanging fruit for the RAC auditors and have been specifically targeted since October 2007
- RACs (especially DCS, Region A) are targeting E/M services

- CERT

- E/M services continue to account for a significant portion of CERT errors

Issues Under Review - Past & Present

- **Current RAC Coding Issues Approved for Review**
 - Automated Reviews (DCS, CGI, Connolly, HDI)
 - IV/Hydration (OP Hospitals, Physician)
 - Overpayments associated with providers billing IV Hydration codes for more than one unit per date of service
 - Rule: You can only bill one unit of service per patient per date of service for IV hydration CPT code 90760 (CPT code 96360 replaced code 90760 January 1, 2009)
 - Initial Infusion Services (OP Hospitals)
 - Overpayments associated with providers billing 'initial' intravenous infusion (90765 and 96365), and subcutaneous infusion (90769 and 96369), with more than one unit of service by the same provider for the same beneficiary on the same date of service
 - Rule: There is only one “initial” drug administration code per encounter, including during an encounter where observation services span more than 1 calendar day. The only exception is if the protocol requires two separate IV sites or if the patient comes back for a second encounter on the same date of service. These services would be identified with modifier 59. Medical documentation is required to justify the use of the modifier.

Issues Under Review - Past & Present

- **Current RAC Coding Issues Approved for Review**
 - Automated Reviews (DCS, CGI, Connolly, HDI)
 - Blood Transfusions (OP Hospitals, Physician)
 - Blood transfusion codes are billed for more than one unit per date of service
 - Rule: Providers should bill CPT codes 36430, 36440, 36450, and 36455 (excluding claims with any modifiers) as one per session, regardless of the number of units of blood transfused on that date of service

Issues Under Review - Past & Present

- **CMS FAQ: Will RACs review E/M services on physician claims under Part B? (updated 5/17/11)**
 - Response: Yes, the review of all E/M services will be allowed under the RAC program
 - The review of duplicate claims for E/M services that should be included in a global surgery were available for review during the RAC demonstration and will continue to be available for review.
 - The review of the level of the visit of some E/M services was not included in the RAC demonstration. CMS will work closely with the American Medical Association and the physician community prior to any reviews being completed regarding the level of the visit and will provide notice to the physician community before the RACs are allowed to begin reviews of E/M services and the level of the visit.

Issues Under Review - Past & Present

- **Current RAC E/M Coding Issues Approved for Review**
 - Automated Reviews (DCS, CGI, Connolly, HDI)
 - **Global Surgery - Pre and Post-Operative Visits (Professional)**
 - Overpayments associated with surgical services
 - E/M services billed the day prior to a major (90-day) surgical service without modifiers 57 or 25
 - E/M services billed the day of a major (90-day) or minor (0- or 10-day) surgical service billed without modifier 25 or 57
 - E/M services billed 10 days following a 10-day minor surgical service or 90 days following a 90-day major surgical service and billed without modifier 24 (unrelated visit in post op period)
 - **E/M Services with Allergy Services (Professional)**
 - E/M services billed without modifier 25 on the same date of service as allergy testing or allergen immunotherapy
 - **New Patient Visits (Hospital OP and Physician)**
 - Overpayments relating to the same provider group and specialty billing more than one new patient E/M service within a 3 year period of time

Issues Under Review - Past & Present

- **Current RAC E/M Coding Issues Approved for Review**

- Anesthesia Care and Packaged E/M Services (Professional)

- Overpayments associated with E/M services billed the day prior to or day of anesthesia services by an anesthesiologist
 - E/M services billed the day prior to or day of anesthesia services without modifiers 24, 25, or 57
 - E/M services billed the same day as code 01996 without modifiers 24, 25, or 57

- Radiologists Billing E/M Services with Diagnostic Mammography Services (Professional)

- Overpayments associated with radiologists billing E/M services on the same date of service as diagnostic mammography services

- Pulmonary Diagnostic Procedures and E/M Services (Professional)

- Overpayments associated with limited E/M services (99211-99212) billed without modifier 25 on the same date of service as a pulmonary diagnostic procedure (94010-94799)

Issues Under Review - Past & Present

- **Current RAC E/M Coding Issues Approved for Review**

- E/M Code with Status S or T Code (Hospital OP)

- Overpayment exists when a provider bills an E/M code (99201-99204, 99211-99214) with OPPS status indicator V (Visit to Clinic or Emergency Department), without modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) on the same date of service as a significant medical or surgical code, with an OPPS status indicator S (Significant Procedure, Not Discounted When Multiple) and T (Significant Procedure, Multiple Procedure Reduction Applies) respectively

- Part B Duplicates (Professional) - Multiple Service Same Day

- Medicare does not pay for duplicate services or equipment. Physicians in the same group practice who are in the same specialty must bill and be paid for E/M services as though they are a single physician. If more than one E/M service is provided on the same day, only one E/M service may be reported unless the services are for unrelated problems. Physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
 - Rule: According to Medicare regulations, only one E/M service may be billed per day, per patient – (Pub. 100-4, Chapter 12 §30.6 – Evaluation and Management Service Codes General).

