THE LEADING EDGE

Pathology Coding and Billing

Billing Technology Results

Vol. 10 | Winter 2013

WELCOME!

Welcome to the winter 2013 issue of the Leading Edge. While the healthcare world has been anything but quiet over the past few months, in late October and early November, SuperStorm Sandy showed all of us what is really important.

Due to solid disaster recovery planning, a robust technology infrastructure, and extraordinary efforts by AdvantEdge team members, our clients saw almost no impact on the work we do for them. The same can't be said for the operations of many of our clients in New York and New Jersey. Or for our operations center in Staten Island.

Our lead story in this issue describes the impact the storm had on our Staten Island office (located only feet from the water) and, more importantly, the effects on three team members. The response to their needs from individuals across the company is a great example of how the worst circumstances bring out the best in people.

Our other feature highlights an emerging trend faced by physicians and hospitals: how do patients understand the costs of a non-emergency procedure in advance? Often referred to as "transparency in health care pricing," we are seeing more and more examples where patients can compare providers on both quality and cost.

Of course, the beginning of a new year brings numerous regulatory updates. We've outlined the changes to the PQRS and eRx programs. These are examples where CMS is moving to replace "carrots" (incentive payments) with "sticks" (penalties). In addition, there are a number of specialty and procedure-specific payment changes by Medicare. They are particularly important for pathology and radiology.

The big news from Washington is that the 26.5% SGR cut to Medicare physician rates has been postponed one more time; in this case for one year. The risk of the 2% sequestration cut remains, now targeted for March 1. We have more details inside and we will continue to keep everyone updated as events unfold.

One lesser noted aspect of the fiscal negotiations is the possible impact on the planned increase in Medicaid payments for 2013 for family, general internal or pediatric medicine. It is worth noting that these increased reimbursement rates may be available to hospitalists and emergency department physicians, though not to other specialties such as radiology.

Please call or email me with your suggestions for the next issue: bgilbert@ahsrcm.com or 908-279-8120.

At this time of year, on behalf of the entire AdvantEdge team, I want to wish you a Happy New Year!

Bill Gilbert

Follow us on Twitter or Facebook to get regular industry and AHS updates: just click on the icons to the left.

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Staten Island Devastation Brings AHS Team Members Together for a Common Cause

Never worry about numbers. Help one person at a time, and always start with the person nearest you.
-Mother Teresa

SuperStorm Sandy forever changed Staten Island and surrounding areas, resulting in staggering estimates of over $30 billion in damaged homes and businesses and a loss of over 40 lives in New York alone. Close to home, the effects of the storm have had long-lasting consequences for several of AHS' own.

The Staten Island office closed on Monday, the day after the start of the storm, and didn't re-open until the following Monday. The office building's first floor was flooded and was inaccessible until the following week. As a symbol of the storm's ferocity that remained weeks after the storm, a tanker washed ashore less than a block from the office's parking lot.

While everyone in the Staten Island office was affected in some way, from lost cars to food that had to be thrown out because of lack of refrigeration/electricity, a few team members were hit particularly hard. When word spread of their devastating losses, the company rallied behind them. The resulting fundraiser provided two ways of helping: one-time cash donations made through payroll deduction, and/or donation of vacation hours.

The results were astounding, and demonstrate AHS' generosity! In total, over $9,000 in cash was raised in approximately eight days; with the company's match, the total jumped to over $18,000. Vacation donations were just as generous, with over 840 hours offered to help with time off needed to meet with contractors, adjustors, etc.

THE THREE TEAM MEMBERS THAT RECEIVED THE AID OFFER THEIR STORIES AND THANKS BELOW:

Elaine has worked with AHS since 1992. Her home was completely destroyed by the storm, as were the homes of family members. Currently staying with a relative whose home was not affected, Elaine has been returning to her home daily to begin the process of rebuilding all that was lost. Because of her devastating loss, Elaine was a reluctant local celebrity with the local news media; the photo below was taken by ABC.

Elaine wanted to send a Thank You to all AHS team members:

"A simple thank you cannot express my gratitude for all of your generosity. Your selfless act of kindness with your donations of monetary value and most precious vacation time has rendered me speechless. The two simple words "Thank you" will never be enough to express the depth of my gratitude for what you have done for me and my family."

Jane has worked for AHS since 2005. Her home was situated on the shore in Staten Island. Jane and her family were not able to evacuate before the storm, and were rescued by boat. After they left their home, they were unable to return for over three days because of the flooding.

(This photo was taken by Pattie Heyde when she went to Jane's home to make sure everything was OK, but she obviously did not make it.)

