Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

www.partbnews.com

January 12, 2015 | Vol. 29, Issue 2

IN THIS ISSUE

All Medicare fees are par, office, national unless otherwise noted.

Quality reporting

4 ways Medicare's turbo-charged PQRS list can make measure selection easier

Take advantage of a new tool that will help you juggle the quality measures your providers must report this year or face a 2% pay cut.

Medicare's physician quality reporting system (PQRS) measures list requirements for 2015 is an Excel spreadsheet, instead of the static PDF you've seen in years past. The new format allows users to quickly navigate through the hundreds of measures and more readily pinpoint the nine PQRS measures in three national quality strategy (NQS) domains, including one cross-cutting measure, that providers must report in 2015.

*(see **Quality reporting**, p. 6)*

ICD-10

Experts: 9 months to go — time for ICD-10 restart with testing, cash reserve

Now that the ICD-10 deadline is less than nine months away, experts warn against foot-dragging and advise you to focus on the big things — finding testing opportunities and shoring up your cash reserves for Oct. 1.

When Congress unexpectedly pushed the ICD-10 deadline back, it seemed to cut the heart out of many practices' preparedness planning (*PBN 3/31/14*). For example, UMass Memorial Health Care in Massachusetts had extensive testing

*(see **ICD-10 restart**, p. 7)*

Recovery auditors

CMS restarts RAC program, makes changes to rules for auditing claims

Practices can expect increased review of claims now that CMS announced the official restart of their recovery auditor (RAC) reviews.

CMS announced Dec. 30 "the implementation of many improvements to reduce provider burden and increase transparency in the program" as well as a new national contract for Connolly LLC to audit home health, hospice and durable medical equipment (DME) claims.

The federal Medicare agency had announced in early 2014 that it would temporarily suspend RACs until the next round of contracts was awarded. But months later, CMS allowed RACs to resume certain audits (*PBN 8/11/14*).

Major changes in store for RACs

In response to industry feedback, CMS has made 20 changes to improve the RAC program. Among those changes, CMS will ensure that RACs:

- **Establish additional documentation request (ADR) limits** based on provider compliance with Medicare rules. Practices with low denial rates will have lower ADR limits. And practices with high denial rates will have higher ADR limits.

The ADR limits will be adjusted as a practice's denial rate decreases, CMS says. That will ensure that providers complying with Medicare rules have fewer RAC reviews, CMS says.

The previously permitted ADR limit amounted to 2% of all claims submitted for the prior calendar year, divided by eight. RACs had been allowed to send a maximum of 400 requests per 45 days to a practice; for providers with more than $100 million in MS-DRG payments, the requests were capped at 600.

- **Apply ADR limits incrementally to new providers under review.** Providers had argued that some who were unfamiliar with the RAC program had immediately received requests for the maximum number of medical records allowed.
- **Complete complex reviews and notify providers of findings within 30 days.** Previously, providers waited 60 days before being notified. This change offers more immediate feedback to providers about the outcome of reviews, CMS says.
- **Wait until after the second level of appeal is exhausted before receiving a contingency fee.** Previously, RACs were paid immediately upon denial and recoupment of claims. Creating a delay in payment will assure providers that RAC decisions are correct based upon Medicare statutes, coverage determinations, regulations and manuals.
- **Face consequences for having high appeal overturn rates.** RACs will be required to have an overturn rate of less than 10% at the first level of appeal, excluding claims denied because of no or insufficient documentation or claims corrected during the appeals process. If a RAC fails to have a low overturn rate, CMS

Subscriber information

Here's how to reach us:

EDITORIAL
Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice president: Tonya Nevin
1-301-287-2454
tnevin@decisionhealth.com

Content manager, medical practices:
Karen Long, 1-301-287-2331
klong@decisionhealth.com

Editor: Roy Edroso, 1-301-287-2200
redroso@decisionhealth.com

Editor: Richard Scott, 1-301-287-2582
rscott@decisionhealth.com

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email to: *customer@decisionhealth.com*

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: *www.partbnews.com*. Also, follow us on Twitter, @partbnews.

CEUs
Part B News is approved, through Dec. 31, 2015, for AAPC CEUs. Credential holders can earn 0.5 CEUs by passing each five-question quiz, for up to 12 CEUs per year. For instructions on how to access the quizzes, log on to *www.partbnews.com/home/ceus_read_more*.

