STRATEGIC USE OF TEMPORARY COVERAGE
Some Advice From Staff Care and Med Travelers

America’s patient care facilities increasingly depend upon temporary providers, from family practitioners to neurosurgeons, from physical therapists to nuclear medicine technologists. Consider the following:

♦ Some 29,000 physicians practiced on a locum tenens basis at some point in 2003.
♦ Traveling imaging technologists filled close to 3,500 otherwise vacant shifts each day, on average, last year.
♦ Almost half (46%) of all facilities nationwide are currently searching for temporary CRNA coverage.
♦ Hospitals, medical groups, clinics, and other facilities spend $2.6 billion on temporary physician services and just over $1 billion on travelers in 2003.

The industry is seeping into the mainstream of healthcare staffing. But what are the implications of this trend?

Anyone responsible for recruiting clinical personnel, directing a department, or overseeing the operations of a group or facility must learn the benefits and pitfalls of temporary staffing, particularly when working with a staffing agency. Too many hospitals and other employers pay scant attention to physician or provider availability until absolutely necessary. Those who employ temps strategically, on the other hand, gain an effective and flexible addition to their staff.

Staff Care and Med Travelers, the nation’s leading staffing firms in the locum tenens physician and traveling mid-level provider fields, suggests that hospitals maintain a relationship with a short list of proven staffing partners. They also offer this advice on the strategic use of interim professionals:

Establish Goals

First and foremost, temporary coverage allows short-staffed facilities to maintain patient care. Recent research suggests a continued shortage of physicians and providers, which greatly affects patient care and the financial well being of healthcare facilities. According to the American Hospital Association:

♦ 19 percent of hospitals report increased wait times for surgeries.
♦ 10 percent have cancelled surgeries.
♦ 17 percent have reduced service hours.

Physician and provider coverage should always be considered when patient wait times increase or when services must be cut involuntarily—for two reasons. One, the lost revenue through patient migration to competing, fully staffed practices is always a concern, particularly in urban areas. The other reason has to do
with staff retention and burnout from overwork. Someone must absorb the patient load. One out of every four administrators lists preventing staff burnout as a key reason to seek temporary physician coverage. An astounding 43 percent of imaging department directors employ traveling technologists in order to prevent staff burnout.

Solving workplace issues such as support and patient load are crucial to staff retention. The goal, however, is not to increase your use of locum tenens and travelers, but to employ them strategically. Proactive use of temporary providers will support permanent staff, making retention easier and diminishing unplanned reliance on short-term coverage. You’ll also ensure seamless patient care.

**Evaluate the Costs and Benefits**

When asked in a recent survey to list their primary concerns when using locum tenens or travelers, administrators ranked cost well ahead of other issues. Cost, however, is a matter of perception. In 2002, healthcare facilities typically paid $6,350 per week for the services of a locums orthopedic surgeon. During an average week, according to Medical Group Management Association figures, a staff surgeon would handle 108 patient visits and generate $23,247 in gross charges.

The important thing is to understand the value of each physician and provider—on a daily or weekly basis. How many patients do they see? What are the gross charges for each procedure? How much is actually billed? It’s all too common for those in hiring or leadership roles to react to dismiss temporary coverage as an overly expensive option. By understanding—accurately—the cost-benefit balance, you’ll be able to make a sound strategic decision.

**Plan For All Purposes**

Staff Care and Med Travelers can provide helpful benchmarking tools for administrators, including the 2004 *Review of Temporary Healthcare Staffing Trends*. This document presents survey data and analysis of industry trends. Consultants with both agencies will explain the details of qualifying a candidate, malpractice coverage, state licensure, and other issues. They work with all physician specialties, imaging technologists, and therapists.

