THE MONTHLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Medical Record Documentation: Time is of the Essence

by Dona Constantine

What is the appropriate time frame for completing medical record documentation in the office setting? According to Medicare, "the service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record."[1,2] So, what is considered "as soon as practicable," or "timely and reasonable?" Although the Centers for Medicare & Medicaid Services (CMS) does not provide any specific period to reflect "as soon as practicable," some Medicare fiscal intermediaries (FIs) have defined a reasonable time frame as 24-48 hours.[3]

Providers should comply with this guideline and complete documentation in a timely manner. Those responsible for coding and/or entering charges need to be cognizant of the timeliness of medical record completion. Some have suggested that it may be unreasonable to expect a provider to recall the specifics of a service two weeks after the service was rendered.[4]

If you are not a Medicare provider, you may think that you do not need to adhere to these documentation requirements. However, be aware that other payors and organizations tend to follow Medicare requirements and recommendations.

Medical record "charting" seems simple, but the process has many pitfalls. A significant dual challenge is to chart in a timely manner while still providing care to the patient.[5] Many cases show that careful and contemporaneous medical charting is the best way to prevail when a dispute arises over patient interactions.[6] Failing to document in a timely manner can have serious repercussions. According to California Business and Professions Code § 2266, "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Additionally, the Medical Board of California (MBC) investigates complaints and can impose disciplinary action for poor or lack of medical record documentation, which can be posted to your public record on the MBC website.

One example of failing to comply with timely documentation of a patient encounter involves a physician who received an after-hours call from a patient complaining of a severe headache. The physician instructed the patient to go to the emergency room (ER) for an evaluation. The patient responded, "Okay," but never went to the ER as instructed and had a massive cerebrovascular accident (CVA) later that night. The patient subsequently sued the physician, alleging that the physician did not direct her to go to the ER. Her allegations were backed by a friend's witness testimony. Unfortunately, the physician did not document the

continued on page 2

June 2022

Continued from page 1

content of the phone call or her instructions to the patient. If the physician had simply documented this conversation, the physician may have avoided a lawsuit. Good documentation practices are vital and include: (1) whether it is a late or delayed entry; (2) the date and time of the note; (3) the date and time of service; (4) the type and method of service; (5) details of the encounter; and (6) any instructions given to the patient. For EMR, even if the entry date is automatic, you still need to identify the notation as a "late entry" and include the elements above.[7] Remember, documentation speaks volumes for one's defense.

Contrast the previous case with another case involving another physician who determined that a patient needed a test performed ASAP. During an office visit, the physician informed the patient of the urgent need for a specific test, and the importance of getting the test performed. The patient agreed and the physician called the testing facility to schedule the appointment while the patient was in the office. The physician expected the test results in two days and kept the patient's medical record on his desk as a reminder to follow up. When the results did not arrive as expected, the physician called the testing facility and was informed that the patient did not show for the scheduled test. The physician promptly called the patient's home and was informed that the patient was in Europe. During the patient's trip, she became extremely ill. The patient subsequently attempted to sue the physician for failing to tell her the importance of completing the test in a timely manner. However, the physician had meticulously documented his conversation with the patient during the last visit, including: the patient's understanding and acceptance of having the test performed urgently; the call made to the testing facility to schedule the test; and his call to the patient's home when the patient failed to show up for the test. Due to the physician's detailed documentation of events, the physician avoided the lawsuit. It became evident that the patient did not want to miss her trip to Europe, a planned trip she had not mentioned during her visit with the physician.

Timely documentation helps to provide you and others with a more accurate and informed timeline of your patient services and encounters. More importantly, it can help you mitigate the risk of certain claims and allegations. Completing and signing off on charts within 24-48 hours is a good risk strategy to avoid unfinished charts slipping through the cracks. Without proper and timely documentation, you may jeopardize both your payment for services and ability to defend against certain claims.

