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IN THIS ISSUE

Patient encounters 1
Human trafficking victims: Know the signs and what to report

Billing 1
CCI edits bundle biopsy codes, revise prolonged service billing caps

Common coding challenge 2
4 tips to ease task of querying clinicians on coding matters

Ask *Part B News* 2
Non-compete clauses may not bind; give the judge some leeway or lose all

***Part B News* brief** 3
MGMA comes out strong for delay in E/M changes, making AUC voluntary

Benchmark of the week 5
Prolonged codes for clinical staff go largely unused, face high denials

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

Patient encounters

Human trafficking victims: Know the signs and what to report

Your practice should be up to speed on your obligations involving human trafficking. Odds are that you've probably treated a human trafficking victim— even if you didn't realize it.

Human trafficking is the use of force, fraud or coercion to subject victims to engage in commercial sex or forced labor. It affects almost 21 million individuals worldwide and has been reported in all 50 states, according to the National Human Trafficking Resource Hotline (NHTRH).

Human trafficking is not limited to the poor or women; it affects men and boys as well as all classes, races, ages and

*(see **Patient encounters,** p. 4)*

Billing

CCI edits bundle biopsy codes, revise prolonged service billing caps

Alert your billing staff to the latest Correct Coding Initiative (CCI) edits, which add 942 new code bundles mostly targeting surgical codes across a range of CPT and HCPCS families. Effective Oct. 1, the CCI version 24.3 update also brings nearly 150 revised medically unlikely edits (MUEs), which change established service-unit caps.

A large swath of the CCI updates bundles biopsy codes into procedure codes, sometimes with a "0" modifier, which restricts billing on the same date of service (DOS), and other times with

*(see **Billing,** p. 7)*

Common coding challenge

4 tips to ease task of querying clinicians on coding matters

When you must approach your physician with a coding question, keep these four points in mind to ensure an efficient response with a minimum of fuss, advises Erica Remer, M.D., a nationally known expert in clinical documentation improvement (CDI):

- You are not questioning their judgement; you are helping them get credit for taking care of complex patients.
- At the same time, it's best not lead off with how the query will impact reimbursement, Remer says. Instead, stress the need to clarify when the medical record is imprecise, incomplete, ambiguous or inaccurate, or leaves questions as to clinical validity, she explains. Also, you must seek clarification if medical necessity is not evident in the physician's documentation.
- Acceptable query formats include those that are open-ended (though this may be the hardest for a provider to quickly decipher and respond to), multiple choice or yes/no questions, depending on the type of information you need. Remember, it's important for providers to include the clinical rationale for their answers.
- Remember that clinicians are short on time so make your query clear and concise so the provider can answer it quickly. — *Laura Evans, CPC* (*levans@decisionhealth.com*)

Editor's note: *Dr. Remer specializes in helping coders and their doctors improve communication with each other. She will share her insights, plus numerous examples of successful physician queries, during the keynote presentation at this year's Advanced Specialty Coding, Compliance & Reimbursement Symposium, Oct. 15-17 in Orlando, Fla. Learn more: www.decisionhealth.com/specialtycoding/index.html.*

Ask Part B News

Non-compete clauses may not bind; give the judge some leeway or lose all

Question: *We have non-compete clauses in our doctors' contracts, saying when they leave us they can't practice within a certain radius of our offices for a certain period of time. But lately I've been noticing legal cases in the paper where doctors have challenged their non-competes and judges have released them. What were those practices doing wrong and how can we avoid it?*

Answer: Courts do regularly release providers from their non-competes, also known as restrictive covenants. But that doesn't mean the practices did anything "wrong" — it may just be that the judges felt their requirements were unreasonable. But you can take pre-emptive steps to limit the damage if they do.

First of all, not every state even allows restrictive covenants, and others have very clear radius and duration covenant restrictions. (The Fox Rothschild law firm has

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a good thumbnail guide here: *https://www.foxrothschild.com/content/uploads/2015/05/National-Survey-on-Restrictive-Covenants-July-2017.pdf*.)

But many state laws say these covenants have to be "reasonable," says Glenn P. Prives, attorney with McElroy, Deutsch, Mulvaney & Carpenter LLP in Morristown, N.J. "Then it becomes guesswork because it's an inexact term. So it's possible you will draft a covenant for good reasons and a court will hold it unenforceable."

