

SAWC FALL
THE SYMPOSIUM ON ADVANCED WOUND CARE

SEPTEMBER 16 - 18, 2009
GAYLORD NATIONAL HOTEL AND CONVENTION CENTER
WASHINGTON, DC

Current Issue
Archived Issues
E-newsletter sign up
Subscribe

Search

Podiatry Today

- Home
- Current Issue
- Archived Issues
- Print Subscriptions
- Letters to the Editor
- Author Instructions
- Request 2009 Rate Card
- Request Media Kit
- View Online Media Kit
- Supplements
- E-newsletter
- Reprints, Rights, Permission and Translation
- RSS Feeds
- Hot Topics
 - Diabetic Foot Care
 - MRSA
 - Flat Foot
 - Plantar Fasciitis
 - Heel Pain
 - Diabetic Wound Care
 - Hammertoes
 - Diabetic Foot Infection
 - Orthotics
 - Foot Pain
 - Peripheral Neuropathy

Podiatry Today



2009 Commercial Desk Reference

View the 2009 Commercial Desk Reference for Podiatry Today

How To Provide Physical Therapy As An Ancillary Service

VOLUME: 20 PUBLICATION DATE: Feb 01 2007

Issue Number: 2

Author(s):
By Jonathan Moore, DPM

It should not be news that adding ancillary services to your practice not only improves patient outcomes (if done right) but moreover, ancillary services have the ability to improve your bottom line dramatically. Some estimates state upward of a 60 percent boost or higher to the bottom line. While podiatry has long been familiar with ancillary services like X-ray, vascular testing, nerve conduction testing and ultrasound, physical therapy (PT) has for many years been left off the table.

Why is this? For the most part, it probably comes from confusion over Stark Law, and even more confusion and fear over how to do it. Before we get into the "why" and "how," let us make sure we have an understanding as to what we are not talking about in our discussion of in-office physical therapy.

For many years (and probably currently), podiatrists would randomly employ the use of ultrasound on a patient after an injection or the use of a whirlpool for a patient with a sprained ankle. In fact, many DPMs would have a nurse provide these services after they left the room while subsequently billing the physical therapy codes for this service.

Under current CMS rules, two components must be in place in order for one to bill for physical therapy services of any kind in the office setting without a physical therapist.

One must have a plan of care in place that specifies short- and long-term goals, objectives and specific modalities appropriate for the condition. In addition, services under this plan of care must be provided by someone formally trained in physical or occupational therapy.

Random whirlpool sessions or ultrasound treatments without a specific physical therapy plan of care in the chart is not only inappropriate as an "incident to" service, it is really not something that improves patient outcomes in the long run.

While it is appropriate for podiatric physicians to provide and bill for physical therapy services themselves, it would be difficult to make this economically feasible in most podiatric offices.

Every state has its own rules and guidelines (local carrier decisions) that pertain to physical and occupational therapy. Some states, in fact, have made physician-owned physical therapy illegal by circumventing Stark and employing rules that make it impossible for a physical therapist to take orders from a physician employer.

Furthermore, the model that is presented below is one model. While there are other legal models for integrating physical therapy, the model below is one that I have found to be the most practical for the podiatry office. Consult your local healthcare attorney to decide what model is best for you.



Emphasizing The Potential Benefits Of Physical Therapy

Physical therapy is an integral part of how we treat our patients and if it is not, it should be. Physical therapy as a profession developed due to the initiative of doctors specializing in the field of musculoskeletal medicine who sought to enhance the recovery and rehab of their patients through focused training in exercise.

While we are used to sending these patients out of the office for their therapy, why not be more involved in this area of care? Here are five simple reasons to bring physical therapy into your

Supervision Of Physical Therapy Services: What You Should Know

In-office ancillary services must be furnished personally by the referring physician, by a physician who is in the same group practice or by individuals who are "directly supervised" by one of those physicians.

Although the Stark statute uses the phrases "personal supervision" or "directly supervised," the regulators have interpreted both of these to mean supervised to the extent otherwise required in the Medicare program.

For example, since Medicare physical therapy does not require an on-premises physician for the services to be covered, "direct supervision," according to Stark, does not actually require that a physician be in the office suite. A group could bill for Medicare physical therapy services when the services are provided by a physical therapist employee or an independent contractor who reassigns his or her right to payment to the group. However, if the services are not billed "incident to" the physician, he or she cannot receive credit as the treating physician for those revenues.