Dona Constantine is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to DConstantine@CAPphysicians.com.

References:

[1]Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners Medicare Program (Revised 3-4-22). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

[2]NOTE: These Medicare guidelines are for general medical office practice settings. This article is not intended to address documentation requirements for specific forms, e.g. completion of H & Ps in a hospital setting, etc.

[3]Complete and Timely Documentation of Medicare Services, WPS Government Health Administrators. Published Nov 10 2017, Last Updated May 07 2019.

[4]Pelaia, Robert Esq., CPCO, "Medical Record Entries: What Is Timely and Reasonable?" September 1, 2013, Medicare Comment No 1 blog/25667. https://www.aapc.com

[5]ECRI. Documentation: a primer on charting in the medical record. Ambul Care Risk Manage 2020 Apr 13. https://www.ecri.org/components/PPRM/Pages/EHR4.aspx

[6]Ownby, Gordon, CAP. Medicine on Trial 1st edition "He Said, She Said." p. 58.

[7]Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and Taking Corrective Actions Table of Contents (Rev. 11032; Issued: 09-30-21). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

MICRA and AB 35
What to Expect With the New Law

In 1975, physicians in California faced a crisis of spiraling malpractice insurance premiums, which drove up healthcare costs and limited patients' access to care. In response, physicians and other stakeholders banded together to pass the Medical Injury Compensation Reform Act (MICRA), the landmark law that protects and reduces the cost of medical malpractice coverage for physicians and groups by putting a $250,000 cap on noneconomic damages (pain and suffering) and additional caps on attorneys' fees in medical malpractice lawsuits.

Over the past 40 years, CAP has staunchly opposed any changes to MICRA and has spent millions of dollars to ensure its protection. This year, alongside our traditional allies, CAP was prepared to defend MICRA once again and fight the Fairness for Injured Patients Act (FIPA) measure set to appear on the ballot this fall.

When the California Medical Association (CMA) and other large healthcare associations and malpractice insurers decided to negotiate with the trial attorney who introduced FIPA and craft Assembly Bill 35 (AB 35), instead of fighting the anti-MICRA ballot measure, CAP took immediate action.

Over the past several months, CAP worked diligently to ensure our physician members were aware of the negotiations and were afforded opportunities to share their concerns with CMA and legislators.

On May 23, AB 35 was signed into law by Governor Gavin Newsom, to take effect January 1, 2023.

Many organizations have suggested that AB 35 was the only fair solution and compromise for avoiding the FIPA ballot measure that would have removed MICRA's protections. However, CAP conducted recent polling showing that the FIPA initiative could have been readily defeated, and CAP was prepared to lead the fight against this anti-MICRA initiative, just as we did in 2014.

Simply put, AB 35 permanently alters and diminishes the fundamental protections of MICRA:

- For non-death cases, the cap on non-economic damages will increase from $250,000 to $350,000, with incremental increases over the next 10 years to $750,000 and thereafter, adjusted annually for inflation by 2%.
- For cases involving a patient death, the cap on noneconomic damages will increase to $500,000, with incremental increases over the next 10 years to $1 million and thereafter, adjusted annually for inflation by 2%.
- The law also creates three separate stacks for noneconomic damages caps that plaintiffs may take advantage of to collect from multiple providers and medical facilities, thereby exponentially increasing the damage cap as early as January of 2023.

continued on page 4

Continued from page 3

AB 35 also increases attorney contingency fees:

- 25% of the amounts recovered, if the recovery is due to a settlement agreement and release of claims executed by all parties prior to the filing of a civil complaint or arbitration demand
- 33% of the amount recovered, if the recovery is pursuant to a settlement agreement, arbitration, or judgment after the filing of a civil complaint or arbitration demand
- Plantiffs' attorneys will be permitted to seek an even higher contingency fee by establishing a good cause and filing a motion with the court if a case has been tried or arbitrated

AB 35 will undoubtedly be a significant challenge for all healthcare providers in our communities. Fortunately, CAP does not anticipate a material increase in rates when its next assessment is levied this November, due to CAP's efficient and unique business model designed specifically to maintain stability as much as possible during turbulent market shifts. CAP's prudent fiscal management, disciplined underwriting practices, and accurate forecasting of claims frequency and outcomes offer our physicians members excellent protection from unanticipated circumstances like AB 35.