While most judges will look at what's common in the industry and base their idea of what's reasonable on that, what seems reasonable to you — and seemed reasonable to the provider when they signed the contract — may not meet with their approval.

"Generally courts do not want to [make it so that] an M.D. can't earn a livelihood," says Prives. "They don't want them to have to uproot their lives to make a living, either. There's a lot of case law out there siding with the complainant. I don't think you could put betting odds on it — but be prepared."

3 ways to make covenants stick

Be specific when you draft it. Have your lawyer look at it, of course, and use language and standards that make business sense. For example, says Prives, you should where appropriate make allowances for the provider's specialty. If the provider is a dermatologist, for example, where and for how long you could prohibit them to practice dermatology may vary from where and for how long they could practice general medicine or a sub-specialty such as plastic surgery.

Include "blue-pencil language." Having your covenant thrown out could set a disastrous precedent for your practice. But if your agreement includes what's known as "blue-pencil language," you could minimize the damage. Named for the editor's blue pencil in journalism, this language "acknowledges that if the court sees it as too broad, the court is authorized to narrow the covenant and enforce more narrow terms it deems appropriate rather than dispose of it entirely," says Prives. "For example, you may have three years/20 miles, and they may say, 'not reasonable, but two years/10 miles is,' and they have the authority to impose that" if the agreement allows blue-pencil language.

But heads up: There has to be language in the contract that allows the court to do this, says Prives; "otherwise, the court must either enforce the covenant as written or have no covenant to enforce at all."

Argue your right to a living. When you get to court, argue that allowing the provider to compete for your business would hurt the practice. "Courts understand the need to protect your business interest," says Prives. "That's the reason to have restrictive covenants in the first place! They have agreed that they deserve that protection." — *Roy Edroso* (*redroso@decisionhealth.com*)

Part B News *brief*

MGMA comes out strong for delay in E/M changes, making AUC voluntary

The 40,000-member Medical Group Management Association (MGMA) is asking CMS to rethink its reconfiguration of E/M coding and documentation for Medicare, adding to the growing pressure on the agency to pull back on the controversial proposal, as well as for other changes in the proposed 2019 Medicare physician fee schedule/Quality Payment Program (QPP) rule.

About 170 health care organizations led by the American Medical Association (AMA) as well as individual physicians and coders have expressed concern over the E/M changes (*PBN 9/6/18*). On Sept. 7, MGMA released a 58-page letter of formal comment on the rule addressed to CMS Administrator Seema Verma with several recommendations targeting those changes, including a warning that if CMS chooses to "collapse [E/M] payment rates" and take up the reimbursement slack with "ambiguous add-on payments," it might lead to "potential unintended consequences."

Jennifer McLaughlin, MGMA senior associate director of government affairs, marvels that CMS would consider making such a change so quickly without more preliminary investigation and user feedback.

"This administration has a trend of pushing out RFIs [requests for information]" before making important changes, as it has done with proposed Stark Law reform and for its Direct Payer Contracting model, says McLaughlin (*PBN 7/2/18, 5/10/18*). "Yet with this massive overhaul, they didn't do that."

She notes also that CMS "opens the door in the proposed rule" for a delay by announcing "we are seeking comment on whether a delayed implementation

date, such as Jan. 1, 2020, would be appropriate for our proposals."

MGMA's letter addresses several other concerns with the rule, including implementation of the appropriate use criteria (AUC) standard. That standard, by which ordering professionals in certain settings must consult specified applicable criteria via qualified clinical decision support mechanisms (CDSMs) before using applicable imaging services, has already been delayed once and is slated in the rule to begin in 2020 (*PBN 7/19/18*). MGMA asks for several changes and in fact asks that the program be made "strictly voluntary."

MGMA goes further in a separate letter it and 27 other medical groups, including the American Academy of Family Physicians and the American College of Cardiology, sent on the same date to the U.S. House Ways and Means Committee and its Health Subcommittee, as well as to the Energy and Commerce and Senate Finance Committees, asking for a legislative solution to the burdens of the program.