What Physical Therapy Equipment May Be Necessary

- Hydrocollator- \$895.00
- Standard hydrocollator covers x 8- \$162.00
- Cervical hydrocollator covers x 6- \$105.00
- Wall mount for covers- \$94.00
- Ice packs x 6- \$54.00
- Med craft tables x 3- \$882.00
- Med craft bolsters x 2- \$78.00
- Med craft taping table- \$355.00
- Recumbent ergometer- \$1,035.00
- Goniometer x 2- \$39.00
- Ultra lotion 5 liters- \$9.00
- Ultra lotion with hydrocortisone- \$130.00
- Thera-Band exercise x 2- \$89.00
- Thera-Band balance x 2- \$41.00
- Weight, deluxe therapy x 2- \$19.00
- Free up massage cream- \$14.00
- Foot stool x 2- \$86.00
- Rocker board- \$65.00

DPM Blogs



David G. Armstrong, DPM, PhD
[Raising Questions About The Treatment Of MRSA In Hospitals](#)



Molly Judge, DPM, FACFAS
[Why We Need To Take A Closer Look At The Roles Of 'Wound Care Specialists'](#)



Lawrence Fallat, DPM, FACFAS
[Reflecting On The Progress Of Podiatric Residency Programs](#)

[more](#)

All Subscriptions are made to qualified persons.

Subscribe to:

- Journal
- Digital Journal
- E-news
- RSS feed

CLICK HERE TO CONTINUE

[Podiatrist Needed - 6/3](#)

Austin or San Antonio, Texas

[SALE OF PODIATRY PRACTICE - 5/11](#)

[Traveling Podiatrist - 5/6](#)

Various Locations- Indiana-Kentucky, Ohio

CME Showcase

["Current Concepts In Healing Chronic Diabetic Foot Ulcerations"](#)



A Complimentary On-Demand CE/CME Webcast

This activity is supported by an educational grant from Advanced Biohealing.

CLINICAL EVENTS

CALENDAR

Jun 10,2009
Jun 22,2009
Summer Seminar at Sea
Baltic, Scandinavia and Russia
Cruise
Royal Caribbean International –
Jewel of the Seas

<http://www.nwpodiatricfoundatio>

Jun 25,2009
Jun 28,2009
2009 Western Podiatric Medical
Congress
Disneyland Resort Hotel
Anaheim, CA

<http://www.thewestern.org/>

Jun 26,2009
Jun 27,2009
5th Annual Seattle Summer
Seminar

Co-sponsored by ACFAS,
Division II
Swedish Medical Center-Cherry
Hill Campus, 500 - 17th Avenue,
Seattle, WA 98122

<http://www.nwpodiatricfoundatio>

Jun 27,2009
Jul 04,2009
DIAGNOSIS AND TREATMENT
OF FOOT & ANKLE
CONDITIONS
Sea Courses Cruises
Location: Alaska Cruise

<http://seacourses.ensembletrave>
story=20081125160136161

[more](#)

Non-Accredited Education

**Understanding Collagen
Dressings and their Benefit in
Wound Care**

Complimentary
Archived Webcast
non-accredited



office.

1. PT provides an added service and convenience for your patients.
2. PT enhances patient satisfaction as patients have access to superior care overseen by their referring physician or surgeon.
3. Improved outcomes result from better compliance and better service from staff patients are already familiar with in your practice.
4. It reduces errors and over-utilization.
5. PT provides an excellent potential for improving your bottom line.



Overall, in-office physical therapy gives physicians a greater role in the physical therapy services provided to patients, thus allowing the therapists and physicians to work together as a team, exchanging information and sharing ideas. Also, the relationship between therapist and physician affords frequent and immediate feedback to allow for the fine-tuning of therapeutic protocols that serves to improve patient outcomes. A 1993 study comparing on-site physical therapy delivered in physician offices versus other sites concluded that patients who receive on-site physical therapy lose less time from work and resume normal duties more quickly.¹

Without question, the ability to exchange information on a patient in a frequent and timely fashion serves to reduce errors. According to another study, 70 to 80 percent of medical errors are related to interpersonal interaction issues. Interpersonal interaction is critical to patient safety and having better physician/therapist communication is what makes this possible.²

In addition, frequent and timely feedback between therapists and physicians reduces over-utilization of services. Consider the following examples.