CAP is committed to helping its more than 12,500 physicians navigate the coming changes and will be unwavering in our efforts to ensure California's independent physicians continue to have access to secure and affordable medical professional liability coverage, and dedicated resources to help them run successful medical practices.

More information and resources will be shared they become available. For assistance, please call Membership Services at 800-610-6642.

Cooperative of American Physicians, Inc. and Mutual Protection Trust Notice of Joint Meeting of Members, July 20, 2022

A regular annual meeting of members of the Cooperative of American Physicians, Inc. (CAP), a nonstock membership cooperative corporation, and the members of the Mutual Protection Trust (MPT), an unincorporated interindemnity arrangement, will be held at:

333 S. Hope St., 8th Floor, Los Angeles, CA 90071
at 1:00 p.m. on July 20, 2022

to transact such business as may properly come before the meeting or any adjournment thereof.

The business day prior to the mailing of this notice shall operate as the record date for the determination of those members entitled to notice of the meeting. The Boards will present no items on the agenda for membership vote.

The next election for members of the CAP Board of Directors and MPT Board of Trustees is scheduled for summer 2023.

Notice of Annual Meeting mailed to CAP members on June 20, 2022.

Your DEA Number: Is it Safe?

by Melvin Barnes, MPA, CPHRM

As an epidemic of controlled substance abuse continues to sweep the nation, numerous healthcare providers have been impacted by theft of their United States Drug Enforcement Administration (DEA) number. A recent survey revealed that approximately 10% of prescribers reported having their DEA number stolen or compromised. In addition, 29% of the prescribers know a colleague who has fallen prey to DEA number fraud.[1]

Unscrupulous individuals can abuse a practitioner's DEA number to gain access to prescription drugs. Once stolen, a physician's ID can amass hundreds of bogus prescriptions before anyone is the wiser. These fraudulent activities directly contribute to prescription drug abuse. Recent data from the Centers for Disease Control (CDC) estimates that overdose deaths from opioids increased to 75,673 in the 12-month period ending in April 2021, up from 56,064 the year before. Overdose deaths from synthetic opioids (primarily fentanyl) and psychostimulants such as methamphetamine also increased in the 12-month period ending in April 2021.[2]

Experiencing an internal or external theft of a practitioner's DEA number can elicit all types of emotions, from anger, to fear, to betrayal. It is hard to imagine how you can find the time or resources to deal with DEA or identity theft issues, when you must manage your practice, see patients, or perform surgery.[3]

When a prescriber's DEA number is stolen or compromised, several things can occur. First, the prescriber may not be able to prescribe any prescriptions for several weeks, or possibly months, while the DEA processes a new DEA number. Second, the state Board of Physicians or Board of Registered Nursing (for Advanced Practice Nurses) may conduct a comprehensive investigation into the incident. This procedure can take a significant amount of time and can be an arduous process.[4]

The process of investigating DEA number breaches places unnecessary pressure on medical practices and institutions, particularly if multiple practitioners' DEA numbers are compromised. These breaches can halt all prescriptions at a medical practice or institution, and result in huge costs for processing fees, investigation processes, labor hours, and lost productivity.[5]

Risk Mitigation Strategies:

How to Report a Theft or Significant Loss of Your DEA number or Controlled Substances:

1. Call the police immediately to report the theft or loss. Be sure to have as much detailed information as you can for the police officer and the DEA. This includes date, time, location, types and amounts of controlled substances lost or missing; witnesses; identification of suspect(s), etc.