While AUC was established by the Protecting Access to Medicare Act of 2014 (PAMA), the groups argue, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) obviates the need for a free-standing AUC with its Merit-based Incentive Payment System (MIPS) and Advanced APM (alternative payment model) programs, both of which "hold clinicians accountable for quality and patient outcomes, as well as for resource use." Continuing to require health care professionals "to participate in a stand-alone AUC reporting program, in addition to the cost reduction and value-based activities of the QPP, will be burdensome, duplicative and costly," they further argue.

Comments on the PFS proposed rule were closed Sept. 10. — *Roy Edroso* (*redroso@decisonhealth.com*)

Resources:

- MGMA PFS comment letter to Seema Verma: *www.mgma.com/getattachment/Advocacy/Advocacy-Statements-Letters/Advocacy-Letters/September-7,-2018-MGMA-shares-comprehensive-comme/MGMA-comments-in-response-to-2019-PFS-QPP-NRPM.pdf.aspx?lang=en-US&ext=.pdf*
- MGMA et alia letter to various House committees on Appropriate Use Criteria (AUC): *www.mgma.com/getattachment/Advocacy/Advocacy-Statements-Letters/Advocacy-Letters/September-7,-2018-MGMA-shares-comprehensive-comme/MGMA-comments-in-response-to-2019-PFS-QPP-NRPM.pdf.aspx?lang=en-US&ext=.pdf*

Patient encounters

(continued from p. 1)

abilities. "We have to leave the stereotypes behind. Any patient could be a victim," says Jordan Greenbaum, M.D., with the Institute on Health Care and Human Trafficking, Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta.

Trafficking not on most physicians' radar

Health care providers have a unique opportunity to help trafficking victims. Up to 88% of victims came into contact with a health care provider while they were being trafficked, says Kelly Herron, director, Mission Services and Catholic Identity, Trinity Health in Livonia, Mich., speaking at a recent American Bar Association's Health Law Section conference. This is often where a victim will seek help, adds Daniel Gomez, M.D., an ob/gyn in Fort Lauderdale, Fla., also speaking at the conference.

However, many physicians and their staffs are not aware of the signs of trafficking, let alone their obligations to address it (*see sidebar, p. 7*). According to the NHTRH, 97% of victims who received medical treatment while being trafficked received no information to help them during the health care encounter.

"The number one thing is to become aware," says Herron.

Physicians also mistakenly assume that victims seek treatment only at hospitals and free clinics. In actuality, they often seek treatment in physician offices, even the most opulent ones, says Gomez. And while more than 50% of these visits are to primary care providers and ob/gyns, patients often go directly to other specialists for care.

"All doctors have had these patients in their office even if they don't know it," says Gomez, who admitted that that first time he treated a trafficking victim he didn't recognize the signs.

Know your compliance obligations

What most providers also don't realize is that they have compliance obligations and risks when they suspect or know a patient is a victim of human trafficking. For example, the failure to comply with mandatory reporting requirements subjects a provider to penalties.

Compliance obligations include:

(continued on p. 6)

