THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Patient's Aggressive Choice Could Remove a Diagnostic Safety Net

This month, we feature a popular "Case of the Month" from the archives written by CAP's former General Counsel Gordon Ownby

When reporting their findings, it is common to see consulting physicians recommend further testing. Absent such an explicit recommendation, a patient's decision to bypass conservative measures can spell trouble for all.

When a diagnostic mammogram on a 57-year-old woman with no family history of breast cancer identified a suspicious abnormality on the left breast, the patient's primary care physician, Dr. PC, referred her for a core biopsy. Dr. P, a pathologist, diagnosed a left breast invasive ductal carcinoma. Dr. P assigned a provision grade of "II/III" and noted that "histologic grading is provisional owing to the limited sampling inherent in needle core biopsies. This may change when the entire lesion is evaluated." Dr. P's report made no other references regarding further tests to confirm cancer. Dr. C, the clinician performing the needle core biopsy, cited Dr. P's diagnosis in the addendum to his report on the procedure and also wrote: "Suggest MRI, to see the extent and additional disease. Then referral to breast surgeon."

Impressions from the subsequent bilateral MRI ordered by Dr. PC included a normal right breast and a "known solitary malignancy" in the left breast. The radiologist included in her recommendations: "The patient is a candidate for a wire localized lumpectomy. I would have her follow up with her breast surgeon."

The patient visited a surgeon, Dr. S, 10 days later and discussed surgical options, including a lumpectomy and nipple-saving mastectomy. Before deciding anything, the patient consulted with a plastic surgeon and a genetics counselor. Though when she returned to Dr. S several weeks later the results of genetics testing were not yet available, and the patient told the surgeon that she wanted a double mastectomy, rejecting a local wire lumpectomy.

Surgery some two weeks later included bilateral nipple-saving mastectomy and left sentinel node biopsy by Dr. S and breast reconstruction with tissue expanders by a plastic surgeon. The surgical pathology report, however, showed no cancer in the removed tissue or lymph node. As for the left breast, the post-surgical report described findings of multinodular adenomyoepithelioma and atypical ductal hyperplasia. A second review performed at a university hospital confirmed the absence of carcinoma. Results of

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genetic testing returned several weeks later showed no BRCA mutations.

When Dr. S subsequently sent the original core biopsy to the university hospital for a new read, the pathologist there commented on a differential diagnosis of adenomyoepithelioma: "Imaging and clinical correlation is advised. Recommend performing IHC markers such as P63, Calponin, and SMMHC to confirm diagnosis of adenomyoepithelioma."

The patient sued Dr. P, alleging that a misdiagnosis resulted in the loss of her breasts. The legal matter was resolved informally.

In many cases alleging a medical error, a subsequent reading of the record will reveal opportunities for avoiding a bad result. In this case, a lumpectomy option, as described in the MRI report and discussed by Dr. S, stands out. Even earlier in the record, Dr. P's comment on getting a more accurate histological grade "when the entire lesion is evaluated"—was apparently not focused enough to trigger the patient's other providers to pursue further tests.

Given the patient's desire to pursue her most aggressive option—the double mastectomy—no one will know if an explicit recommendation in Dr. P's report for further tests would have put the patient's care on a different course. But without such qualifications, the report ended up shouldering a big responsibility.

National Healthcare Decisions Day is April 16

Did you know that April 16th is National Healthcare Decisions Day (NHDD)? NHDD was founded in 2008 and is promoted by the Institute for Healthcare Improvement (IHI) to highlight the importance of making Advance Directives. Advance Directives include much more than deciding what care an individual would or would not want; it starts with expressing preferences, clarifying values, identifying care preferences, and selecting an agent to express healthcare decisions if an individual is unable to speak for themselves.[1]

Unfortunately, many adults do not have advance directives. According to one study, only 38.7% of adults have one.[2] As a physician, you can greatly assist your patients in their directive decision making. We encourage you to:

- Read the March 2023 *CAPsules* article, **"The Importance of an Advance Directive Cannot be Overlooked"**
- Counsel your patients on this topic and encourage them to complete an advance directive
- Set an example and complete one for yourself

There are numerous resources available on this topic, including:

- Guidance on getting the conversation started with your patients:
  www.nhdd.org.
  http://www.nationalhealthcaredecisionsday.org/
- Advance healthcare directives forms. Although a specific form is not required in California, California's Office of the Attorney General developed a sample Advance Healthcare Directive form:
  https://oag.ca.gov/system/files/media/ProbateCodeAdvanceHealthCareDirectiveForm-fillable.pdf
- CMS fact sheet on billing and coding for Advance Care Planning: **2023-03-09-MLNC | CMS**

[1]NHDDCaseStatement.pdf (theconversationproject.org)
[2]https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0175

Updated *Take Aim at Risk* CME Program Now Available!

One of the things physician members and their staff admire most about CAP is how we consistently aim high to provide products and services that help ease the stress of running a successful medical practice. And our comprehensive risk management and patient safety programs are no exception.

In our effort to address current issues and regulations that impact you and your practice the most, we recently updated and expanded our flagship *Take Aim at Risk* online CME risk management program.

Offered at no cost to CAP members, *Take Aim at Risk* provides information and strategies for reducing professional liability risk exposure as well as for improving patient safety and the patient care experience.

Courses Designed for all Clinical Staff

Take Aim at Risk was developed by CAP's risk management experts to help physicians prevent patient injury and reduce malpractice claims. The program explores the main factors that lead to medical errors, such as communication breakdowns and medication mismanagement.

In addition to guidance on longstanding malpractice topics such as apologies, informed consent, and documentation, *Take Aim at Risk*'s revised content now addresses:

- E-prescribing guidelines
- Updated nurse practitioner (NP) and physician assistant (PA) supervision requirements
- New specifications for email, texting, and telehealth
- And much more!

The program is comprised of seven modules that offer 2.5 hours of CME credit.*

We encourage physician learners of all specialties and practice locations, and other health professionals, including nurse practitioners, physician assistants, and RNs, to enroll.

How to Register

To enroll in *Take Aim at Risk*, click here (if you have an existing account on CAP's learning management platform, Absorb, please log in before clicking on the link). Or for more information or assistance, contact **Alicia Alexander** at **213-576-8503** or **AAlexander@CAPphysicians.com**.

The Cooperative of American Physicians, Inc. (CAP) is accredited by the California Medical Association (CMA) to provide continuing medical education for physicians.

*The Cooperative of American Physicians, Inc. designates this internet enduring material activity for a maximum of 2.5 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure to Learners

No planner, reviewer, faculty, or staff for this activity has any relevant financial relationships with ineligible companies.

APRIL 2023

Save the Date

Saturday, April 22, 2023

9:00 a.m. to Noon

Spring Litigation Education Retreat

Supporting CAP Members During a Medical Professional Liability Lawsuit

Whether you are in the process of a medical professional liability lawsuit, or simply interested in learning more about the litigation process, the Cooperative of American Physicians' Litigation Education Retreat can provide valuable support and guidance.

During this virtual, interactive event, you will learn techniques to help you secure the most favorable litigation result and alleviate the anxiety that most physicians experience during this exceptionally stressful time. Participants who attend this live virtual event will earn three CME* AMA PRA Category 1 Credit(s)™

Register at **www.CAPphysicians.com/Spring23LER**

The Cooperative of American Physicians, Inc. (CAP) is accredited by the California Medical Association (CMA) to provide continuing medical education for physicians.

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Ask My Practice

by Andie Tena

E/M Documentation Training Recap: Quick Answers to Frequently Asked Coding Questions

In February, CAP hosted a webinar on Evaluation and Management coding, titled *2023 E/M Billing, Coding, and Documentation Rules Impacting Your Practice*, presented by healthcare coding and billing expert, Terry Fletcher.

