Practical Tips to Use Daily to Ensure Concise and Compliant Documentation

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Disclaimer

• This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.
COMPLIANT DOCUMENTATION

DOING IT RIGHT AND GETTING PAID FOR IT
Medical necessity is the
– “overarching criterion for payment in addition to the individual requirements of a CPT code.
– It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
– The volume of documentation should not be the primary influence upon which a specific level of service is billed.
– Documentation should support the level of service reported.”
Medical Necessity

• CMS has stated that medical necessity drives the level of service not the volume of documentation

• Medical Necessity defined by a payer is the amount of work necessary to treat the problems presented or found at this visit.
How sick is the patient?

• The history will provide the necessary information to support the level of work needed to treat the patient

• New findings in an exam may require additional work up and medical decision making

• Co morbidities may make care of this patient more complex
1995 & 1997 Guidelines

• DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
• Bill is here
• Since his last visit
Nature of Presenting Problem

- Presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter,
  - **With or without** diagnosis being established at the time of the encounter.

- The **extent** of the history and examination is dependent upon clinical judgment and the nature of the presenting problem(s)
1995 Guidelines for Evaluation and Management services

- "Medical record documentation is required to record
  - Pertinent facts
  - Findings and observations about an individual's health history including
    - Past and present illnesses
    - Examinations
    - Tests
    - Treatments and outcomes."
• Documentation:
  – Provides a narrative of the care being given to a patient.
  – Should include:
    • Progress
    • Response to and changes in treatment
    • Diagnosis and any revision to it
– In the hospital setting
  • Communicates information about the patient's status
  • Shows what direction the physician is taking in the care and treatment of the patient on a daily or hourly basis.
Medicare judges an E/M visit at which a single, chronic, well-controlled problem is evaluated and managed to be a visit that, regardless of how much history and examination is documented, is a low-intensity service based on medical necessity.

- Trailblazers MAC
Likewise, Medicare judges that such a visit remains a low-intensity service even for patients with multiple chronic diagnoses unless the record specifically demonstrates additional physician work performed because the additional chronic conditions complicated the condition under evaluation or they were otherwise specifically managed at the visit.

• Trailblazers MAC
Explain

• Demonstrate additional physician work
  – “Medication list reviewed with patient”
  – “Medication list reviewed with patient and analyzed for problems with dose and interactions “
  – “Medication list reconciled with patient. Attention paid to dose, interactions and contraindications that could create problems for the patient”
  • Macro?
Documentation of E&M Visit

99213

- History – EPF
  - HPI: 1-3
  - ROS: 1
  - No PFSH
- Exam - EPF
  - 2 to 7
- MDM – Low (need 2)
  - 2 Stable problems or
    - 1 Est prob not stable or
    - 1 New problem
  - Order or review of Lab & X-ray or
    Lab & Medicine Test
  - 2 Self limited or
    - 1 Stable chr illness or
    - Physiological test/no stress (ie PFT) or
    - Minor Surgery with no risk or
    - PT or OT

Nature of Presenting Problem:
Low to Moderate Severity

99214

- History – Detailed (need 2 for Est. Pts)
  - HPI: 1-3
  - ROS: 2-9
  - PFSH: 1
- Exam - Detailed *
  - 2 to 7
- MDM: Moderate (need 2)
  - 3 Stable problems or
    - 1 Est prob not stable and 1 Stable or
    - 1 New problem
  - Order or review of Lab & X-ray with personal visualization of x-ray or
    X-Ray, Lab & Medicine Test
  - 1 Chronic illness with mild exacerbation or
    - 2 or more stable chr illness or
    - 1 Acute illness with systemic symptoms or
    - Physiological test with stress (ie Cardiac Stress) or
    - Minor Surgery with identified risk or
    - Prescription drug management

*Check with your Medicare Carrier
It could be 4-7 exam elements

Nature of Presenting Problem:
Moderate Severity
Pt has a sore throat for 1 week. Her nose has been stuffy.
Exam reveals significant post nasal drainage
Strep screen done in office was negative and chest x-ray ordered