For more information contact Tracy Fletcher, The MHA Group, 1-800-876-0500 or 469-524-1755 or Kristen Hajduk, The MHA Group, 1-800-876-0500 or go to their website at [www.mhagroup.com](http://www.mhagroup.com)

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**COUNTRY DOCTOR OF THE YEAR NOMINATIONS SOUGHT**

IRVING, TX—The good old-fashioned country doctor is fading from American culture. Those few who remain typically work longer hours, treat more patients, and earn less money than their urban counterparts. Yet few doctors accomplish so much for a community. One saved a North Carolina coastal community from Hurricane Isabel’s destructive winds. Another battled colon cancer while treating patients from several West Virginia mountain counties. A doctor in Pennsylvania revived his town’s struggling economy. Then there’s the physician who single-handedly saved a rural Mississippi hospital by working over 100 hours each week—at the age of 74.
The **Country Doctor of the Year Award**, now in its tenth year, recognizes the work of America’s top rural physicians. Staff Care, a Dallas-based locum tenens (temporary physician) staffing firm, sponsors the annual award, presented to a physician who best exemplifies the spirit, skill, and dedication of America’s rural medical practitioners.

While 20 percent of Americans live in rural areas, only 10 percent of all doctors practice in small communities. Some 460 rural hospitals closed since 1980, leaving physicians with little support. In addition, many patients at rural facilities carry no medical insurance, almost one in five are elderly, and 16 percent live in poverty. Yet the great country doctors persevere.

“Each year, rural practitioners rally communities, keep struggling hospitals open, and save lives,” says Joe Caldwell, executive vice president of Staff Care. “They deserve recognition.” Anyone may nominate a worthy physician. The award will be presented in December.

**Nomination forms for the 2004 Country Doctor of the Year award may be requested by calling (866) 756-0002 or by visiting www.countrydoctoraward.com. Materials must be completed and returned by September 3, 2004.**

**Award Criteria**

A selection committee comprised of healthcare executives, country doctors, and healthcare leaders will judge nominations based on the following criteria:

- **Scope of care.** Nominees must provide primary care to patients of all ages.
- **Rural location.** Nominated physicians must practice in a community of 25,000 people or less.
- **Dedication.** Nominees must have demonstrated extraordinary dedication to their patients and community, both during the year and over the course of their career.

Each year the award committee learns of physicians who routinely sacrifice normal comforts in order to save a life, mend a scratch, or merely treat a cold. “Stories of 4 a.m. house calls, of lives being saved in cornfields, of doctors rushing out at night throwing a smock over their pajamas, of payments in the form of watermelons and jars of molasses may seem quaint,” Caldwell says, “but they speak of the country doctor’s dedication to his or her patients. Those are the doctors we’re looking for.

**An Honor Roll Of Legendary Doctors**

The Country Doctor of the Year Award highlights “local legends” whose exploits might otherwise escape national attention. The previous award winners are:

- Charles Boyette opened his home as an emergency room after the local hospital shut down in anticipation of Hurricane Isabel. A year earlier, his efforts attracted Federal grants for a project to raise 320 homes above flood level, saving the town from terrible storm damage.

- James Blume lists 7,000 active patients at his clinic in Forest Hill, West Virginia, a town of 75. He worked through colon cancer and sold property to pay rising malpractice premiums.

- Kamlesh Gosai of Bentleyville, Pennsylvania. He stepped in after several other doctors refused offers from the dying town and rebuilt a community.

- Howard Clark of Morton, Mississippi, who single-handedly kept the local hospital open. At age 73 he still worked close to 100 hours a week.
- Paul F. Maddox, who kept his Campton, Kentucky, clinic open 24 hours a day, 365 days a year, for three decades. In 1999 he continued to practice after being diagnosed with cancer, scheduling patients around daily chemotherapy.

- Elton D. Lehman, for 35 years a country doctor in Mount Eaton, Ohio. Dr. Lehman brought modern medicine to the large Amish community of Stark County while also serving as the town’s mayor.

- William Hill served as a solo physician in Carrollton, Alabama, for over 50 years, carrying on a family tradition. Physicians from the Hill family treated patients in Carrollton since before the Civil War.