During the one-hour presentation, Ms. Fletcher covered a number of E/M rules and 2023 updates, including time-based versus Medical Decision Making (MDM) guidelines, Public Health Emergency (PHE) guidelines and changes, and hospital coding. To view the full program or obtain the slides referenced in the answers below, please click here: **https://www.pathlms.com/capphysicians/courses/50000/video_presentations/251000**

The following represents the top 10 questions submitted by the live webinar attendees, answered by Ms. Fletcher.

Q. Anthem Blue Cross California is not accepting the 99222/99223 code for consultants, unless the claim is the first claim received. The guideline states it's to be used by one physician. Can you advise on this issue?

A. Many payers, including Anthem, said they had a glitch in their system that was corrected in January 2023, and they will be sending payments, so do not rebill.

Q. When do I use G-codes for prolonged time and when do I use 99415-type codes?

A. G-codes are specific to Medicare when the highest code (level 5 in the office) or highest code in the hospital is exceeded by more than 15 minutes. See slides 52 and 53 of the presentation.

Q. Is NO change of medication also considered prescription management? If I say, "Medication list was reviewed. At present, medication A is tolerated well and discussed with patient that patient should continue with the current medication at same dose"?

A. Yes, but it is a best practice to also include the specific dosages and the status of the condition. See slides 7 and 8 of the presentation.

Q. Can I use CPT code 99214 with POS 22?

A. Yes, if you are asked to see a patient in the hospital observation setting or outpatient setting and they are established to you or your practice.

Q. I thought another level of care that qualified as moderate was two or more stable chronic illnesses (that would normally be low-level complexity but if you have 2+ then it's moderate). Is that still true in 2023?

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A. It only qualifies for one element of the MDM for problems addressed. And, yes, that starts as moderate. But if there are no or low data points, and the only management is to RTC in 3-6 months, you are still at a level 3 visit or low level.

Q. Can you skip billing for ordering lab work until the results come back and THEN document discussion of results?

A. No. This question gets asked a lot and the AMA is clear that you bill in order. You can only bill for review of result if it's an external physician who originally ordered or someone in the group ordered that is in a different specialty, i.e., multi-specialty group.

Q. If billing for a service as code 99215 and the session extends beyond the time limit, how do you bill the additional time?

A. If the time for a level 5 has exceeded the maximum time listed in CPT by 15 additional minutes, then you can add 99417 for commercial insurance and G2212 for Medicare. These are getting audited. See slide 52 of the presentation.

Q. Can you include EHR documentation time in the overall time?

A. Yes, but there is also an expectation that the majority of the EHR documentation time will be done as the provider sees the patient. Also, that time documenting must be on the same date as the face-to face-encounter. Any charting the day before or after is not counted towards total time. See slide 14 in the presentation.

Q. If a patient is non-compliant with healthcare and keeps going to the hospital ER, can we bill 99221-99223?

A. These codes are only for inpatient or observation initial admissions. If you are seeing the patient in consultation from a repeat ER and asked to consult, you must use the 99233-99231 codes or 99215-99212 codes depending on the status of the patient.

Q. Can we still use E/M codes with place of service 10 for telehealth?

A. You can if you want to, but Medicare will reimburse the facility rate which is 20% below the Medicare Fee Schedule. Until the end of 2023, if you use the POS 11 or where the patient would have been had they come into the office in person, you have payment parity. Once you start using POS 10 you will take the reduction.

CAP members who were unable to attend the live webinar and would like to watch the recorded version in its entirety may access it here: **https://www.pathlms.com/capphysicians/courses/50000/video_presentations/251000**

Andie Tena is CAP's Director of Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

To Have and to Hold:

Clearing up Misconceptions About 5150 Holds in Healthcare

By Bradford Dunkin

As challenges associated with mental and behavioral health illnesses increase, physicians should review available options when they suspect a patient may be a danger to themselves or to others so they can provide timely and appropriate care, not violate citizen/patient rights, and reduce professional and legal liability exposure for themselves.