ADVERTISING
To inquire about advertising in *Part B News*, call 1-301-287-2230.

Part B News® is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of UCG. *Part B News* is published 48 times/year by DecisionHealth, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $597/year.

will place it in on a corrective action plan that could include decreasing ADR limits or ceasing certain reviews.

- **Provide more public information about the RAC program.** CMS plans to provide increased public reporting of data such as appeals, quality assurance activities and timeliness standards, the federal Medicare agency says.
- **Have a provider relations coordinator** as a point of contact when providers have complaints or concerns about the RAC program.

CMS previously announced that Latesha Walker would serve as that coordinator. Practices with review process concerns or suggestions can email her at *RAC@cms.hhs.gov*.

In addition, CMS is considering developing a provider-satisfaction survey that would give practices and other providers an opportunity to provide feedback about RAC performances. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Resource:

- Changes CMS made to the RAC program: *http://go.cms.gov/1kckzVN*

Coding

Follow these 5 tips on modifier 25 to correctly bill separate E/M services

When a patient in for a procedure requires additional services, you'll want to make sure same-day E/M services are distinct and documented comprehensively to avoid a modifier **25** denial, which accounts for millions in denied claims annually.

The Office of Inspector General (OIG) reports that approximately 35% of claims submitted with modifier 25 are done incorrectly, according to a recent CMS-administered webinar. In fact, your practice may have received a Comparative Billing Report (CBR) in the mail detailing your use of 25 as compared with that of your peers; eGlobalTech, a CMS contractor and partner of Part B contractor Palmetto GBA, delivered 25-related CBRs to approximately 10,000 physician practices in November.

The CBRs were delivered to physicians for "educational purposes," but the big price tag associated with 25 underscores the fed's focus — the 15 most commonly billed codes with modifier 25 are linked to more than $126 million in denied claims, according to 2013 Medicare data, the latest available (*see benchmark, p. 5*).

CMS is "looking at it more closely," says Betsy Nicoletti, president, Medical Practice Consulting, Springfield, Vt. Think your same-day E/M services are legit? Then follow these tips to correctly bill E/M services that occur on the same day as a separate procedure and maintain your reimbursement amid heightened scrutiny.

- **Ensure what the E/M service covers is unrelated to the procedure.** This is the letter of the law. The National Correct Coding Initiative (CCI) Policy Manual, an annual CMS publication, states that modifier 25 may be used with an E/M code "to indicate that the E/M service is significant and separately identifiable from other services reported on the same date of service."

Said another way, you can bill an additional E/M service if that service goes beyond the initial minor surgical procedure (e.g., skin lesion removal) or preventive medicine service (e.g., annual wellness visit). "Modifier 25 should be reserved for the unexpected and unrelated," explained Cyndi Wellborn, RN, Palmetto GBA lead analyst, during the webinar.

Consider this example: If a patient shows up at your office for a follow-up visit to an episode of hypertension but also complains of a skin lesion and you remove the lesion the same day, you should code for the surgical procedure as well as the E/M code for hypertension diagnosis using modifier 25.

But, in most cases, without the extra diagnosis, do not use 25. "If they're coming in strictly for a procedure, there's no need to have an E/M with it," advises Maxine Lewis, consultant with Medical Coding and Reimbursement in Cincinnati. To extend the above example, if a patient comes in to have a skin lesion removed and no other needs arise, do not bill an E/M too.

However, in some situations, you can perform a procedure and conduct a diagnosis on the same day and get paid for it — simply look to your evaluation level. Nicoletti offers the following example: An anemic patient enters the ER, and an endoscopy reveals bleeding in the stomach. In this case, you're safe to bill an E/M in addition to the endoscopic procedure. "If you have to evaluate the condition, then you can get paid for it," says Nicoletti.

- **Audit your own medical records to make sure your same-day E/M documentation stands up to scrutiny,** suggests Palmetto. When in the medical records, use a marker to cover up the documentation for the given procedure — what's left "should be enough to support a significant level of service" for the separate E/M that you billed.

• **Use modifier 25 carefully with annual wellness visits (AWVs) and other preventive services.** High denial rates afflict preventive services used with modifier **25** — a 23% denial rate for **G0438** (Annual wellness visit; includes a personalized prevention plan of service [pps], initial visit) and 19% for **G0402** (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment), which accounted for more than $8 million in denials in 2013. But the Medicare Claims Processing Manual makes it clear: When you provide a "significant, separately identifiable medically necessary E/M service in addition to the IPPE or AWV, CPT® codes **99201-99215** may be reported."