Benchmark of the week

Prolonged codes for clinical staff go largely unused, face high denials

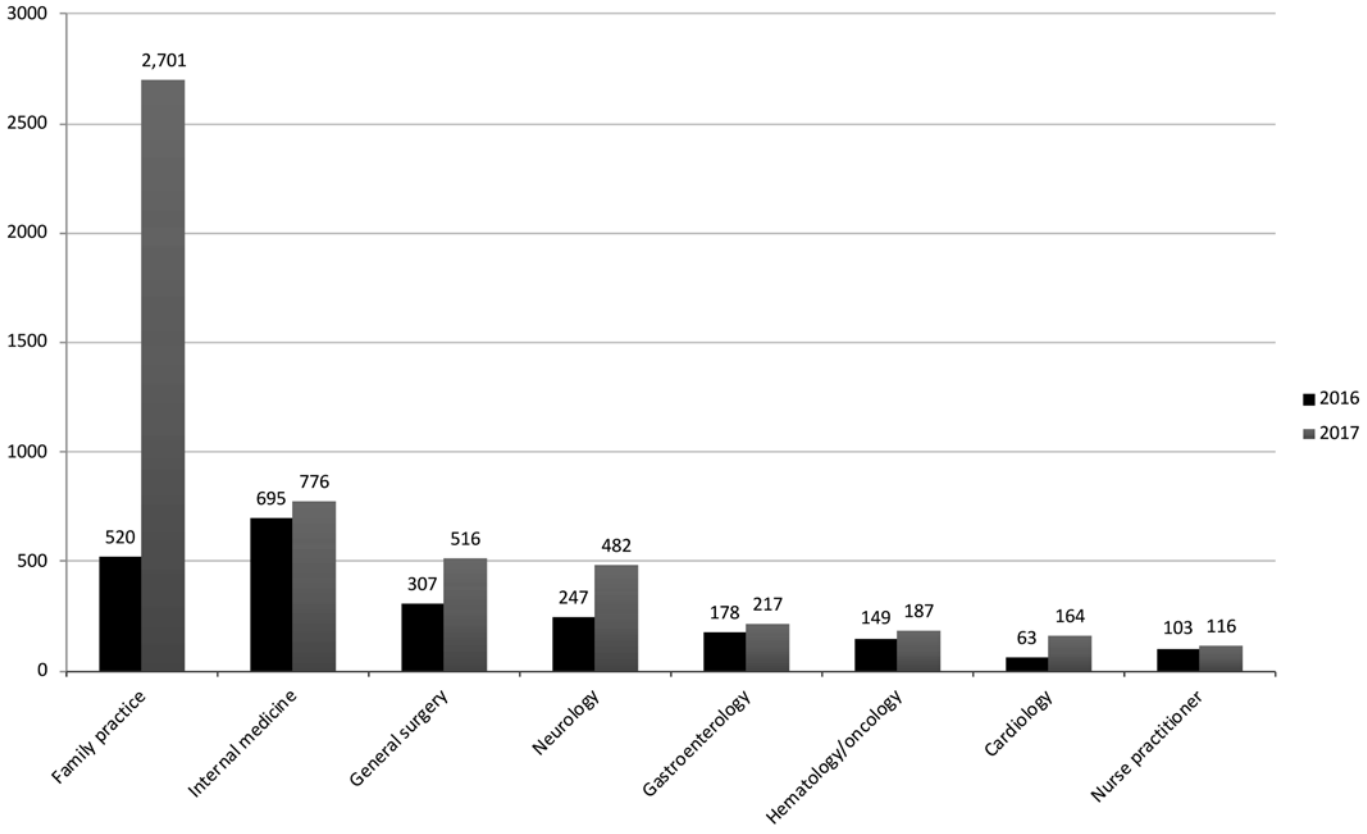
Most practices have been hesitant to tap into the prolonged service codes that are allowed when clinical staff spend extra time with a patient. Even as service utilization increased about 97% between 2016 and 2017, total claims remain scarce.

In 2016, CMS approved the use of two CPT codes reflecting prolonged clinical staff time — **99415** (Prolonged clinical staff service [the service beyond the typical service time] during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; first hour [List separately in addition to code for outpatient E/M service]) and **99416** (… each additional 30 minutes [List separately in addition to code for prolonged service]). At the time, experts surmised that practices would wield the codes infrequently, and the past two years of claims data shows that to be case, according to a review of 2016 and 2017 Medicare claims data (*PBN 2/1/16*).

All told, practices reported 5,700 claims for 99415 in 2017, up from 2,901 claims in the code's inaugural year of coverage. However, the denial rate also increased year-to-year from 26% to 41%, netting practices a shade more than $21,150 in payments. Family practice providers led the way, with 2,700 claims for 99415 in 2017, followed by internal medicine providers (776 claims), general surgeons (516) and neurologists (482).

Notably, denial rates for the latter two groups, at 5% and 4.4%, respectively, were significantly lower than the average denial rate of 53% for primary care physicians. In 2017, practices reported just 659 claims for add-on code 99416. — *Richard Scott* (*rscott@decisionhealth.com*)