All fifty states and the District of Columbia allow emergency holds to be placed on anyone who is a danger to themselves or others. While most laws specify that the danger must be due to mental illness, others do not. Generally, it must be shown that the threat is imminent and that the patient has the means and the plan to carry it out.[1]

In California, Welfare and Institutions Code 5150 establishes the conditions under which an adult who "as a result of a mental disorder is a danger to others or himself or herself, or gravely disabled," may be detained for a 72-hour evaluation and treatment—involuntary detention or "5150 hold".* 5150 falls under the broader California Lanterman-Petris Short Act[2] which authorizes involuntary psychiatric treatment in very limited circumstances. Persons suffering from Alzheimer's disease, brain injuries, or other organic brain disorders may be eligible for evaluation and treatment under 5150. A person may also be considered gravely disabled if they are debilitated by being under the influence of alcohol or controlled substances (as distinguished from a routine police arrest for intoxication) and may be detained for a period of 72 hours.[3]

Most physicians are not able or qualified to initiate and execute a 5150 involuntary hold on a person/patient. There are specific individuals, identified by statute, who can determine if a person/patient qualifies for 5150 detention. Detaining a patient under the 5150 statute when the healthcare provider is not designated or qualified to do so could lead to liability consequences for the healthcare provider, possibly resulting in allegations of false imprisonment.

Under 5150, only the following individuals or "professional persons" are qualified to execute a 5150 hold:

- A peace officer
- A professional person in charge of a county-designated evaluation and treatment facility (approved by the county Department Healthcare Services) or mobile crisis team
- Other professional persons designated by the specific California county

There is a specific process which must be followed by professional persons processing a 5150 hold which includes: (1) assessing the patient to determine if they can receive voluntary treatment or must be detained as they are a danger to themselves, others, or are gravely disabled; (2) applying to the designated

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facility indicating the circumstances of the hold; (3) transporting the patient to the designated facility by ambulance or police car; (4) providing the person with pertinent information related to the 5150 hold; and (5) creating a medical record to document pertinent information, including the name of the professional person taking the patient into custody.[4]

While in an involuntary hold, the patient has the right to refuse medical treatment or treatment with medications, including antipsychotic medications, except in an emergency.

As a side note, persons who undergo a 5150 hold are prohibited from possessing or purchasing firearms for a five-year period. Persons who undergo two 5150 involuntary holds within a twelve-month period are prohibited, indefinitely, from access to firearms.

At the expiration of the 72-hour detention period, the patient may be:

- Released or discharged if it is determined the patient is not a danger to self or others
- Admitted to the facility as a voluntary patient
- Certified by a qualified individual for additional 14 days of intensive treatment or "5250 hold" if certain criteria are met[5]

When faced with the prospect that a patient does not qualify for a 5150 hold, a provider may still be concerned about the welfare of a patient and the need for the patient to acknowledge they need professional help. The physician should encourage the patient to undergo mental and behavioral health treatment voluntarily. In this instance, it is important for the provider to be aware of mental and behavioral health resources in the county where they practice to make these resources available to patients while counseling and encouraging them to seek treatment. The provider may also enlist the aid of the patient's support system to facilitate the patient's engagement with appropriate mental, behavioral, and substance abuse resources and treatment options. A California county by county resource guide is included in the notes of this article.[6]

In summary:

- Become familiar with provisions of 5150 involuntary holds and who is qualified to initiate and execute a 5150 hold
- Stay within boundaries and do not exceed your scope of practice by attempting to execute an involuntary hold on a patient, as it could have serious implications for the patient and legal and liability consequences for you
- Identify the facilities in your county that are officially designated as 5150 hold facilities
- Identify and become familiar with mental, behavioral, and substance abuse resources in your county to assist patients with voluntary access to appropriate expertise, support, care, and treatment

Bradford Dunkin is Assistant Vice President, Risk Management and Patient Safety, CAP. Questions or comments related to this article should be directed to BDunkin@CAPphysicians.com.

* Section 5585 of the Welfare and Institutions Code under California State Law allows a minor (under 18) who is experiencing a mental health crisis to be involuntarily detained for a 72-Hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled.