1. If the doctor deems the desired outcome to have been achieved, then one can immediately discontinue services.
2. If the doctor determines another therapy modality is appropriate, then one can make a shift in a timely manner.
3. If it appears that physical therapy is not yielding desired results, one can consider other therapeutic techniques, including surgery.

Patients want and should have access to quality, comprehensive and non-fragmented care. Giving patients the option to choose the site of their care is vital and when patients get a choice, most will choose the site with the best outcomes and the most convenient site for them.

Lastly, in-office physical therapy offers patients direct and immediate access to the therapy after you have seen them (incident to). In fact, most of the time, we are able to schedule physician and physical therapy appointments at or near the same time and in the same office. This eliminates the need for patients to travel to two different appointments.

Negotiating The Rules And Exceptions Of Stark Law

Passed in 1989, the Stark I Law established the basics of what many refer to as "the self-referral laws," prohibiting physicians from referring Medicare and Medicaid patients for "designated health services" (DHS) with which the physician has a financial relationship. However, there are many exceptions to the Stark Law, listed as "safe harbors" under Stark's Rules.

While the first Stark Law mostly applied to clinical laboratories in medical physician's offices, the law also had an "in-office ancillary service exception." This exception encompassed services defined in Medicare as ancillary services for items such as in-office laboratory testing which physicians could perform in their own practices.

In 1993, Congress, led by Rep. Pete Stark (D-Calif.), decided that more services needed to be included as exceptions. Accordingly, Congress enacted Stark II, which expanded the list of exception services to include additional "designated health services," one of which was physical therapy services.

There are now nearly 20 different exceptions included under Stark's rules. While they all have their own qualifying provisions and details, for the purposes of DPMs, here is a short list of the exceptions under Stark rules.

1. Physicians' services
2. In-office ancillary services (PT)
3. Prepaid plans
4. Other permissible exceptions as determined and specified in regulations as not posing a risk of program or patient abuse
5. General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds

Under the aforementioned in-office ancillary service exceptions, a physician can refer Medicare patients to a physical therapy center owned and operated by the physician's clinic. However, these services must be performed in the same office suite in which at least one member of the physician group has a physician practice or services must be performed in a location that is used for the centralized provision of the physical therapy services. In order to meet the criteria for the in-office ancillary service exception, your practice must also meet the statute's definition of a "group practice."

What qualifies as a "group practice," according to Stark? A group practice must involve at least two or more physicians who are legally organized in a partnership, professional corporation, foundation, nonprofit corporation or other similar association. A sole proprietorship with employees, which is not "legally organized" as a group, cannot qualify as a group practice under the definition.

Each physician is a member of the group (including shareholders, partners and employees but not independent contractors) must substantially provide his or her normal full range of DHS and other services in the group practice through the joint use of shared office space, facilities, equipment and personnel. These services must be billed under a billing number assigned to the group and amounts received must be treated as receipts of the group. As a whole, the amount of time physician members of the group (excluding independent contractors) spend in work dedicated to the group must average 75 percent.

- Walking belt- \$9.00
- Athletic tape- \$41.00
- Touch test complete foot kit- \$140.00
- Cramer prewrap- \$29.00
- Ultrasound/therapeutic x 2- \$1,500.00
- Elliptical stationary sitting bicycle- \$1,000.00
- Washer/dryer vs laundry service- \$800.00
- Towels/wash cloths- \$250.00

Total = \$7,921.00
Editor's note: According to the author, a desk, chairs, computer, rolling stools and Anodyne equipment were already in place and were accordingly not calculated into this cost estimate.

This activity is sponsored by the North American Center For Continuing Medical Education (NACCME).

To access this Webcast, visit www.naccme.com/program/n-559/

Current Concepts In Diagnosing And Treating MRSA In The Diabetic Foot



This activity is supported by an educational grant from Pfizer. This activity is sponsored by the North American Center of Continuing Medical Education (NACCME).

To access this activity, visit www.naccme.com/program/n-529/

MRSA And Diabetic Foot Wounds: Where Do We Go From Here?



Archived Accredited Webcast with Q&A

This activity is supported by an educational grant from Pfizer. This activity is sponsored by the North American Center For Continuing Medical Education (NACCME).

PERIPHERAL ARTERIAL DISEASE (PAD) AND CRITICAL LIMB ISCHEMIA (CLI):



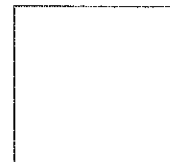
Managing Vascular and Wound Healing Challenges with Current and Emerging Technologies

Archived Accredited Webcast with Q&A

This activity is supported by an educational grant from Baxter Healthcare Corporation.