Issues Under Review - Past & Present

- **Current OIG ED Coding Issues Identified**

- OIG FY2011 Work Plan: The OIG selects areas of vulnerability based on the evidence or suspicion of improper payments prevalent in these areas.

- Planned audits for E/M coding and payments (pg. I-14)

- Review of E/M claims to identify trends in the coding of E/M services and whether coding patterns vary by type of provider

- Medicare paid \$25 billion for E/M services in 2009 (19% of all Medicare Part B payments)
 - Providers must ensure that E/M codes submitted reflect the services provided. E/M codes must represent the type, setting, and complexity of services provided and the patient status, such as new or established. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1)

Issues Under Review - Past & Present

- **Current OIG ED Coding Issues Identified**

- OIG FY2011 Work Plan

- Planned audits for E/M coding and payments (pg. I-14)

- Review of the number of inappropriate payments for E/M services and the consistency of E/M medical review determinations.

- Providers must “select the code for the service based upon the content of the service” and that “documentation should support the level of service reported.” Medicare contractors have noted an increased frequency of medical records with identical documentation across services. (*Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1)
- Review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.

Issues Under Review - Past & Present

- **Current OIG ED Coding Issues Identified**
 - OIG FY2011 Work Plan
 - Planned audits for E/M coding and payments (pg. I-14)
 - Review of industry practices related to the number of E/M services provided by physicians and reimbursed as part of the global surgery fee.
 - Under the global surgery fee, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E/M services provided during the global surgery period. We will determine whether industry practices related to the number of E/M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 40)

Issues Under Review - Past & Present

- **CERT – Comprehensive Error Rate Testing**

- **Purpose:** To find errors in payments made by FIs, MACs and Carriers when paying providers' Medicare claims

- Goal is to reduce Medicare Fee For Service and Contractor-Specific paid claims error rates

- Hospitals and other providers are affected

- The provider must submit requested medical records

- If the CERT uncovers an error, the CERT will take back money from the hospital

- **Current Findings Relative to E/M Services**

- E/M services continue to account for a significant portion of CERT errors for WPS, the J5 Part B MAC (In 2011)

- E&M codes account for approximately 36% of the errors received for Cahaba GBA, the J10 Part B MAC (November 2010)

Issues Under Review - Past & Present

- Current **CERT Reviews** for E/M services currently being conducted
 - Documentation does not support level of E/M service billed
 - Documentation must support the level of service billed. Currently claims are being recoded because the level billed is not adequately supported in the documentation
 - Documentation for inpatient hospital care must support that a face-to-face visit occurred. You cannot bill for E/M if you do not see the patient. Example: Reviewing the patient's chart and writing an order cannot take the place of a face-to-face encounter
 - Inpatient Split/Shared Evaluation and Management (E/M) Services
 - Current review of medical records indicates an increasing number of Initial and Subsequent Hospital, as well as Emergency Department services, being billed as split/shared visits between the billing physician and a Non-Physician Practitioner (NPP) **from the same group practice**
 - Low-Level Evaluation and Management Services – CPT 99211
 - E/M errors were due to incorrect coding – down coded or up coded by only one level

Issues Under Review - Past & Present

- **Current CERT Reviews**

- Blood transfusion service (36430)

- **Incorrect Coding**

- Provider billed one service per pint of blood but the definition of this code is one service per transfusion session
 - **EXAMPLE:** An ER visit where one transfusion session occurred during which 2 pints of blood were administered to the beneficiary. Hospital billed for 2 units of 36430 (Transfusion, blood or blood components). According to the definition of the code, two units of 36430 would be for 2 separate transfusion sessions in the same day.

CMS Audits – Educational Articles



CMS Audits – Educational Articles

- Message for Providers:
 - RACs and other auditors base their overpayment and underpayment decisions on written Medicare policy, Medicare articles, and Medicare-sanctioned coding guidelines to determine if coding is accurate
 - Review MLN articles and supporting coding guidelines, and take steps to meet Medicare’s documentation requirements to avoid unnecessary claim denials
 - Avoid billing errors and other improper activities under the Medicare FFS program
 - Realize the consequences related to billing errors and noncompliance with Medicare regulations and policies
 - Take action to avoid the problem
 - Providers are advised to understand the lessons learned from the RAC demonstration and implement appropriate corrective actions

CMS Audits – Educational Articles

- CMS created a new Web Page for all MLN Provider Compliance Educational Products (11/29/2010)
 - Contains MLN products and MLN Matters articles that educate FFS providers about how to avoid common billing errors and other improper activities identified through CMS' various claim review programs
 - **MLN MATTERS ARTICLES**
 - **NATIONAL EDUCATIONAL PRODUCTS**
 - **Medicare Quarterly Provider Compliance Newsletters**
 - **Comprehensive Error Rate Testing (CERT) Reports**

http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp

CMS Audits – Educational Articles

- Important educational articles addressing billing errors, coding risk areas, and documentation reminders
 - Volume 1, Issue 1 – October 2010 “Medicare Provider Compliance Newsletter – Guidance to Address Billing Errors”
 - Focuses on issues uncovered during reviews by the General Accounting Office (GAO), and the Office of the Inspector General (OIG), RACs, PSCs, ZPICs, and MACs
 - Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors (Volume 1, Issue 2 – February 2011)
 - Recovery Audit Finding: Not a New Patient – Incorrect Coding (Physician)
 - Recovery Audit Finding: Chemotherapy Administration and Non-chemotherapy Injections and Infusions – Incorrect Coding (OP Hospitals and Physicians)
 - Recovery Audit Finding: Evaluation and Management (E/M) Billing During the Global Surgery Period (Physician)