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[1]What Is a 5150 Hold? 72-Hour Holds From a Nursing Perspective, Kirsten Slyter, 01/03/22

[2]Lanterman-Petris Short Act: https://en.wikipedia.org/wiki/Lanterman%E2%80%93Petris%E2%80%93Short_Act#, accessed 03/16/23

[3, 4]Mental Health: 51 Holds/72 Hour Detention, Document #3109, CMA Legal Counsel, California Medical Association, July 2022

[5]Rights for Individuals In Mental Health Facilities Admitted Under the Lanterman-Petris Short Act, Rights for Individuals In Mental Health Facilities.pdf, accessed 03/16/23

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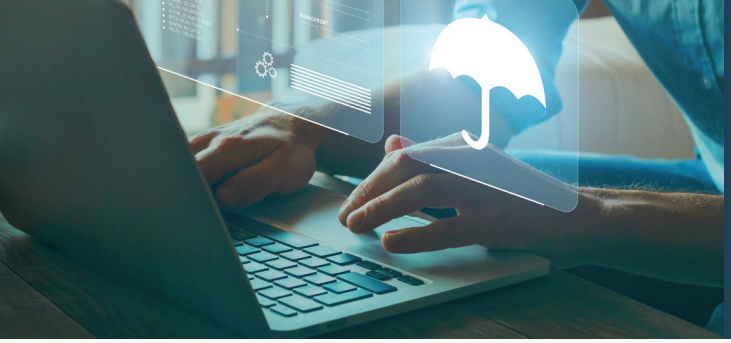

Is Your Website Exposing You To Lawsuits?

Meta Pixel May Be to Blame

More and more healthcare providers are taking advantage of the many benefits of digital marketing —from improving the patient experience to building and maintaining a thriving business. But with the introduction of new and more advanced technologies comes an increased risk for a serious data breach.

Tokio Marine HCC, CAP's CyberRisk Insurance carrier, has reported a significant rise in the number of class action lawsuits alleging the unauthorized disclosure of personally identifiable information (PII) and personal health information (PHI) through Meta Pixel, a tool many providers use to track website user interactions.

What is Meta Pixel and How Can it Impact Your Business?

Meta Pixel (offered through Facebook's parent company, Meta) and similar tools use a snippet of JavaScript code that can be used by website owners for tracking user activity using cookies.

According to *The HIPAA Journal*, Meta Pixel collects any information contained in HTTP headers, button click data, form field names, and other user-specified data to help businesses with website optimization, identifying trends, and improving the user experience on their websites and web applications.

Unfortunately, many medical practices and facilities are not aware of the data that these tracker tools are collecting. If trackers are not configured correctly, they may be transmitting sensitive data to Meta (Facebook), which is then shared with a massive network of marketers who target patients with advertisements that match their conditions. And since Meta is not a business associate of HIPAA-covered entities and under HIPAA, any data sent to Meta would require patient consent and a business agreement to share PHI between companies.

How to Protect Yourself

Tokio Marine HCC strongly encourages healthcare providers to identify all specific forms or pages on your company website containing Meta Pixel, and removing it, by using the following information:

- Use a tool, such as Blacklight, to assess whether your website uses Meta Pixel: https://themarkup.org/blacklight*
- Remove Meta Pixel by following the instructions on the below links:

  If hardcoded on your website: https://www.facebook.com/business/help/4224030857607474

  If plugin, direct website/partner integration, or Google Tag Manager implementation: https://back2marketingschool.com/delete-facebook-pixel/

In addition to these mitigation efforts, CAP Physicians Insurance Agency, Inc. (CAP Agency) recommends that you secure comprehensive CyberRisk coverage to protect you and your practice or facility from potentially severe penalties, by unintentionally violating HIPAA privacy rules. In addition to the $50,000 CyberRisk protection CAP members automatically receive, CAP Agency offers outstanding additional coverage through Tokio Marine HCC with limits up to $1 million to further protect you. For more information, please call CAP Agency at **800-819-0061** or **CAPAgency@CAPphysicians.com**.