- Claire Louise Caudill, otherwise known as the “Mother of Rowan County.” Dr. Caudill delivered over 8,000 babies in Morehead, Kentucky, during her 50 year career. The town named St. Claire Hospital in her honor.

- John Harlan Haynes, described by patients as “a cross between Marcus Welby and Daniel Boone.” Dr. Haynes practiced in rural Vivian, Louisiana, and saved the local hospital.

As sponsor, Staff Care provides the Country Doctor of the Year with an interim physician for one week at no cost, a service valued at up to $10,000. This will allow the award winner to take some well-deserved time off.

Those with questions or comments regarding the award may email Dave Faries at dfaries@mhagroup.com or call at 469-524-1470 or visit www.countrydoctoraward.com.

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The Power Behind Payment Data to Strengthen Hospital Compliance and Increase the Bottom Line

By Jacqueline T. Hodges, MBA, RHIA

For hospitals trying to make it in a competitive health care market, their success may have more to do with tracking and trending their services than with all the beds they can fill or rates they can raise. It’s the data—payment data in fact! With the myriad of other payer obligations hospitals contend with everyday, it’s more important than ever for them to know where they’ve been so they can predict where they are going. Hospitals really don’t spend a lot of time looking at their payment data. They use it to post to their accounts receivable but they really don’t look at the detail. That’s unfortunate because there is a wealth of information there and it’s easy to access.

The payment files are basically the result of provider coding and billing accuracy. Facilities send a string of numbers on a UB-92 or 1500 that tells the story of the services rendered to a patient. In exchange, the third-party payer sends a string of numbers back with the results of what was submitted. This string of numbers provides detailed information about payment, partial payment, outlier payments, denial or suspended claims status. While this information is filled with potential compliance and reimbursement concerns only a sampling is presented here.
Managing the 72-hour rule

The diagnosis related groups’ (DRGs) 72-hour rule simply states that all diagnostic outpatient services (including clinical diagnostic laboratory tests) that fall within 72 hours of an inpatient visit must be merged with the inpatient bill, regardless of the reason for the visit. This applies to outpatient services provided to a beneficiary by the admitting hospital or by an entity wholly owned or operated — sole owner or operator — by the hospital (or by another entity under arrangements with the hospital).

Outpatient services cannot be billed separately unless they are therapeutic in nature, and they are not related to the inpatient admission as defined by the principal diagnosis. Despite this directive, providers either inadvertently continue to be paid for outpatient services in violation of the 72-hour rule or continue to receive denials from the Fiscal Intermediary (FI). In order to retain the integrity of their revenue process and make sure they are being paid correctly, facilities should regularly query their payment data file.

Hospitals should utilize Section 415.6 of the Medicare Hospital Provider Manual to develop a query to analyze their payment data files by:

- Trending payment data for outpatient/inpatient claim overlaps that occurred within 72 hours of the inpatient claim. Even if the claim was denied, the FI still stores the fact that the denial occurred.
- Tracking provider numbers that would fall under the wholly owned and operated scenario. These provider numbers were not included in the original Department of Justice settlement and continue to be a source of compliance risk.
- Tracking and trending reason denial code CO-60, “Outpatient/Inpatient Claim Overlap”.
- Closing the loop on this process to ensure accurate payments in a compliant manner.

APC issues

Ambulatory Payment Classifications (APCs) make up a complicated payment system, but also incorporate a rich supply of detailed APC coding information. Hospitals can glean much of this information through their own payment data. Several areas have raised the potential for compliance problems and lower-than-appropriate reimbursement.