Pt has had a sore throat for 1 week. Her nose has been stuffy and she has been running a fever.
Exam reveals white spots on her tonsils and lung crackles bilaterally
Strep screen done in office was positive, Pulmonary function test and x-ray were ordered
Antibiotic prescribed
99214

- History – Detailed (need 2 for Est. Pts)
  - HPI: 1-3
  - ROS: 2-9
  - PFSH: 1
- Exam - Detailed *
  - 2 to 7
- MDM: Moderate (need 2)
  - 3 Stable problems or
    1 Est prob not stable and 1 Stable or
    1 New problem
  - Order or review of Lab & personal visualization of x-ray or
    X-Ray, Lab & Medicine Test
  - 1 Chronic illness with mild exacerbation or
    2 or more stable chr illness or
    1 Acute illness with systemic symptoms or
    Physiological test with stress
    (ie Cardiac Stress) or
    Minor Surgery with identified risk or
    Prescription drug management

Nature of Presenting Problem:
Moderate Severity

99215

- History – Comprehensive (need only 2 of 3 for est pts)
  - HPI: 4
  - ROS: 10+
  - PFSH: 2 or 3
- Exam - Comprehensive
  - 8+
- MDM: High (need 2)
  - New problem with workup or
    2 Est problem not stable
  - Order or review of Lab and Medicine test & visualization of x-ray or
    Order or review of Lab and Medicine test & Review and summary of old records
  - 1 or more chr illness w/ severe exac or
    Acute or chr illness w/threat to body funct or
    Abrupt change in neuro status or
    Cardio imaging study w/ risk or
    Diagnostic endoscopy w/risk or
    Elective major surgery w/risk or
    Drug therapy requiring monitor for toxicity or
    DNR

Nature of Presenting Problem:
Moderate to High Severity
The pt thinks she has the flu. Pt complains of a sore throat with a headache for the past 4 days. She has been fatigued with joint and muscle aches.

Exam
- Consti: bp 150/80 resp 18
- HEENT- throat slightly red otherwise exam normal
- Heart – RRR
- Lungs- slightly decreased breath sounds

Exam (cont’d)
- All other systems negative
- Strep screen done in the office was negative. Chest x-ray and pulmonary function tests ordered.

DIAGNOSIS???

Is this a level 5??
For example, if you see an elderly patient with severe chronic obstructive pulmonary disease, congestive heart failure and hypertension, you do not need to individually document all the systems reviewed. Instead, you could document the positive or pertinent negative responses for the relevant systems and then simply note, “all others negative,” if appropriate, to cover the other systems reviewed.
Electronic Records

• Most rules have not been changed from paper records
  – Additional documents must be properly referenced to be included
  – Documentation should be for original work on patient (ie physical exam)
  – Name of person on documentation should be person who made entry
Electronic Health Record Issues

- Ownership of input device
- Cut and paste portions of record
- Pull forward
- Pre-population of data based on type of service or chief complaint
Electronic Health Record Issues

- Templates checking all things
- Conflicting information
- No logic to assessment and plan

- Is the work documented being done?
Dear Chief Executive Officers:

As leaders in the health care system, our nation’s hospitals have been at the forefront of adopting electronic health records for use in coordinating care, improving quality, reducing paperwork, and eliminating duplicative tests. Over 55 percent of hospitals have already qualified for incentive payments authorized by Congress to encourage health care providers to adopt and meaningfully use this technology. Used appropriately, electronic health records have the potential to save money and save lives.

However, there are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it’s illegal. These indications include potential “cloning” of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate “upcoding” of the intensity of care.
Law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided. The Department of Justice, Department of Health and Human Services, the FBI, and other law enforcement agencies are monitoring these trends, and will take action where warranted. New tools provided by the health care law authorize CMS to stop Medicare payments upon suspicion of fraud and to mine data to detect it in the first place. These efforts have contributed to record-high collections and prosecutions. Prosecutions in 2011 were 75 percent higher than in 2008. That said, we will continue to escalate our efforts to prevent fraud and pursue it aggressively when it has occurred.