Podiatry Today News Wire

Coming Soon In Future Issues





With this said, let us take a closer look at the criteria that must be met in order to be compliant under this "in-office ancillary service" exception.

1. The physician must have direct supervision of these services (see "Supervision Of PT Services: What You Should Know" below). Be aware that this criterion disqualifies many practices from being compliant.
2. The therapy must be performed as an in-office ancillary service under your roof. In-office ancillary services must be provided in a building in which the referring physician or another member of the group practice furnishes physician services unrelated to DHS or in another building that is used by the group practice for "the centralized provision of the group's designated health services."
3. The physician must bill these services under his or her billing number.

A Closer Look At Billing And Compensation

The only legal way for a physician group to bill physical therapy services to Medicare is to bill those services as "incident to" physician services. To bill under this method, however, the physical therapist must be employed by the physician group or at least be a leased "common law" employee of the physician group.

Moreover, the physical therapy services must be "incident to" that physician's services. That means the physician must have seen the patient at some time to initiate the plan of care. One may accomplish this by having the initial visit be between the physician and the patient. This visit would then be followed by an evaluation of the patient by the physical therapist pursuant to the physician's designated plan of care.

Any compensation that the physician provides to the non-physician therapist must be calculated in a manner that does not take into account the "volume or value of referrals" between the parties. However, in an almost counterintuitive interpretation of the law, the regulations explicitly state that time-based or unit-of-service-based payments are allowed "even when the physician receiving the payment has generated a payment through a DHS referral."

So you have your framework in place and you have your team on board. Where do you go from here?

A Guide To The Economics Of Hiring Physical Therapy Staff

This very much depends upon your needs and your location. In my case, I found the best therapist in my area and asked him to be a part of my physical therapy program. Considering the fact that he had nothing to lose and everything to gain, it was not a hard decision for him. Remember, quality is key. Find someone you can trust with your patients. Also, finding someone part-time may be easier than finding a full-time physical therapist. Many larger groups will often hire a full-time physical therapist while others might hire a physical therapist as a part-time contract employee (as specified by Stark Law).

Physical therapists earn an average of more than \$30 an hour or about \$65,000 to \$70,000 a year, according to the Bureau of Labor Statistics. Considering the expense of hiring a full-time physical therapist and the fact that the only physical therapy that can be performed under your oversight is lower extremity physical therapy, you may have a hard time hiring a PT initially.

There are several vital factors that come into play when it comes to getting your physical therapy program off the ground. Here is a sampling of questions:

1. What equipment do I need to start?
2. What ICD-9 codes are the most appropriate to drive the provision of efficacious CPT code choices?
3. How do I refer and manage physical therapy patients in my PT program?

One consideration is to start off with a part-time physical therapist who will perform all of the initial and follow-up evaluations while leaving most of the day-to-day therapy to a PT assistant. A PT assistant can work full time under the oversight of your part-time physical therapist. Oversight by the physical therapist is not mandated by private insurers or Medicaid. However, Medicare patients (according to most interpretations of Medicare rules) must have direct physical therapist oversight. A physical therapy assistant cannot take orders from a DPM. Accordingly, in regard to overall physical therapy overhead, one would need to add a \$12 to \$15 per hour physical therapy assistant who will be the primary face of your physical therapy program.

Again, make sure your state allows a physical therapy assistant to work under a physical therapist. Some states may have rules that necessitate the physical therapist to be present at all times during the care of the patients in your office. Most states allow the PT assistant to work independently as long as the overseeing physical therapist is available via phone.

Weighing The Additional Costs Of Space And Equipment

Physical therapy equipment varies tremendously in size, function, sophistication and cost. Your menu of services and your therapist's preferences will dictate your equipment needs. A therapy table is a must. Other basic pieces might include bands, weights of varying sizes, a wall pulley system, hot and cold therapy supplies, and an exercise bicycle. Most podiatric therapy centers will also have ultrasound and electrical stimulation equipment.

For further information on equipment types and prices, be sure to do some comparison shopping on the Internet. Vendors include RehabShopper.com and Advantage Medical and Supply (www.advantagemedical.com). For a more practical list of what you need to start your physical therapy program, see "What Physical Therapy Equipment May Be Necessary?" below.