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The People's Power to Legislate

by Gabriela Villanueva

California is one of 26 states and the District of Columbia that provides its registered voters the opportunity to legislate via the ballot box. Voters legislate either through the direct initiative process or the veto referendum process. California allows voters the option to use both processes.[1]

The initiative and referendum processes provide pathways to shape policy outside of the legislative process. Whether initiated by activists, advocates, special interest groups, or the business sector, these processes are available to one and all, as evident from the number of initiatives and referendums appearing every election cycle.

What is an Initiative? What is a Referendum?

An **Initiative**[2] is the ability to directly propose and enact state laws and amendments to the California Constitution. In order to be placed on a statewide ballot for consideration by voters, an initiative petition must be presented to the Secretary of State, certified by local election officials to have been signed by a specified number of qualified registered voters. An initiative measure may not address more than one subject.

A **Referendum**[2] is the power of electors to approve or reject statutes, or parts of statutes, enacted by the Legislature. However, a referendum does not apply to urgency statutes, statutes calling elections, and statutes providing for tax levies or appropriations for usual current expenses of the State.

In order to be placed on a statewide ballot for consideration by voters, a referendum petition must be presented to the Secretary of State and certified by local election officials to have been signed by a specified number of qualified registered voters. A referendum petition must be submitted to the Secretary of State for certification within 90 days after the enactment date of the statute.

Both options require certain signature thresholds to be met to qualify for the ballot. Here in California, the number of signatures required to qualify a measure is determined by a percentage of the total number of votes cast for the office of governor in the preceding election.

Although the 2024 General Election is still over a year away, there are already at least a half-dozen initiatives and referenda headed for the ballot, all with potentially heavy economic effects that will generate multi-million-dollar campaigns advocating for and against critical issues.

Critics have expressed concerns over an overuse and abuse of the initiative and referendum processes, which arguably allow motivated and well-funded groups or individuals to easily advocate for or advance specific interests and bypass the traditional legislative process.

Currently, freshman State Assembly member Isaac Bryan (D-Los Angeles) has introduced a bill, AB 421, that would include new requirements for petition circulators to qualify a statewide ballot initiative or referendum. Assemblymember Bryan's bill aims

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referendum. Assemblymember Bryan's bill aims to ensure voters are better informed before signing a petition by requiring:

- The name of the top three funders of the petition to be disclosed on the first page, along with an unbiased summary of the measure.
- Paid signature gatherers to register with the California Secretary of State and wear a badge.
- Petition signers to initial a statement saying that they've reviewed the top funders.
- That at least 10% of the signatures are gathered by an unpaid volunteers.

As of this writing, AB 421 is yet to be assigned a committee hearing.

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

References:

[1]https://ballotpedia.org/Ballot_initiative

[2]https://oag.ca.gov/initiatives/faqs

No-Cost Professional Support and Guidance for Everyday Life

As one of many exclusive valuable benefits to support physician well-being, CAP members and their families have access to expert counselors and resources at no cost to help them navigate difficult personal and professional issues and situations.

Offered by CAP Physicians Insurance Agency, Inc. (CAP Agency) in partnership with MetLife, this program provides a variety of assistance to help address life issues like:

- **Family:** Divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Relocation, building relationships with coworkers and staff
- **Legal:** Civil, personal, and family law, financial matters, real estate, and estate planning
- **Money:** Budgeting, financial guidance, retirement, buying or selling a home, taxes
- **Identity Theft Recovery:** ID theft prevention tips and help if you are victimized
- **Health:** Anxiety/depression, getting the proper amount of sleep, unhealthy habits
- And much, much more!

Take Advantage of This Free Program

Call **1-888-319-7819** to speak with a counselor or schedule a phone or video conference appointment.

When you call, select "Employee Assistance Program" when prompted and immediately get connected to a counselor. Provide your name and identify yourself as a member of the Cooperative of American Physicians. Family members will need to identify themselves as a dependent of a member of the Cooperative of American Physicians.