Unlisted specific procedure codes

These non-specific procedure codes represent unusual, variable or new services that are typically packaged into or paid as the lowest rated APC for the category. The biggest problem in using these codes is that most often, the code doesn’t represent the service rendered. It can be a target for review. These codes are very vague and very easy to use incorrectly. At several hospitals, I uncovered the frequent use of code 94799 — unlisted pulmonary service or procedure — for pulmonary rehab, which is not covered by Medicare. It’s really an unlisted procedure code for respiratory therapy. This issue is on the radar screen of the FI and/or Office of Inspector General (OIG) staff. In such cases the hospital should have coded the individual respiratory treatments that were provided to the patient.
Outlier payments

Within a hospital’s payment data is a record of all its outlier activity for each claim. Hospitals should conduct queries of their payment data to see in which instances outlier payments are occurring. And if so, whether the claim was coded and billed correctly. This is a targeted area for the OIG Work Plan 2002.

I often see hospitals’ incorrect use of CPT and HCPCS codes that results in a claim generating an outlier payment when it should have produced a regular payment.

One example involved a hospital that billed $46,932.80 in total charges for insertion of a pacemaker procedure. While that may not sound out of line, there were two fundamental problems with the claim: (1) rather than putting the correct code on the bill for the actual pacemaker procedure charge, the hospital inserted a nonspecific code 33999 — unlisted procedure, cardiac surgery; and (2) there was no C code on the bill for the pacemaker device which had a charge of $36,500.

The low payment for the nonspecific code (33999) of $91.57 coupled with the lack of C code for the pacemaker device caused the claim to receive an outlier payment of $11,943.12 in addition to the APC payment totals of only $177.92. The total payment for the claim was $12,121.04.

If the claim had the correct CPT code for the insertion of pacemaker procedure (33213) and the C code for the pacemaker device (C1785) then the Medicare payments would have been $2,776.03 and $10,297.00 respectively. Thus the total claim would have been correctly paid at $13,159.38, which is in excess of the previous payment and would have eliminated the potential red flag associated with the high outlier payment for a non-specific procedure.

Correct modifier usage

Incorrect modifier usage will trigger overpayments and underpayments. Since the hospital’s payment data contains the history of modifier usage, this is the first place hospitals should look to find solutions for this issue.

Yet modifiers are a sticky wicket for hospitals especially when their systems don’t edit out incorrect usage. Some errors are more obvious than others. Many hospitals use modifier–50, bilateral procedures, in places where by definition, you don’t have these types of bilateral body sites. I also frequently see hospitals attaching modifier–91 — repeat clinical diagnostic lab test — for services other than laboratory services. There are also many cases where the hospital payment data will have a denial for incorrect or missing modifier (CO-4).

Upon investigating this issue, it turns out the modifier code was placed on the billing record not by a coder, but by a business office staff person. This online claims adjudication occurs once the claim has been filed by the hospital and suspended by the FI. The changes are actually made in the FI system and not on the hospital’s data.

Analysis of the provider’s payment data is the only way to ensure that there are no breakdowns in the revenue cycle regarding accurate modifier coding.

Denial trending

With APCs, hospitals are filing much detailed, service level information. Denials will occur at both a claims level and at the service level.
The payment data file provides the hospital with a wealth of information that the third-party payer already knows. For hospitals that don’t see the detailed payment information, a service level denial will not be identified since the payment is posted at the claim level. They are getting that high level information that incorporates submitted charges, co-payment, deductible, and payment. However, the service level denials that exist within the body of a claim will not appear until the patient complains about the additional amount owed that was not anticipated. This results in a public relations issue and a potential compliance issue because the partially denied claims are not identified through routine posting of payments.

An example of a service level denial occurs when requested information was not provided or is insufficient. For that, hospitals will receive denial reason code CO-17. Using a modified barium swallow as an illustration, facilities need to remember that sometimes more than one set of information is required when Medicare requests documentation. In this case, a modified barium swallow involves both radiology and speech pathology data and hospitals will need to provide both pieces of documentation — a radiology report and a speech pathology note.

I recommend that hospitals query their payment data file and trend denials by reason code and dollar volume.