As for space, a room as small as 300 square feet may do but much will depend on the therapist and the range of service you need for your base of patients. Keep in mind that you should only be doing lower extremity physical therapy for your patients so this will dictate the kind of equipment you need.

In our office, we set aside approximately 650 square feet to accommodate four physical therapy tables, an ergometer, two therapeutic ultrasound stations, an Anodyne® (Anodyne Therapy) station and full office section for the therapist.

Keep in mind that when initial evaluations are being performed on a new patient, a treatment room or an enclosed area for privacy is always best.

Keys To Fulfilling Staff And Training Needs

Aside from the therapists, make sure your existing staff can accommodate the additional patient volume and billing work. You may also need to increase a staffer's hours or hire part-time help. Your biller may also require training to understand the time-based CPT codes and nuances of billing for multiple services provided in one therapy session. The American Medical Billing Association offers an online basic course (www.medicalbillingcourseonline.com/ptcourse.htm). Also, when you do find the

therapist you want to work with, make sure he or she is appropriately trained and understands what your expectations are in regard to specific modalities, documentation and follow-up.

The better communication that exists between you and the therapists, the better care your patients will receive.

How you start and build your physical therapy program is up to you but there are services available that can offer "turn key" solutions to get your program off the ground both legally and efficiently. One such business is Thera Med Systems, a Florida company that specializes in the implementation of rehab and its associated services, enabling a relatively low cost.

Remember, if you cannot offer better lower extremity physical therapy than anyone in your area, you should not be doing it. Patient outcomes and satisfaction should drive your therapy program in all aspects.

Finally, there are a few other considerations with regard to the importance of staffing. Some carriers require pre-certification and the initial physical therapy evaluation prior to approving visits, and it is vital for your staff to know what and when to ask. I recommend that your staff call to establish whether pre-certification is required for all of your private insurers.

It is important for your staff never to forget to tell patients about the co-pays and deductibles that may be required at time of service. Many private insurance companies require a co-pay upon each physical therapy visit. Ensure that your staff makes the patient aware of this upon making the appointment and also make sure your staff collects the co-pay upon each physical therapy visit.

Getting A Handle On Potential Costs And Reimbursement

Aside from the costs of building an addition or modifying the infrastructure of your office setting, and apart from labor and attorney fees, your cost in starting your physical therapy program can range between \$5,000 and \$10,000 (depending on how elaborate you get with your equipment). Remember that used equipment is okay as long as it functions well.

In addition, one can expect to spend around \$3,000 to \$5,000 in healthcare attorney fees, which will be money well spent as you formalize your plan. The good news is that for lower extremity physical therapy, expensive pulley systems, elaborate weights and upper body tools will not be needed.

As far as expenses for your physical therapists and other labor charges, you need to negotiate these rates based on the advice of your healthcare attorney to make sure they are compliant with Stark regulations. Many experts recommend reimbursement upon a "per unit" basis but make sure there are no volume incentives or bonuses in their compensation.

CPT codes for physical therapy services range from 97001 (Initial evaluation) through 97799 (physical medicine procedure). Medicare fees vary by geographical location but for an initial evaluation, reimbursements range from \$69 to \$88. For most common treatment codes, the range is \$25 to \$32 per unit of service. However, for some common codes, including 97032 (electrical stimulation) and 97035 (ultrasound therapy), reimbursement can fall well below that range.

The units of service, which apply to many of the codes, represent periods of time that seem straightforward but they are not. Moreover, when providing multiple services in one visit, you may be able to bill for some services but not others. For an idea of the billing limitations and complications involved, see the explanatory outline of billing scenarios by CMS at www.cms.hhs.gov/TherapyServices/02_billing_scenarios.asp#To.

Also keep in mind that the 2006 Medicare cap for outpatient physical therapy and speech language pathology combined is \$1,740. Accordingly, it is important to ensure your patients and billing staff keep these figures in mind in order to avoid trouble.

Key Insights On Revenue Potential

Your profit potential will depend mostly on the number of referrals you put into your physical therapy program along with the managed care payers' reimbursement for the services you will provide. Next, conservatively estimate the number of patients you are likely to refer for physical therapy in a week. Base this on your past referral habits and use the Medicare reimbursement rate for those services as your guide. Take your labor costs per patient you see per month (our labor costs range between \$270 and \$290 per patient, per month). You will need to estimate the number of modalities performed per visit (usually three) and then break down the numbers.