Number of claims reported by specialty for prolonged code 99415, 2017



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

- **Human trafficking reports.** At least seven states specifically require reporting of suspected human trafficking, although the requirements vary greatly, warns Holly Atkinson, M.D., program director of human rights at the Icahn School of Medicine at Mount Sinai Medical Center in New York City.
- **Reporting abuse or other criminal activity.** All states require providers to report, typically to Child Protective Services or law enforcement, if the provider suspects that a child is being abused. Many states also require reporting of cases of domestic violence, injuries of a specific nature such as gunshot wounds, or abuse of a vulnerable individual. A human trafficking victim may need to be reported pursuant to these laws, depending on the state law.
- **Education obligations for providers.** At least 13 states have laws that direct providers to obtain education about human trafficking. Some, like New Jersey, specifically state that health care providers must receive this training; others like Vermont, say that "employers" need this training. Some states require specific training; in others, it's more flexible. For example, Tennessee, rather than specifying who needs the education, has directed the applicable state agency to develop a general education plan on the subject. Michigan requires education in human trafficking as a condition of obtaining or renewing one's medical license.
- **Hospital requirements.** Hospitals are increasingly adopting protocols regarding the identification and handling of suspected trafficking victims. The protocols themselves and the obligations they place on affiliated medical staff vary tremendously, notes Greenbaum.

Patient encounters

Signs that a patient may be a victim of human trafficking

It's often difficult to discern whether a patient is a victim of human trafficking.

"It's not clear cut; sometimes you just get one hint," says Kelly Herron, director, Mission Services and Catholic Identity, Trinity Health in Livonia, Mich., speaking at recent American Bar Association's Health Law Section conference.

Here is a representative list of clues that a patient may be a victim of human trafficking:

- Avoids eye contact and displays other fearful behavior.
- Gives very vague answers.
- "Branding" tattoos, often in non-exposed parts of the body.
- Drug or alcohol dependence.
- Inconsistent or scripted stories.
- Physical signs of abuse, such as bruising.
- Is accompanied by a person who does things like answers for the patient, refuses to leave the patient's side or handles all of the patient's documents and paperwork.
- Pays in cash; doesn't have insurance.
- Can't provide details about him or herself, such as an address.
- Indicators of sexual exploitation, such as reporting high numbers of sexual partners, inadequate clothing for the weather, sexually transmitted diseases.
- Evidence of being controlled, such as excessive concerns about pleasing a family member or employer.
- Injuries from physical trauma.

There are also health consequences of human trafficking that the patient may exhibit, such as anxiety, malnutrition or stress-related illnesses, such as irritable bowel syndrome. "Victims [additionally] often have poorly managed chronic conditions," says Jordan Greenbaum, M.D., Institute on Health Care and Human Trafficking, Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta.

For a complete list of red flags, go to the National Human Trafficking Hotline, at *https://humantraffickinghotline.org/sites/default/files/What%20to%20Look%20for%20during%20a%20Medical%20Exam%20-%20FINAL%20-%202-16-16_0.pdf.*

CCI version 24.3 scorecard

Changes effective Oct. 1.

(For more on CCI version 24.3 edits, see related story, p. 1.)

Code range	CCI code pairs added	CCI code pairs delete	MUEs added	MUEs de-leted	MUEs revised
0001T – 0999T	317	0	4	0	0
00000 – 09999	0	0	0	0	0
10000 – 19999	21	0	0	0	0
20000 – 29999	134	1	0	0	8
30000 – 39999	63	0	0	0	20
40000 – 49999	97	0	0	0	13
50000 – 59999	231	0	0	0	0
60000 – 69999	59	0	1	0	7
70000 – 79999	4	0	0	0	0
80000 – 89999	11	2	0	0	0
90000 – 99999	2	2	0	0	1
A0000 – V9999	3	0	40	1	99
Totals	**942**	**5**	**45**	**1**	**148**

Note: Code range is based on the comprehensive code of the edit.

Source: *Part B News analysis of CCI version 24.3 changes*

- **HIPAA compliance.** HIPAA places limits on how a provider can disclose human trafficking to a third party. HIPAA allows reporting of patient information without patient authorization to comply with mandatory reporting requirements. Providers also can report to law enforcement without patient authorization if certain criteria are met, such as a serious/imminent threat to an individual or where there's evidence of criminal activity. However, a provider can't disclose a patient's personal information to other third parties — such as the trafficking Hotline or a local shelter — without the patient's authorization. — *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Resources:

- National Human Trafficking Hotline: *https://humantraffickinghotline.org/*
- HIPAA's rules regarding reporting to law enforcement: *www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf*

Billing

(continued from p. 1)

a "1" modifier, which allows billing on the same DOS in certain circumstances.