Or

Log on to **metlifeeap.lifeworks.com** and provide the username "**metlifeeap**" and password "**eap**" to access additional free resources online, such as:

- 24/7 counseling and online well-being resources
- Wellness tools and personalized recommendations, such as assessments, digital clinical programs, and challenges to help you reach your health and fitness goals and keep you on track
- Perks to help you save money on daily essentials and key life events
- 24/7 access to trusted, expert-led online audio, video, and articles on a variety of vital topics

CAP Agency partners with MetLife to provide CAP members and their families with some of the value-added insurance benefits automatically received upon joining CAP, as well as the personal insurance products available for purchase at competitive group rates. Call **800-819-0061** or email **CAPAgency@CAPphysicians.com** to learn more.

Your benefit includes up to five phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. Any personal information provided is completely confidential.

This service is provided by MetLife and LifeWorks and limitations may apply. MetLife and LifeWorks abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

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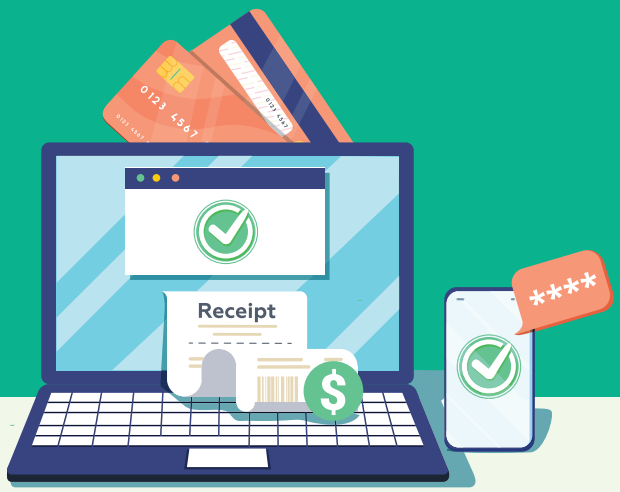

Use Your Checking Account to Pay Your CAP Bill Electronically and Automatically for Safer, Hassle-Free Transactions!

You can now go online and set up recurring payments to pay your CAP bill easily and securely directly from your checking account, just like a paper check but with a lot less hassle.

Benefits of Setting Up Automatic Payments Using Your Checking Account:

1. **Faster processing time:** No need to write and mail a paper check
2. **More secure and reliable:** Reduce the chance of lost or stolen mail
3. **Save time and money:** Save on the cost of stamps, checks, envelopes, and time

Even if you pay your bill by credit card, setting up recurring electronic payments from your checking account may be a better and more secure option to save you time and headaches.

For CAP members enrolled in autopay prior to 2023, please be reminded that you will need to set up a new recurring payment schedule, given recent changes to CAP's electronic billing procedures.

Set Up Automatic Payments Today!

It's Easy and Convenient!

Don't wait!

Set up automatic payments using your checking account.

1. Visit **https://member.CAPphysicians.com** to log into your CAP account.
   Visit **https://member.CAPphysicians.com/register** to create an account if you do not have one.
2. Then, click on the **"Pay CAP Bill"** button ("Agree" to the terms and conditions when prompted).
3. Click on the "Set Up Autopay Payments" button and select the "New Bank Account" option under the payment method drop down menu.
4. Provide the required information to complete your enrollment.

For assistance with your account or if you have questions about your membership, please call **800-610-6642** or email **MS@CAPphysicians.com**.

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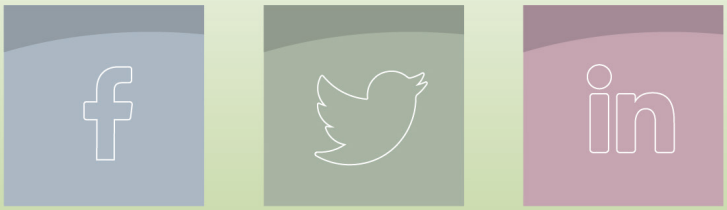

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