The nation’s hospitals share our goal of a health system that offers high quality, affordable care. We thank you for your relentless work toward this goal which can be better achieved once all Americans have privacy-protected electronic health records. The health information technology incentive program promotes electronic health records that go beyond documentation and billing and towards meaningful use as a foundation for new payment and delivery models. The Affordable Care Act has accelerated the spread of such models like Accountable Care Organizations, patient-centered homes, and value-based purchasing which shift the incentives away from volume and towards value. As we phase-in electronic health records, though, we ask for your help in ensuring that these tools are not misused or abused.

Sincerely,

Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services

Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice
“The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR).

While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.”
• Ch 12 Â§ 30.6.1 (Volume of documentation does not support reason for visit); 1995/97 E/M Guidelines for DOS: 11/20/2012. Dx: 435.9 (TIA).

• Relevant documentation supports down code from billed 99215-25 with carve-out for new and/or relevant components only to 99213

• Volume of documentation far exceeds reason beneficiary is being seen, and there is a copy/paste identical duplication of the majority of the History's HPI/ROS, and Physical exam (except for VS) from the 3 previous visit notes submitted.
Missing:

- a) medical necessity support for the injection. There is no clinical support for the administered drug (Vit B12), although he did order a B12 level and added a Dx of Chronic Fatigue Syndrome this DOS. No prior level was mentioned, nor a prior relevant dx under treatment or monitoring to support the drug, therefore the injection is non-covered, and no need for the 25 modifier

- b) while documentation is high volume, it is not all relevant to the specific reason for visit or comorbid follow-ups (volume exceeds medical need).
Physicians and non-physician practitioners, referred to below as "provider," may use templates, checklists, and/or electronic medical records to assist in documenting Evaluation and Management (E&M) services and saving time. Medicare considers these as acceptable documentation.

However, the documentation submitted must be specific to the patient and the service in question.
Here are some things to keep in mind when using templates, checklists, and/or electronic medical records.

- Either the ancillary staff or the patient may complete the Review of Systems (ROS) and the Past Family Social History (PFSH) as part of the template, checklist, and/or electronic medical record.
- The provider must notate his/her review of the information.
- Additions to the file or confirming notations substantiate the provider’s review.

The provider may use an ROS or PFSH from a previous encounter.

- The provider must notate the date of the earlier ROS or PFSH and review all elements of the previous encounter noting any changes or elements not reviewed.
The billing provider must perform the History of Present Illness (HPI).

- The ancillary staff cannot collect this information and enter it into the medical record with the provider only signing or acknowledging they read the notation.
• The provider must describe any abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ(s) systems.

• Providers **should be wary of templates** that have pre-printed information indicating certain "comprehensive" level services were performed.

• **Documentation for each encounter must be specific to that encounter.**
Medicare Contractors

• Insurers studying link between electronic records and billing
  – Aetna and Cigna
• 45 out of 100 claims analyzed were paid in error
  – Also noted that patterns of over coding services were found with template-generated records.
    • Trailblazers
• Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

CGS, Palmetto
• “Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services.”

• They warned doctors that it would refuse to pay them if they submitted “cloned documentation.”

– NGS
Statistics

• Study by the Society of Critical Care Medicine
  – 82% of medical residents and 74% of attendings copy and paste more than 20% of their EHR patient progress notes from one session to the next.
  – The authors found that after a vacation day, 94% of attendings copied information from their own notes, with cloned information making up an average of 61% of the new progress note.
STUDY of VA PATIENTS

• 1,479 Patients
• 167,000 Progress notes
  – 90,000 instances when pairs of documents contained identical 40 word sequences
  – 54.8%
• REMEMBER: Any field in an EHR that is automatically populated presents potential risks related to compliance as well as patient quality and safety.