For example, you'll find a pair of tongue biopsy codes, **41100** (Biopsy of tongue; anterior two-thirds) and **41105** (Biopsy of tongue; posterior one-third), bundled into tongue-removal procedures defined by codes **41140** (Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection) and **41145** (Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection). Those code pairs take the restrictive 0 modifier.

Approximately 200 of the new pairs involve a 0 modifier on biopsy codes that are bundled into procedure codes, spanning a range of services, including biopsy of cervix with scope (**57454**) and total hysterectomy (**58150**), and skull biopsy (**61140**) and removal of brain lesion (**61510**), among others. The 0 modifier means that practices submitting both codes on the same DOS will face an automatic denial of the biopsy code.

About 300 of the new code bundles wrap together biopsy and other procedural codes with two fine needle aspiration codes – **10021** (Fine needle aspiration; without imaging guidance) and **10022** (Fine needle aspiration; with imaging guidance). For example, 10021 and 10022 are bundled into **21920** (Biopsy soft tissue of back), **29840** (Wrist arthroscopy) and **44382** (Small bowel endoscopy), among dozens of others. All of the bundles involving fine needle aspiration take a 1 modifier, which means you're limited in reporting the bundled services on the same DOS.

"I can understand the reasoning behind the aspiration and the biopsy codes," says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. "Why aspirate when you are biopsying the lesion? Fluid probably is contained in the biopsy and there is no need for the aspiration."

Unless you can evince medical necessity for the fine needle aspiration service, you should refrain from reporting it for the same patient encounter.

Revised prolonged service limitations

The CCI version 24.3 edits provide updates on multiple prolonged service codes. The first revision deletes a code bundle between inpatient prolonged service codes **99356** and **99357** and psychotherapy service code **90847** (Family psychotherapy [conjoint psychotherapy] [with patient present], 50 minutes). That means, come Oct. 1, you won't face a bundling edit on the codes and you can tack the prolonged services onto the psychotherapy service when appropriate without automatic scrutiny from your Medicare administrative contractor (MAC).

While that frees up your prolonged-service coding in some acute-care situations, you'll find greater limitations on a single office-based prolonged care code. On Oct. 1, you'll find a limit cap of three units for code 99416 (Prolonged clinical staff service [the service beyond the typical service time] during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes [List separately in addition to code for prolonged service]). The current allowance is four units, and the edit is likely routine maintenance on what is an infrequently reported code (*PBN 2/1/16*)."Probably because [CCI] searched the data and found that it rarely was reported at four units," explains Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash.

Toe surgery code bundled

You'll find 21 new bundles involving big-toe procedure code **28310** (Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe [separate procedure]). Marked by a 1 indicator, the bundles wrap 28310 into a range of codes, including **28150** (Removal of big toe) and **28760** (Fusion of big toe joint), among others. The updated edit means you'll have to support medical necessity to get both codes through on the same DOS.

Drug codes see revised unit caps

The latest CCI edits revise the service caps on more than a dozen drug codes, and the new limits generally reduce the number of units you can report on a given day. For instance, you'll see a reduction in units allowed for **J0130** (Injection abciximab, 10 mg), which goes from six to four. The allowable units for **J0638** (Injection, canakinumab, 1 mg) fall from 180 to 150, and the units you can report for protein C injection, using code **J2724** (Injection, protein c concentrate, intravenous, human, 10 iu) are reduced from 4,000 to 3,500 per day. — *Richard Scott* (*rscott@decisionhealth.com*)

From the *Part B News* blog

Take note of the news that happens between *Part B News* issues by checking out the free *Part B News* blog at *https://pbn.decisionhealth.com/Blogs/default.aspx*. Here's a sampling from this week.

3 more steps to protect your practice from a ransomware attack and the aftermath

In the most recent issue of *Part B News*, we offer six preventive steps that can save your data in the event of a ransomware attack. In case you want to be extra-secure, our experts now offer three more. Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200751*.

CPT 2019: Check the 6 new E/M codes, and don't overlook the new guidelines

You'll find new guidance that will help practices document services, code correctly and combat denials in your 2019 CPT manual. The electronic version of the 2019 CPT manual is available and DecisionHealth has reviewed the book to create this overview of some of the revisions and additions that you'll find. Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200750*.

And now, the worst compliance advice ever

Anesthesia practices: Don't confuse the compliance advice you want to hear with the compliance advice you need to hear. Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200749*.

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