Advanced Beneficiary Notices

It is important for hospitals to regularly review their payment data to see if the FI accurately classified any ABN-related claims. Hospitals look at one of two things when they submit a claim that triggered an ABN Medicare denial:

- the patient disagreed with the hospital’s decision and wants it to submit the claim to the FI for approval or denial. After reviewing the claim, the FI will likely ask to see the medical record and will determine whether the procedure is medically necessary. The result of that determination will be found in the payment data with one of the following codes if it was denied: COB-22 “Denied Based on Diagnosis” or PR-46 “Non-covered Services.”

- when the hospital knows a service is not covered but needs that denial from the FI to file the claim with a third-party payer.

Claims must have an ICD-9-CM code attached for the procedure to evidence medical necessity. Facilities should query payment data files for all COB-22 or PR-46 denial reasons to determine if the provider initiated the request or if the FI denied based on incomplete claims information submitted.

This is not only a compliance issue, but also a lost revenue concern. One hospital had service-level denials (not claims level) over a one-month period that amounted to $11,974. $5,000 of that amount could be tied to code CO-B22. That means that approximately 45 percent of its service level denials were attached to this ABN issue. Without analysis and intervention, this can grow to substantial losses. If you have a good compliance plan, you will also secure your revenue.

Jackie T. Hodges, MBA, RHIA, is President of Med-Data Management, Inc. a healthcare regulatory and reimbursement consulting firm. She speaks extensively to healthcare professional associations across the country and has developed provider specific training programs related to Medicare, Medicaid and third party payer requirements. She has served as an expert witness in legal cases related to documentation and compliance issues.

For more information go to their website at www.meddata.com
Ramsey, Krug, Farrell & Lensing (RKF&L) is one of Arkansas’ largest insurance brokerage and consulting firms with well over $100,000,000 in annual written premium. The office is located in Little Rock and staffed by 103 employees. RKF&L has seven (7) specialty divisions including Healthcare, Construction, Transportation, General Commercial Business, Personal Accounts, Life and Employee Benefits and Risk Management Resources.

The Healthcare Division of RKF&L is a specialty group of eleven (11) staff members dedicated to providing liability and property insurance to healthcare providers in Arkansas and some surrounding states. This group currently serves forty-seven (47) hospitals, over 2000 doctors and numerous other healthcare providers for their professional liability and collateral lines including property; auto; directors’ and officers’ liability; managed care errors and omissions; and other miscellaneous coverage. RKF&L is not only Arkansas’ largest agency for healthcare providers but is one of the largest in the Southeast U.S.

The RKF&L Advantage

Market Access
RKF&L has access to the broadest range of carriers for hospitals in Arkansas, several of which are on an exclusive or preferred basis. This is the result of RKF&L’s commitment, size, expertise, and professionalism that is widely respected in the industry. Constant touch with the healthcare professional and collateral lines market place is maintained by RKF&L in regard to markets, trends and available coverage beneficial to Arkansas hospitals.

Local Claim Handling
A significant benefit to being a customer of RKF&L is having local medical professional and general liability claim representatives that provide superior claim service to hospital clients on a 24/7 basis. The majority of carriers contract the servicing of claims to RKF&L due to the expertise of its staff, local presence and in depth knowledge and experience in the various legal environments in Arkansas. Proper claim service is the most important aspect of the insurance process. It requires local knowledge of jurisdictions, claim values, and the attorneys involved, both plaintiff and defense.

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No matter the size of the hospital, RKF&L can tailor a program that best meets the needs of the facility. Professional and general liability can be structured in a number of different ways including first dollar/small deductible, large deductibles and self-insured retentions. Comprehensive property insurance programs are available ranging from the small single location hospital to the largest multi-location medical system. RKF&L has also developed programs specific to Arkansas hospitals in the areas of directors’ and officers’ liability, automobile and other property and liability lines of business.
Loss Control/Quality Assurance

RKF&L has loss control specialists on staff experienced in medical professional, general liability, automobile and property risk management that work separate or in conjunction with the carrier loss control personnel. This is dependent upon the plan structure of the client’s insurance program. In cases where the insured opts to enter a self-insured status, our loss control staff will provide services as part of the third-party administrator (TPA) agreement. Risk management seminars are routinely held for clients in the areas of professional liability and workers’ compensation.