• It always is essential that the documentation in a medical record relate only to actual services provided, clearly identifies the individual who provided them, and contains current and accurate findings about the patient.
Physicians may occasionally utilize the services of a “scribe” to assist with documentation during a clinical encounter, which can be in an office or a facility setting, between the physician and the patient.

A scribe can be a Non-Physician Practitioner (NPP), nurse or other ancillary personnel allowed by the physician to document his/her services in the patient’s medical record.

The “scribe” does not act independently in Evaluation and Management (E/M) services, surgical, and other such encounters, but documents the physician's dictation and/or activities during the visit.

The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply "scribed" by another person.
CAHABA MAC on Scribes

Documentation of scribed services must include the following:

Who performed the service;
- Physician co-signs the note indicating the note is an accurate record of both his/her words and actions during that visit
  - Example: I, Dr. __________, personally performed the services described in this documentation, as scribed by __________ in my presence, and it is both accurate and complete.

Who recorded the service;
- Record entry notes the name of the person "acting as a scribe for Dr. X."
  - Example: I, ____________, am scribing for, and in the presence of, Dr. _______.

- Qualifications of each person
- Signed and dated by both the physician and the scribe
• Handwritten Note:
  – Identification of scribe:
    • '______ scribing for Dr._______' or '______ is scribing for me today'
  – Notation from physician/NPP that he/she reviewed for accuracy:
    • 'I agree with the above documentation' or 'I agree the documentation is accurate and complete'

• EMR/Dictated Note:
  – Identification of scribe:
    • 'Dictated by ______'
  – Notation from physician/NPP that he/she reviewed for accuracy:
    • 'I agree with the above documentation' or 'I agree the documentation is accurate and complete'
"Scribe" situations are those in which the physician utilizes the services of his, or her, staff to document work performed by that physician… the "scribe" does not act independently, but simply documents the physician's dictation and/or activities during the visit.
DOCUMENTATION OF PROCEDURES
1995 & 1997 Guidelines
- DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.
  - Risk – a patient that has more than the normal risk in undergoing the procedure

WPS – MAC
- The medical record should not only show why a procedure was performed but what occurred during the procedure and how the patient did during and immediately after.
TIME BASED CODING
When counseling and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or unit/floor time in the hospital or nursing facility) time may be considered the key or controlling factor to qualify for a particular level of E/M service.”
“Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

– Diagnostic results, impressions and/or recommended diagnostic studies
– Prognosis
– Risks and benefits of management (treatment) options
– Instructions for management (treatment) and/or follow-up
– Importance of compliance with chosen management (treatment options)
– Risk factor reduction
– Patient and family education”
“The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.”
Using Time

• More than 50% of time spent counseling and coordinating care
• Documentation of overview of conversation
• Note must support medical necessity of level of visit
  – “15 min 65%C&C”
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Transitional Care Management

• Providing or overseeing the management and coordination of services, as needed
  – All medical conditions
  – Psychosocial needs
  – Activity of daily living supports
Transition From Where to Where?

Patient Discharged From:
- Inpatient hospital setting
  - Including acute hospital, rehabilitation hospital, long-term acute care hospital
- Partial hospitalization
- Observation status in a hospital
- Skilled nursing facility/nursing facility,

Patient Discharged To:
- The patient’s community setting
  - Home
  - Domiciliary
  - Rest home
  - Assisted living
Who can initiate?

- CY 2013 PFS final rule with comment period, we adopted a policy to pay separately for care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary’s primary physician in the community.
• If the hospital makes an appointment for the patient following discharge or if the patient calls for an appointment following discharge, does this count as the initial interactive contact?