CMS Audits – Educational Articles

- Important educational articles specific to E/M services
 - CMS Pub. 100-1, Chap. 4; Pub. 100-2, Chaps. 7 and 15; and Pub. 100-4, Chaps. 1, 11 and 12 of the CMS Internet Only Manual (IOM)
 - NHIC Education Articles (**J14 MAC Part B**) – Evaluation & Management Coding Requirements Updated 2/10/11
http://www.medicarenhic.com/ne_prov/edarticles_df.shtml
 - CMS IOM, Medicare Claims Processing Manual (Pub. 100-04 Chap. 12, Section 30.6 at <http://www.cms.gov/manuals/downloads/clm104c12.pdf>)
 - CMS “Evaluation and Management Services Guide,” 1995 Guidelines, and 1997 Guidelines at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

CMS Audits – Educational Articles

- Important educational articles specific to E/M services
 - Comprehensive Error Rate Testing (CERT) Fact Sheet: Evaluation and Management (E/M) Services: Overview
 - “New patient” defined; Medicare Claims Processing Manual, Chapter 12, Section 30.6.7 at <http://www.cms.gov/manuals/downloads/clm104c12.pdf>
 - MLN Matters® Article MM4032 - <http://www.cms.gov/MLNMattersArticles/downloads/MM4032.pdf>
 - E/M Billing During the Global Surgery Period; Medicare Claims Processing Manual, Chapter 12, Section 40

CMS Audits – Educational Articles

- Important educational articles specific to IV Hydration and Infusion Services, Blood Transfusions
 - IV Hydration
 - Medicare Claims Processing Manual 100-04, Chapter 12, pages 31-32; IOM 100-20, Transmittal 419, page 7
 - Infusion
 - CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Sections 10.4 and 230.
 - CMS Hospital Outpatient PPS, OPPTS Guidance for CY 2006
 - HighMark Medicare Services, Article (A47797), revision date of 12/12/2008
 - Palmetto GBA (07/15/2009) - Jurisdiction 1 Part A Infusion/Injection/Hydration Services
 - Johnson, Laurie M. "Clarifying the Infusion and Injection Quandary." *Journal of AHIMA* 78, no.8 (September 2007): 76-79

CMS Audits – Educational Articles

- Important educational articles specific to IV Hydration and Infusion Services, Blood Transfusions
 - Blood Transfusions
 - Federal Register, Vol. 67, No. 212, page 66868; Federal Register, Vol. 73, No. 223, page 69016
 - Program Memorandum Intermediaries, Transmittal A-01-50, April 12, 2001, page 1
 - CMS Pub 100-04, Medicare Claims Processing Manual, Chapter 4, Section 231.8

Where to Go to from Here?



Managing the CMS Audit Landscape

Prepare for Audits

- Prepare for increased claims scrutiny
 - Analyze your hospital's audit workflow and identify gaps in the overall audit process
 - Develop and document policies and procedures to respond to audit requests, including tracking requests and responses for all payers
 - Finalize the process for record delivery and tracking
 - Designate an internal point of contact for the audit and verify that the individual(s) is the contact person with the various auditing entities
 - Ensure that correspondence from Auditing entities are directed to the internal point of contact
 - Keep current with MLN Matters articles and other CMS and State educational materials
 - Prepare for the expansion of RACs into Medicaid?
 - Become familiar with state-specific Medicaid coding and billing policies, and appeals processes

Prevent Adverse Findings

- Conduct your own data analysis and select claims that are likely to come under RAC and other regulatory review
 - Data on your E/M level distribution, codes 99281-99285 and critical care 99291 should be monitored for both your facility and professional coding patterns
- Have external party perform a coding audit to identify coding, documentation, medical necessity, and billing compliance issues
- Consider conducting audits subject to attorney client privilege
- Provide audit education to management and coding staff to help remediate root causes identified by the audit review
- Implement corrective actions and revise policies and procedures to prevent future overpayment recoveries
- Focus physician education on documentation to support medical necessity decisions
- Provide complete, legible records in a timely manner

Prevent Adverse Findings

- What's else do you need to do?
 - Use data mining tools
 - Leverage the use of consistent, unbiased methodologies for ED and other high acuity charging and coding
 - Find out what optimal charging and coding of ED levels looks like, as well as what you need to do to assess your overall risk
 - Attend Session 2 on June 21 at 4:00 PM EDT



Thank You.

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