But be careful with the documentation on your designated E/M service, warns CMS. "Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service."

• **Understand the global period of surgery and use 25 only if another service arises.** Be careful about billing a separate E/M service on the same day as a minor surgery (e.g., endoscopy). Do not use modifier 25 to submit a claim for a physician visit on the same day of the minor surgery, as this same-day visit is "always included in the global surgery package," says CMS. Use 25 only if the E/M service goes "beyond the usual pre-operative and post-operative care associated with the procedure or service."

Mind the global surgical period of the service provided to make sure you're not billing twice. Surgical packages are based on the number of post-operative days. The chart below shows payment surgery indicators and associated global period.

Payment surgery indicator	Post-op/Pre-op period
000	0 days post-op (endoscopy or some minor surgeries)
010	10 days post-op (other minor procedures)
090	90 days post-op; 1 day pre-op (major surgeries)
YYY	Contractor-priced codes; 0, 10 or 90 days post-op

Look to the post-op days to know when to bill a separate E/M. Do not bill a separate E/M for services that fall within the post-op or pre-op period. For procedures with indicator 010, for example, do not bill a service related to the recovery of the procedure within 10 days of the surgery.

Do use 25 if the patient requires a significant, separate E/M during the pre-op or post-op period. You do not need to report a different diagnosis to use 25, but you'll need to make sure the E/M service is medically necessary, according to CMS guidelines.

You do not need to use 25 for new patient codes **92002, 92004,** 99201-99205, **99281, 99285, 99321-99323,** and **99341-99345**. New patient codes are automatically excluded from the global surgery package and therefore reimbursed separately without the need for a modifier, according to NCCI.

• **Let non-physician practitioners (NPPs) conduct services and use 25.** Using modifier 25 is not limited to physicians. NPPs have the green light as well. Just remember that the same NPP must provide both the E/M and procedural service to the same patient to be reimbursed. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- National Correct Coding Initiative: *www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/*
- Comparative Billing Report, Modifier 25: *http://cbrinfo.net/cbr201409.html*
- Medicare Claims Processing Manual, Chapter 12: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*

Open Payments

More CME payments to providers may be reportable under CMS clarification

A clarification from CMS on Open Payments and continuing medical education (CME) leaves your physicians vulnerable to more nettlesome associations with drug and device companies online.

CMS removed its previous reporting exemption for fees paid to providers who serve as speakers in a CME context, according to the final 2015 Medicare physician fee schedule released Oct. 31 (*PBN 11/10/14*). But that rule also says that payments reaching providers via CME events are not reportable if the manufacturer does not "provide the payment or other transfer or value in whole or in part to a covered recipient," which has been taken by some to mean that as long as the manufacturer does not direct the

Benchmark of the week

Top denial rates of modifier 25 include low-level E/M, preventive services

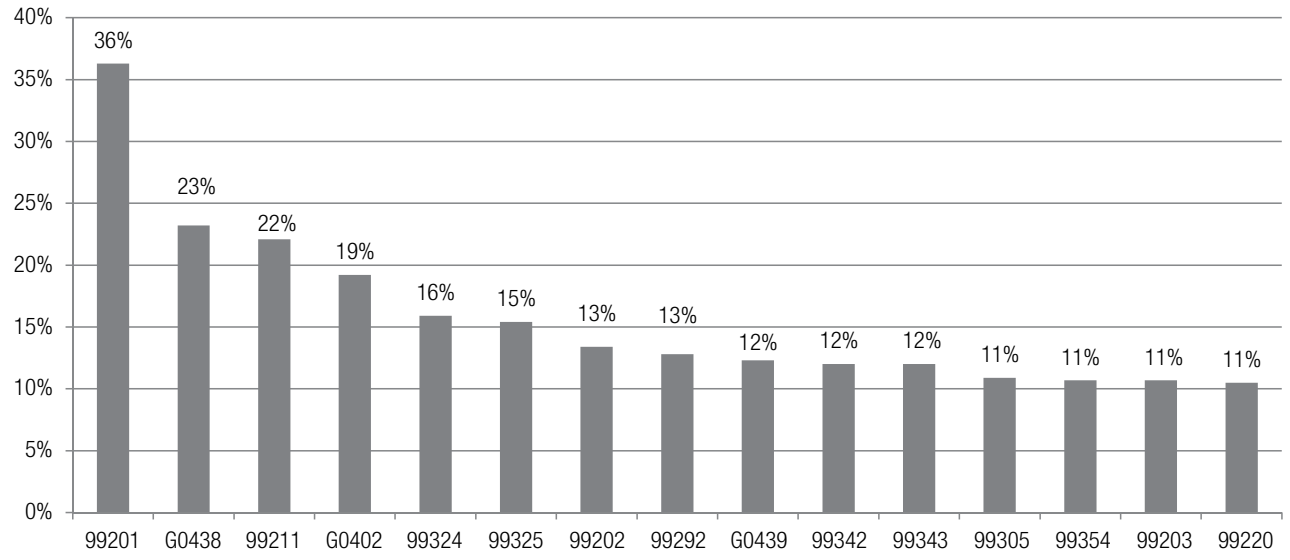
Modifier **25** (Significantly, separately identifiable E/M service) is linked to hundreds of millions of dollars in denied claims annually, according to an analysis of 2013 Medicare data, the latest available.