The family has temporarily relocated to a relative's home in New Jersey while they await word on rebuilding. Jane also wanted to extend a thank you for AHS' generosity;

My family and I are overwhelmed by the support of my fellow employees and company. We have been through very trying times in the last month. The prayers and well wishes are helping us get through.

On Monday, Oct 29th 2012, the night of the storm, we tried to evacuate but were unsuccessful. As the water came through our home, our faith kept us strong through a difficult night. We were rescued by our neighbors the following morning. As we left on a small motor boat we didn't know when or if we would be able to return to our home. Thankfully the 16 feet of water that entered our home receded after three days. We did not expect this type of devastation. My children have had the opportunity to witness the triumph of the human spirit and the power of compassion. Our community begins its healing process. Our will is strong and we will forge forward.

Your generosity will help us begin our road to recovery to restore our home.

Fondly, Jane & Family

Denise has been employed by AHS since 2010. Her home was severely flooded during the storm, and she is still in the process of quantifying losses sustained and the extent of the damage. She asked that the following "Thank You" be published with this article:

To My AHS Coworkers:
My two story home in Staten Island was partially destroyed by Hurricane Sandy. The evening of the storm, I had evacuated with my son Michael 16, and my daughter Jenna 14. We drove out of the area to my brother's home. In the course of the evening, we had lost contact with my parents. They were flooded and could not evacuate in time. We never slept that night, as we prayed for the safety of my parents. Sirens blared and people screamed in the streets all night long.

My parents joined us at 7am the following morning. Later that day, we went back to our homes. The ocean surge came through and completely flooded my basement from floor to ceiling. We lost everything in it, including our heating system. There was nothing left to be salvaged, not even one thing.

We are slowly but surely recovering. It will be a long time before things are back to normal for us. I will never recover my children's first drawings and their story books. They will just be a memory for me. I wanted to thank each and every one of you, for donating to me. My words can never express the gratitude I have for all of you. I will use my donated time and money to rebuild my home. I will always remember this horrible tragedy. However, I will never forget the kindness of my co-workers, who have helped me through my difficult journey.

Denise Conroy

IN THE NEWS

NOVEMBER 6

AdvantEdge Healthcare Solutions named as the 4th fastest growing company in New Jersey by NJBiz as part of its **"50 Fastest Growing Companies in New Jersey."**

NOVEMBER 21

Imaging Biz article **"Eyeing the ACO: Demonstrating Engagement and Appropriateness"** has extensive quotes and great insights from AdvantEdge client Alan Kaye, M.D., CEO of Advanced Radiology Consultants (Fairfield, Connecticut). The article is available here.

DECEMBER 17

Philip Bolger joins AdvantEdge Healthcare as Senior Vice President Sales and Marketing. He has over 30 years of sales, marketing and operations experience in healthcare with several public and private companies.

SGR CUTS AVERTED FOR 2013 BUT SEQUESTRATION STILL LOOMS

On New Year's Day, Congress passed the "American Taxpayer Relief Act" as a partial solution to the "fiscal cliff." It replaces the tax hikes that took effect at midnight on January 1 with tax rates as they were at the end of 2012, except for individuals earning more than $400,000 and households earning more than $450,000.

The bill also delays the SGR cut of 26.5% for one year and replaces it with a "zero percent update" to the Medicare conversion factor. This update is not a freeze to the 2012 fee schedule; it only nullifies the 26.5% cut for a year. RVU and other changes published in the 2013 Medicare Physician Fee Schedule remain in effect, reducing or increasing Medicare payment rates.

The bill also pushes back the 2% sequestration cut to physician fees until March 2013. The next Congress will consider whether to allow sequestration to take place or replace it with other cuts in federal spending and/or higher taxes.

The bill also extends by one year several Medicare payment policies that were set to expire on January 1:

- The existing 1.0 floor on the physician work index
- Current payment exceptions process for outpatient therapy services
- Ambulance Add-on Payments for ground including super rural areas through December 13, 2013, and the air ambulance add-on until June 30, 2013.

Although at least 13 provisions were used to offset the cost of the one-year SGR fix, estimated to be $30 billion, here are the ones that could affect our clients:

1. Equalize payments for stereotactic radiosurgery services provided under Medicare hospital outpatient payment system (HOPPS). Savings: $0.3 billion.

2. Increase the Medicare Part B equipment utilization assumption for advanced imaging services from 75% to 90% effective for 2014 and subsequent fee schedules. Savings: $0.8 billion.