Self-Insurance Trust Administration

RKF&L has structured and currently manages a number of self-insured trusts related to medical professional, general liability and workers’ compensation. It has the necessary third party administrative functions such as claims, loss control and underwriting personnel in place to support a self-insurance program. In addition, RKF&L has formed special relationships with the country’s leading healthcare law firms and actuarial firms that are required to properly administer a self-insurance plan.

AHA Self Insurance Trust Administrator

RKF&L is the administrator for the Arkansas Hospital Association Workers Compensation Self Insurance Trust. Our clients benefit through the better coordination of coverage that is frequently required between the WC and other liability coverage. RKF&L is also a sponsored service provider of the Arkansas Hospital Association working closely with it to provide the best in service and product to Arkansas hospitals.

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Agfa Becomes Authorized Dealer of InSiteOne Products

Agfa’s IMPAX® PACS with InSiteOne’s InDex® provides on-demand access to images stored both on-site and off-site

Ridgefield Park, NJ – May 27, 2004 – Agfa, a world leader in Picture Archiving and Communication Systems (PACS), and InSiteOne, Inc., America’s leading supplier of integrated on-site and off-site archiving of digital medical images, announced today an Authorized Dealer agreement. The agreement enables Agfa and InSiteOne to assist clients in meeting their long-term image storage and archiving requirements on a fee per study basis without the need for facility management and long-term hardware scalability.

Under the new agreement, Agfa customers gain access to InSiteOne’s InDex® line of secure integrated DICOM storage solutions. These complement Agfa’s already robust variety of on-site solutions for capturing and storing digital medical images, which include RAID, Storage Area Networks, (SAN), Network Attached Storage (NAS), Content Addressed Storage (CAS), MOD, DVD, and Tape Libraries.

“We want to make the transition from analog to digital as seamless as possible and provide streamlined access to complimentary technologies,” says Michael Green, Vice President, Global Marketing at Agfa HealthCare. “Agfa’s alliances with leading-edge suppliers like InSiteOne, provides numerous benefits for our customers.”

“We are pleased that Agfa recognizes the value of our archiving services that include onsite and redundant offsite archiving and disaster recovery models for digital medical images,” says Jim Champagne, Senior Vice President of InSiteOne. “Through this agreement Agfa can provide customers with a leading-edge PACS and Best-of-Breed short-term and long-term solutions to manage health information and images.”

About InSiteOne
Headquartered in Wallingford, CT, InSiteOne, Inc. (www.insiteone.com) is a leading service provider of Web-enabled digital image storage and archiving solutions to the medical community. The InDex® product line is designed to integrate with any PACS component and optimize the storage and archiving of medical images for healthcare facilities transitioning to filmless digital imaging.

InSiteOne offers hospitals, imaging centers and physician group practices a cost-effective, versatile, pay-as-you-go service that delivers exceptional speed, flexibility, economy and security for short-term and long-term access to and archiving of DICOM images. InDex® provides on-demand access to images residing either locally or at a storage facility linked via an Internet VPN to a health care facility’s network.

About Agfa
The Agfa-Gevaert Group is one of the world’s leading imaging companies. Agfa develops, manufactures and markets analogue and digital systems, intended mainly for the graphics industry, healthcare, micrographics, motion picture and photography markets.
Agfa’s headquarters are in Mortsel, Belgium. The company is active in 40 countries and has 120 agents throughout the world. Together they achieved a turnover of 4,215 million euros in 2003. Product and company information can be found on Agfa’s home page on the World Wide Web at: www.agfa.com.

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For more information or to set up an interview, please contact:

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