2. Call your local DEA field division office within one business day to report your theft or loss. This is required by federal regulations.[6]

continued on page 6

Continued from page 5

3. You, the registrant, must also complete and submit DEA form 106 regarding the theft or loss to the local field division office in your area. Thefts and significant losses must be reported whether the controlled substances are subsequently recovered, or the responsible parties are identified, and action taken against them. The form is available at https://www.deadiversion.usdoj.gov/21cfr_reports/theft/

4. Check your credit report for unusual behavior under your name. If your DEA number has been compromised, your personal data, such as your name and address, may have been used for fraudulent activity. Your ability to open a line of credit can also be affected.[7]

Please call the CAP Hotline at 800-252-0555 for expert guidance from an experienced Senior Risk Management and Patient Safety Specialist.

Melvin Barnes is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to MBarnes@CAPphysicians.com.

References:

[1]Protect against DEA number theft with Electronic Prescribing of Controlled Substances. *Imprivata*, 2017. Available at: https://www.imprivata.com/sites/imprivata/files/resource-files/CID-DS-DEAtheft-0318.pdf

[2]Centers for Disease Control National Center for Health Statistics Press Release 2021. Available at: https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

[3]Someone has stolen my controlled substances. *Jan Woods, Cubex, 2019* Available at: https://cubex.com/someone-has-stolen-my-controlled-substances-now-what/

[4]Protect Against DEA Number Theft with Electronic Prescribing of Controlled Substances, *Health Outcomes, Source, Imprivata, 2022*. Available at: https://www.healthitoutcomes.com/doc/protect-against-dea-number-theft-with-electronic-prescribing-of-controlled-substances-0001

[5]Imprivata 2017.

[6]Woods, Jan. *Cubex*.

[7]Woods, Jan. *Cubex*.

DEA Resources:

United States Department of Justice, Drug Enforcement Administration, Diversion Control Division, 2022. Available at:
https://www.deadiversion.usdoj.gov/21cfr_reports/theft/

DEA form 106
https://www.deadiversion.usdoj.gov/21cfr_reports/theft/DEA_Form_106.pdf

Theft/loss reporting instructions
https://www.deadiversion.usdoj.gov/21cfr_reports/theft/
https://apps.deadiversion.usdoj.gov/TLR/

DEA Contact Information
https://www.dea.gov/who-we-are/contact-us

California's State Budget Revision: What's Included for Healthcare?

by Gabriela Villanueva

On May 13, 2022, Governor Newsom presented a revised FY2022-2023 state budget proposal to the Legislature, also known as the May Revision. The purpose of the May Revision is to update the Governor's January budget with additional proposals or changes based on the latest economic forecasts and state revenue projections.

It is the second year in a row California has a substantial surplus, driven largely by income tax revenue from the state's highest earners. State lawmakers and Governor Gavin Newsom will have a $97.5 billion surplus this year, half of which must be earmarked for education and other constitutional requirements. After mandatory budget allocations, the Governor has a $52 billion General Fund surplus to distribute in the May Revision.

Importantly, part of the surplus spending would include significant healthcare-related investments, such as $1,500 bonuses for hospital and nursing home employees. Other healthcare-driven investments proposed in the $300.6 billion spending plan are:

- $933 million to provide $1,500 "retention bonuses" to workers in hospitals and nursing homes, which were hit hard by the pandemic and continue to face staffing shortages
- $304 million to boost insurance premium assistance for roughly 700,000 Californians on eligible Covered California plans
- $125 million to expand access to reproductive care. This includes funding for the anticipated flood of new patients from other states in search of abortion care and services.
- $300 million to improve public health infrastructure at the state and local level. Local health jurisdictions would receive a minimum base allocation to support workforce expansion, data collection and integration, and partnerships with healthcare delivery systems and community-based organizations
- $1.2 billion in 2021-22 and $760.8 million in 2022-23 to bolster the COVID-19 response. Of this amount, $1.1 billion would fund the SMARTER Plan for the next phase of California's pandemic response. The SMARTER Plan includes a range of services, from testing, vaccination, and therapeutics to education, outreach, and unanticipated emergency responses
- An additional $85 million to increase Children and Youth Behavioral Health Initiative grants to schools, cities, counties, tribes, and/or community-based organizations. These grants would support programs that teach wellness and mindfulness practices to teachers and students. Grants could also be used to expand parent support and training programs to help parents address their children's behavioral health needs
- An additional $65 million to increase access to behavioral health services for students, increasing the total funds for the Student Behavioral Health Incentive Program to $194 million

The May Revision includes an additional one-time $41.8 Million Opioid Settlements Fund in 2022-23, allocating additional funding to the following programs:

- $29.1 million for substance use disorder provider workforce training, increasing the total program funds to $51.1 million

continued on page 8

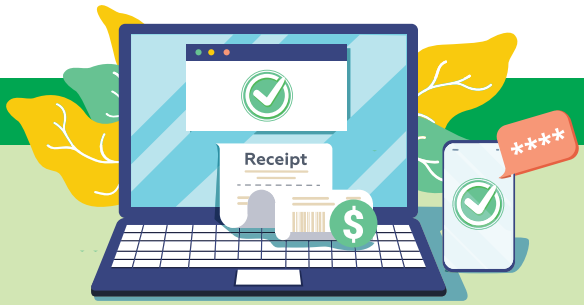
Continued from page 7

- $10 million for the naloxone distribution project targeting unhoused populations, increasing the total program funds to $15 million
- $2.7 million for a public awareness campaign targeted towards youth opioid education and awareness and fentanyl risk education at the California Department of Public Health, increasing the total program funds to $40.8 million

The revised budget will ultimately be determined by state legislators who decide how to spend Californians' tax dollars. Over the past several weeks, Governor Newsom and top state lawmakers have been negotiating the details of May Revision.

The Legislature must be signed by the governor by June 30, 2022, in order to take effect by the next fiscal year that starts on July 1, 2022.

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



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Ask My Practice

by Andie Tena

No Surprises Act Independent Dispute Resolution (IDR) Portal

The No Surprise Billing Act went into effect on January 1, 2022, and affects physicians that see patients who are uninsured or who self-pay for medical services.

Per the guidelines of the act, patients can no longer be balance billed for services. Therefore a new process was put in place for physicians to notify patients up front what they can expect to pay out of pocket if services are not covered under an insurance plan. This rule is called the Good Faith Estimate (GFE) and a sample GFE form can be seen here: **https://www.cms.gov/files/document/good-faith-estimate-example.pdf**. The estimate is provided to the patient prior to their visit and is based upon when the patient scheduled their visit. For further information on the GFE, please visit **https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources**.

With the implementation of the No Surprise Billing Act and protections against out-of-network balance billing also comes a new process to dispute claims paid with insurers. Physicians and facilities can no longer dispute a denial, or an amount paid to them directly with the patient, and must follow a new process called Independent Dispute Resolution (IDR). This process is initiated through CMS, and a portal guides the user through a questionnaire that determines if the claim is eligible for dispute.

The CMS Independent Dispute Resolution Process:

- Brings in a third-party, known as a certified independent dispute resolution entity, to decide the payment amount. The parties have an opportunity to select the independent dispute resolution entity from a list of certified organizations, and everyone involved must attest to having no conflicts of interest
- Requires the provider or facility and the health plan to submit payment offers to the dispute resolution entity and additional information supporting their payment offers.
- Requires the dispute resolution entity to select from the disputing parties' payment offers. Both the provider or facility and the health plan must abide by the entity's decision and payment must be made within 30 calendar days.