Of the 50 most-billed E/M services using modifier 25, the chart below depicts the 15 codes with the highest denial rates. Leading the way is **99201**, which sees a 36% denial rate when appended with modifier 25. Two of the next three codes on the list deal with preventive services — **G0438** (Annual wellness visit; includes a personalized prevention plan of service [pps], initial visit), which is denied at a 23% rate, and **G0402** (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment).

Code **99211**, used for established patients, is the clear front-runner in terms of bulk of services combined with a high denial rate. In 2013, practices billed 99211 with modifier 25 more than 1.5 million times and witnessed a 22% denial rate equating to more than $14.4 million in lost dollars.

The remainder of the list is comprised of home visit codes, other lower-level E/M codes, a third preventive service code and nursing facility care, among others. All told, the denied claims for these 15 codes alone account for more than $126 million. — *Richard Scott (rscott@decisionhealth.com)*

Denial rates of commonly billed E/M services using modifier 25



Source: Part B News *analysis of Medicare claims data*

CME vendor to pay the specific provider, no reportable relationship exists.

The new guidance, however, says that starting in 2016, an "indirect payment" — such as one that goes to a CME provider who in turn pays a physician for speaking — may be reportable the following year if the manufacturer "knows or finds out the identity of the physician attendees/speakers within the reporting year or by the end of the second quarter of the following reporting year."

In other words, if a drug company pays a CME event provider, and your doctor speaks for the event provider and is paid by them — and the drug company eventually finds out where its money went — your doctor could wind up listed on the Open Payments site as having received a payment from the drug company.

Payments to CME providers are not generally reportable if they're in the form of an "unrestricted grant" — that is, not earmarked for continuing medical education as a condition of grant, points out Judy Waltz, partner at Foley & Lardner in San Francisco. But if the unrestricted money gets used for speakers' fees, a provider gets it and the payer finds out, the new guidance suggests that's reportable.

'Knew or should have known'

After the guidance was released, medical education advocacy group The CME Coalition complained this was

"inconsistent" with the final rule — specifically citing the line, "we did not intend to remove the exclusion regarding subsidized fees provided to physician attendees by manufacturers at continuing education events" — and the Coalition "believe[s] this creates the need for further clarification."

Ominously, CMS says in one of its guidance scenarios that these payments are also reportable if a manufacturer "is able to determine who the physician speaker was" who received their money through the CME company after the fact. The phrase "able to determine" suggests that if it's possible for the manufacturer to find that out, it's incumbent on him or her to do so and then report under "the legal standard of 'knew or should have known,'" says Jennifer Searfoss, CEO of SCG Health, Ashburn, Va.

"A CME vendor is not a reporting entity in Open Payments — it is manufacturers and GPOs [group-purchasing organizations]," says Waltz. "But they might be surprised to see themselves reported at all if they thought they were doing something for a CME vendor and it turned out they had a report on the Open Payment database. Hopefully, CME vendors will be sharing this information up front with the physicians, to the extent that they have any objection in terms of reports."