• No. The initial interactive contact is more than simply making an appointment. It is an interactive exchange of information.
Medication Reconciliation

• Medication reconciliation and management must occur no later than the date of the face-to-face visit.
Under direction of a physician or other qualified health care professional

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Regarding aspects of care.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.
- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources.
- Facilitating access to care and services needed by the patient and/or family.
Non-Face-to-Face Services by Provider

- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.
Medical Decision Making (MDM)

Moderate Complexity

• Multiple possible diagnoses and/or the management options

• Moderate complexity of the medical data (tests, etc.) to be reviewed

• Moderate risk of significant complications, morbidity, and/or mortality as well as comorbidities

High Complexity

• Extensive number of possible diagnoses and/or the management options

• Extensive complexity of the medical data (tests, etc.) to be reviewed

• High risk of significant complications, morbidity, and/or mortality as well as comorbidities
Template for TCM Documentation

- Name
- DOB
- Discharging Physician
- Date of Discharge
- Discharge summary
- Discussion with discharging physician
- Summarize hospitalization
- Diagnosis
- Medications on discharge
  - Noting reconciliation done
- Notation of interactive contact
  - Date, who, service or method
Template for TCM Documentation

• Diagnostic tests
• Services
  – Community
  – Other care givers and agencies
• Education
• Documentation of Medical Decision Making
• Use MDM template from HGSA Audit tool
• Notations of follow up care instructions and follow up visits
Transitional Care Management Reimbursement

• 99495 – Moderate Complexity  
  – 4.82 RVU = $ 164.00

• 99496 – High Complexity  
  – 6.80 RVU = $231.00
CHRONIC CARE MANAGEMENT
CCM
Code GXXX1 - Chronic care management services furnished to MEDICARE patients with multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;  
– 20 minutes or more; per 30 days.
CCM - Medicare

• Minimum of 20 minutes of clinical labor time

• It is believed many aspects of this service will be provided by clinical staff – and thus, clinical staff will be involved in the typical service for the full 20 minutes.

• Services provided by clinical staff would be performed “incident to” provider’s services
CCM - Medicare

• Required element
  – Availability to a beneficiary 24-hours-a-day, 7-days-a-week to address the patient’s chronic care needs

• If the need for contact arises outside normal business hours
  – It is likely that the patient’s initial contact would be with clinical staff employed by the practice (for example, a nurse) and not necessarily with a practitioner
CCM - Medicare

• If outside normal office hours
  – Practitioner probably not available to provide direct supervision
• Policy exception created to require only general, rather than direct, supervision for these incident to services
  – Not restricted to outside practice’s normal business hours
  – Must be clinical staff who are direct employees of the practitioner or practice.
Payment CCM

• Proposed for 2015
  – $41.92
Non-physician Practitioners

Office
• Incident to
  – Established patients only
  – Plan of care
  – Direct supervision

Hospital
• Split Shared
  – Each provider (MD/DO and PA/NP) performs a part of the service
  – Each document the work they have done
“Hospital Inpatient/Outpatient/Emergency Department Setting

B. When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number.

MCM – Chapter 12 – 30.6.1b
2015 proposal

– Collecting data on expenses via use of modifier
– There is a growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments.
– CMS seeks to better understand how this trend affects payments under the MPFS and OPPS, as well as beneficiary cost-sharing obligations.
MODIFIER 59 – SUB-SET MODIFIERS
• The -59 modifier is both commonly used and commonly abused.
  – 2013 CERT Report data
    • Projected $2.4 Billion in MPFS payments were made on lines with modifier -59
    • With a $320 Million projected error rate.
      – 13%
Modifier 59

• Used in a wide variety of circumstances
  – Different encounters
  – Different anatomic sites
  – Distinct services.

• CMS believes that more precise coding options coupled with increased education and selective editing is needed
Sub Set 59 Modifiers

• **XE** - Separate Encounter
  – A Service That Is Distinct Because It Occurred During A Separate Encounter

• **XS** - Separate Structure
  – A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

• **XP** - Separate Practitioner
  – A Service That Is Distinct Because It Was Performed By A Different Practitioner

• **XU** - Unusual Non-Overlapping Service
  – The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”

Thank you!

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