Here is an example to consider.

- Assume five patients with the same diagnosis (plantar fasciitis) are referred into your office's physical therapist per week for an entire year.
- Assume those five patients attend all 12 visits within a given month (three visits per week for four weeks).
- Assume the same standard set of modalities is utilized (ultrasound, etc.) for each patient (three per visit).
- Assume your expenses per patient per month (\$270) are the same.
- Average all of the insurance reimbursements (Medicare, Medicaid and privates).
- Consider into the equation the average reimbursement for an initial physical therapy evaluation and re-evaluation.

Total reimbursement per patient per month (12 total visits) after your expenses (\$270 per patient per month): \$1,115

Then factor in five of the same plantar fasciitis patients per week for one year: \$1,115 X 5 patients X 12 months =

Total profit for those five plantar fasciitis patients referred weekly for 12 months: \$60,000 to \$67,000.

Consider the following factors regarding the above scenario. First, not every patient will attend every visit prescribed. Some will attend half of their visits while other may attend all. Second, there will be some occasions when only two modalities are performed in a given visit. Third, take into account that other diagnoses (like postoperative rehabilitation) will reimburse less per modality due to the type of modalities used. If the patient receives Anodyne therapy (which is now not covered by Medicare), this will decrease revenue for that regimen of therapy. Fourth, your labor costs per patient per month will greatly dictate your overall profit. Fifth, some insurers will bundle modalities and thus only pay for two instead of three. Your billing staff will understand this as many insurers will only pay for the least reimbursed modalities of the three.

Final Thoughts

Physical therapy is a designated health service regulated by Stark laws so you must proceed

carefully to make sure your setup qualifies under the in-office ancillary exception. You will need expert legal guidance to make sure you do not violate federal or state anti-kickback statutes. As long as you proceed cautiously and focus your program on patient outcomes, you have a great chance to succeed.

As a reminder, the service you provide to Medicare and Medicaid patients must be billed either by the physician rendering or supervising it, by his or her group, or by an entity that is wholly owned by the physician or his or her practice.

You cannot distribute ancillary-derived profits in proportion to the percentage of referrals a doctor makes to that service. For instance, if one partner in a four-doctor group makes 50 percent of the referrals to its X-ray service, the doctor cannot get half of the profits from that service. Profits must be divided without regard to the volume or value of referrals.

Integrating physical therapy into your podiatric medical practice can be incredibly rewarding in many ways but there are certainly challenges. In our office, physical therapy has been a natural fit for our group practice of four. While providing physical therapy provides excellent additional revenue, I think it is more important that we can say with confidence that our practice provides the best lower extremity physical therapy in town.

Dr. Moore has a master's degree in medical education and is a former University of Texas Diabetic Foot Fellow practicing in Somerset, Ky. He is a board member of the American Academy of Podiatric Practice Management.

References:

1. Hackett GI, Blundred P, Hutton JL, O'Brien J, Stanley IM. Management of Joint and Soft Tissue Injuries In Three General Practices: Value of On-Site Physiotherapy, Br J Gen Pract. 1993 Feb; 43 (367): 61-64.
2. Interdisciplinary Teamwork Is a Key to Patient Safety in the Operating Room, ICU, and ER, Agency for Health Care Research and Quality, available at 222.ahcpr.gov/research/jan04/0104RA25.htm.

Start Page:

36

End Page:

43

Average:

No votes yet

[Email this page](#)

Post new comment

Comment: *

Empty text area for user comment.

- o Web page addresses and e-mail addresses turn into links automatically.
 - o Allowed HTML tags: <a> <cite> <code> <u> <dl> <dd>
 - o Lines and paragraphs break automatically.
- [More information about formatting options](#)

CAPTCHA

This question is for testing whether you are a human visitor and to prevent automated spam submissions.

N X M 2 i

What code is in the image?: *

Copy the characters (respecting upper/lower case) from the image.

Preview comment Post comment

REVIEW OUR OTHER HMP BRANDS Check out our other resources for healthcare professionals of all specialties.



HMP Communications LLC (HMP) is the authoritative source for comprehensive information and education servicing healthcare



professionals. HMP's products include peer-reviewed and non-peer-reviewed medical journals, national tradeshow and conferences, online programs and customized clinical programs. HMP is a wholly owned subsidiary of HMP Communications Holdings LLC. ©2009 HMP Communications