Be prepared

Waltz thinks these new reports shouldn't cause too many headaches. Both manufacturers and physicians have already "been through a cycle of reporting now," she says, "… so presumably folks are getting used to the idea that payments or transfers of value from the industry will be available to the public."

Providers should prepare to explain themselves to curious patients and press — for example, "I was paid to educate my fellow physicians; I have no direct connection with the company," says Paul Meade, president and founder of Thought Leader Select, a consultancy to the biopharmaceutical, medical device and diagnostics industries in Chapel Hill, N.C. — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- CMS guidance on Open Payments and CME: *www.cms.gov/OpenPayments/About/Law-and-Policy.html*
- CME Coalition statement: *www.cmecoalition.org/news/cms-releases-sub-regulatory-guidance-on-continuing-education-events-and-the-sunshine-act*

Quality reporting

(continued from p. 1)

The spreadsheet provides instructions for searching by measure number, NQS domain, reporting method and keywords. Note that if your Excel program's filter function does not provide a search bar, use the "Text Filter" function and select "Contains" to search and display relevant measures.

Here are four more ways you can use the spreadsheet:

- **Crosswalk reporting methods.** Moving from one reporting method to another, such as claims-based to

electronic health records (EHR), may not require staff to learn new measures. To determine which measures may be reported by both methods in 2015, go to the spreadsheet's Reporting Method(s) columns (K-P) and use the filter function for the claims-based (K) and EHR (M) columns.

You can refine those search results by performing a word search in the "Measures Description" column. For example, a practice that has reported Measure #130 (Documentation of current medications in the medical record) using claims could search for "Medication" and find that the measure also can be reported by EHR.

- **Pin down NQS measures.** You must include at least three NQS domain measures in the PQRS mix. First, use the filter function for the Measure Title column (A) to create a list of the nine measures alone. For example, a practice that intends to use registry reporting selects:

1. Documentation of current medications in the medical record.
2. Falls: Risk assessment.
3. Osteoarthritis (OA): Function and pain assessment.
4. Pain assessment and follow-up.
5. Pneumonia vaccination status for older adults.
6. Preventive care and screening: Body mass index (BMI) screening and follow-up plan.
7. Preventive care and screening: Tobacco use: screening and cessation intervention.
8. Preventive care and screening: Unhealthy alcohol use — screening.
9. Use of high-risk medications in the elderly.

A review of the NQS Domain column (F) for the shortened list confirms that yes, the measures fall into three domains:

1. Community/population health.
2. Patient safety.
3. Person- and caregiver-centered experience and outcomes.

- **Verify cross-cutting measures.** To make sure that the list of measures also contains at least one cross-cutting measure, filter column R to show the selected measures that are also cross-cutting measures. Five of the measures in the above example qualify.
- **Review measures groups.** Medicare made a number of changes to the measures group option in 2015. To review the individual measures in each of the 22 measures group sets, perform a word search or filter in the Measures Group(s) column (Q). Because some measures appear in several measures groups, if you select the group name from the filter list, you may receive only some of the results. For example, selecting General Surgery from the list will retrieve five individual measures. A search for "General" will return all seven measures in the group. — *Julia Kyles (jkyles@decisionhealth.com)*

Resource:

- PQRS 2015 Measure List: *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_2015_Measure-List_111014.zip*

ICD-10 restart

(continued from p. 1)

regimen last March, including four-hour dedicated sessions, dummy claims with realistic medical scenarios and integrated testing with their various providers, says Deborah Graham, senior analyst/programmer at the health system (*PBN 3/17/14*).

But "when Congress delayed ICD-10, UMass let all the consultants go and removed the budget," Graham reports. "Now, we are testing with payers on a one-by-one basis and doing it with fewer people, no dedicated team and no budget. It is considered to be just one more task on our to-do list as opposed to being *the* item on the to-do list."

Most of the large providers Beacon Partners works with "have maintained momentum, though some more than others. On the other hand, I know some small or medium-sized practices may not have even started [ICD-10 prep]," says Yvonne Dawdy, executive consultant with Beacon Partners in Weymouth, Mass.

If you haven't returned to ICD-10 action, get back to it fast, experts say. In many cases, you'll have to generate compliant ICD-10 orders before the transition, says Dawdy. "I may schedule a surgery in August, but it may not be delivered till October," she says.