At the onset of the IDR process implementation, the negotiated amount to be paid to the provider was based on the Qualifying Payment Amount (QPA), which was a calculated average payment amount determined by specialty and region for the service rendered. Due to a recent ruling by a federal judge, the negotiated rate has since been revised and is now based not wholly on the QPA but more heavily on the physician's level of training or experience, clinical quality and outcomes, market share,

continued on page 10

Continued from page 9

patient acuity, service complexity, teaching status, case mix, and scope of services of the facility, and good faith efforts by either party to enter into in-network agreements and contracted rates.

If your practice needs more information about the IDR process or would like to open a dispute, please visit the following CMS link to learn more about the process. **https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans**

If you have additional questions about No Surprise Billing Act and the IDR process, please contact *My Practice* at **213-473-8630** or via email at **MyPractice@CAPphysicians.com** for immediate assistance.

My Practice was created as part of CAP's commitment to providing you with valuable products, services, and resources to support a successful medical practice, so you can spend more time focusing on superior patient care.

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

Critical Tips for Protecting Your Practice from Dangerous Business Risks

June 2022

Medical practices are legal business entities that carry significant financial risks. While it is impossible to remove 100 percent of everyday risks, physicians should take prudent steps to mitigate business and financial risks to their practices.

Accidents happen more often than you may think and the impact on your practice can be far reaching. An accident such as a fire or flooding can cause a medical practice to incur significant, unanticipated expenses, expenses such as securing temporary office space, notifying patients, increasing payroll costs, and replacing and repairing damaged inventory or equipment.

A Business Owners Policy (BOP) is one of the best ways to protect your practice and mitigate your business losses. It combines a wide range of business liability and property/casualty coverage into a single package.

A Good BOP Policy:

- Provides insurance against alleged claims of personal injury or damage unrelated to medical malpractice, including cost of legal defense and settlements
- Repairs or replaces damaged buildings, equipment, or other business property
- Reimburses lost income or costs if the practice closes following a property loss
- Covers the cost of replacing or restoring damaged records or files due to a property loss
- Pays for medical costs of individuals other than employees who are injured at your practice

continued on page 12

Continued from page 11

PLUS—Some BOP policies include the additional installation of a free water sensor program to help avoid potentially devastating water damage!

Although a BOP policy will cover the financial damages associated with a non-employee, non-clinical injury that occurred in your practice, it will not cover employee injuries occurring because of a workplace accident. There are many common risks in a medical practice that can lead to employee injuries - biological hazards, needles, other chemical and drug hazards and regular trip and falls.

Most medical practices are likely well-acquainted with a safety-first culture and provide the necessary OSHA training for employees to help avoid accidents of any kind. However, accidents will and do happen. That is why all California employers are required to have workers' compensation insurance. Failure to do so may results in heavy fines and penalties.

When an injury occurs on the job, both productivity and profits suffer, yet many employers continue to be inadequately covered or not covered at all. Workers' compensation insurance protects you and your employees.

A Good Workers' Compensation Policy:

- Covers the medical expenses of the injured employee
- Covers the employee's lost income
- Helps the employer return their employee to work sooner
- Protects the business owner from accident-related lawsuits
- Ensures a seamless and effective claims process

Pricing for workers' compensation varies but is primarily driven by gross payroll costs and claims history. When shopping for insurance, physicians should find a trusted financial advisor to discuss how much coverage they need. If possible, physicians should either consolidate their insurance business with an agency that can handle all of their insurance needs, or create visibility of their entire portfolio for their advisor to see.

CAP Physicians Insurance Agency, Inc. (CAP Agency) is a full-service insurance agency created to support CAP members. CAP Agency's licensed and trained professional insurance agents have expertise in all lines of business and personal insurance coverage, and they know healthcare. They can provide you with a comprehensive review of your risk exposures, assess your current coverage, and provide you with comparative, competitive quotes at no cost to you. To learn more, call **800-819-0061** or email **CAPAgency@CAPphysicians.com**.

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