Start testing ICD-10 claims

CMS' end-to-end testing, which closely simulates real-world transmissions, is your best bet for preparing (*PBN 3/17/14*). But CMS has caps on the number of providers it will include in each round of testing — for the coming round of testing this month, it's 850 providers nationwide. That doesn't leave a lot of room for you. But CMS has extended the application deadline to Jan. 21 for its upcoming April 26 to May 1 end-to-end testing. Forms are available at *www.cms.gov/Research-*

Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map.

Here are two tips to test your claims even if you're not part of the official program:

- **Check with your contractor.** Though CMS ordered the end-to-end testing, contractors are administering it and you can get in touch with them directly to find out whether they offer more opportunities. CGS spokesman Adam Myrick says that contractor will have end-to-end testing in July for providers in its jurisdiction, and CGS will post an application form on its website in April. That too will have caps, but many of your peers may not notice when this rolls out, which would increase your chances.

Even if you can't get end-to-end testing, ask your contractor about acknowledgment or simple transmission testing, says Summer Scott Humphreys, executive consultant at Beacon Partners. It's better than nothing.

- **Check with private payers.** Even after the delay, says Michael Bearnson, ICD-10 project manager at ADP AdvancedMD, some commercial payers have been opening up testing to anyone who wants to test. But some have grown more selective. "The bigger carriers are saying they want to do targeted testing — that is, with just their higher-revenue clients," he says.

But you may be able to change their minds. David Zetter, president of Zetter Healthcare Management Consultants, Mechanicsburg, Pa., got a commercial payer to do end-to-end testing with one of his cardio practice clients — basically by asking. "They weren't having much success getting end-to-end testing, so I contacted VPs at three different commercial payers and negotiated," he says. The cardio practice is "big and busy," which gave them some leverage, says Zetter. But whatever your status, it never hurts to ask, he says. Get phone numbers from your payers' websites and start calling.

Make internal improvements before testing

In addition to working with partners, make sure you've got your own house in order too. "If you're not ramped-up to produce the right codes to submit for testing, then testing is a waste," says Sue (Sunni) Patterson, co-founder of revenue cycle management consultants RMK Holdings in Chicago. Set up these internal checks:

- **Crosswalk your codes.** "Build an ICD-9 code report from your PMS [practice-management system] and then build a crosswalk to ICD-10 for every one of those codes," says Zetter. Resist the temptation to just "buy a crosswalk off the Internet," he says. "You'll get the standard codes, but you won't get your codes. No two practices are the same."
- **Do chart audits for documentation.** "Have five to 10 charts reviewed for documentation to see how your providers' current habits are," says Zetter. "And I don't mean the diagnosis code; I mean the diagnosis because you have to code from the diagnosis, and that's what payers will audit to deny on grounds of medical necessity."
- **Check all the touch-points.** "Look at every position in the practice to see how they deal with ICD-9," says Zetter. Even the front desk has to be considered because ICD-10 affects how they take down information — "not just that a patient has a broken leg, but how they broke their leg, where they broke it, etc.," Zetter says.

Also check the tools and forms relating to the process. For example, make sure your charge slips are able to accommodate all the new information requirements, says Bearnson.

Money problems

Finally, be aware that even if you do everything right, the transition will not be snafu-free, and that will cost money. Shore up some cash or a line of credit to use if your cash flow is impeded by botched or delayed claims in early days, advises Kent Smith, vice-president of sales of RCM company MediRevv, Coralville, Iowa.

You can be proactive about this and head off some anticipated ICD-10-related cash drains. For example, Humphreys has seen providers and payers add a stopgap provision to their contracts — "a true-up so if there's a sudden cash drop-off [because of ICD-10 issues], you'll still get some payment," she says. Typically the payers agree to forward the provider a percentage of the expected payment if there are delays because of payer handling of the new claims.

Also, you can revisit your software vendor contracts "to determine if they also include remediation post-conversion, and work out a contingency plan so they respond quickly," so if your claims software botches your claims you can be sure it will be fixed promptly, says Patterson. Like the end-to-end testing, these involve some negotiation, but it never hurts to ask.

— Roy Edroso (redroso@decisionhealth.com)

How did you get this email?

It is illegal to forward **Part B News Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Part B News Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk,** not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Steve McVearry at 1-301-287-2266 or email him at *smcvearry@ucg.com*. Copyright violations will be prosecuted. And **Part B News** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Part B News Online** or photocopying of our newsletter.