3. The Therapy Multiple Procedures Reduction will go from 25% to 50%, beginning April 1, 2013. Savings: $1.8 billion

4. Non-Emergency Ambulance Transports: Reduces rates by 10% for individuals with ESRD obtaining non-emergency basic life support services involving transport: Savings: $0.3 billion

HEALTH CARE PRICE TRANSPARENCY: WILL PATIENTS SHOP FOR YOUR SERVICES?

Health care costs are expected to rise 7.5 percent in 2013 according to a study by PricewaterhouseCoopers.[1] Continuing increases in the cost of medical care are driving up insurance premiums, resulting in higher deductibles and co-pays, and many more high deductible health plans. This ongoing trend means that consumers are becoming much more interested in knowing the price **before** they receive medical services.

Health care may be the only, and certainly the largest, consumer industry that does not provide price information to its customers. Groceries, clothes, hair salons, landscape services, plumbers, etc., all make their fees known, either by price tags, price lists, or quotes for services.

Health care prices, when they can be discerned, vary widely. This is particularly true for surgical procedures, diagnostic imaging and laboratories, even within the same geographical area and for services where quality is relatively comparable. Many say the prices set for services have nothing to do with the actual cost or quality of the service but are driven by profit margins and physician leverage. In a 2011 study on health-care costs, Martha Coakley, Massachusetts attorney general, found that health care was plagued by widespread pricing disparity. Insurers were paying some physician groups as much as 230% more than others for the same services, while same-service payments to hospitals varied by as much as 300%. Coakley termed the health-care market dysfunctional, later adding that costs were not based on factors such as quality or value, but instead on the leverage of providers.[2]

Per the U.S. Government Accountability Office, there are clinical and legal factors that make it difficult for patients to obtain price information for the services they receive, including the difficulty of predicting the exact combination of health care services a patient will need in advance, billing from multiple providers, and the variety of insurance benefit structures.[3]

Although the demand for price transparency has been on the radar for a while, it has been slow to gain momentum. One reason is that the lack of independent information on the

quality of care may reinforce patients' tendencies to rely on physicians for advice about where to receive their care, and patients may be unwilling to go against a clinician's advice in the interest of saving a few dollars. Plus patients may perceive that better care is given at larger, well-known and more expensive hospitals than at lesser-known facilities, particularly for more complex services. But mostly the momentum has been slow because the majority of patients are insured and have paid very little of their cost: i.e. they have no incentive to choose a lower-cost provider.

However, the number of people with these traditional health plans declines every year and stands at 78% of health plans in 2011, according to the Employee Benefit Research Institute in Washington, DC. In seven years, high-deductible plans have increased from 10% to 23% of all plans and experts say that trend will continue to grow.[4] Plus co-pays and co-insurance amounts are increasing even for traditional plans. While there is no data yet, it appears likely that the new insurance exchanges in 2014 will accelerate the trend to high-deductible plans.

EMPLOYERS

Employers looking to lower their costs have pressured insurance companies for reduced premium health care policies for their employees. In most cases, this results in higher deductibles and co-insurance for the employee, making knowledge of provider pricing a necessary feature of contracting with a health insurer.

According to a 2012 survey by the consulting firm, Towers Watson and the National Business Group on Health, 15 percent of employers required their health plan to include price information and another 22 percent plan to do so next year.[5]

INSURANCE CARRIERS

Driven by employer requests for more affordable plans and most recently by the added requirements of health care reform (free preventive care services, insuring children up to age 26 under their parents' plan), insurers are more focused on controlling their health care costs than ever.

Insurance carriers have always negotiated rates with different health care providers, with the best rates usually going to the larger, well known facilities and medical groups.

PRICE TRANSPARENCY OPTIONS

PHYSICIANS AND PATIENTS

Online Medical Pricing Websites

There are several online websites that claim to help patients compare physician, lab, imaging center and hospital fees along with quality ratings. Health Care Blue Book is probably the best known site.

Health Care Blue Book

Five years ago, Dr. Jeff Rice, after being charged $200 for a simple cholesterol test that should have cost about $20, founded the company that publishes the Healthcare Blue Book. The Healthcare Blue Book is a free consumer guide to help patients determine fair prices in their area for healthcare services, based on the average amount that most providers in the area will accept from major insurance carriers. The website also provides a practical guide to healthcare consumerism and tools for negotiating and documenting provider fees. It also provides a customized version of the website for employers.[1]

Other Sites:

Castlight Health »
ClearCost Health »
Change Healthcare Corp. »

RADIOLOGY

The Radiology Imaging Shopper Program (RISP)

The RISP is run by AIM (American Imaging Management), a radiology business management company, which contracts with many health insurers to provide prior authorization for advanced diagnostic imaging services. Under the RISP program, when a patient's

But employer and consumer voices have become louder, so insurers have looked at ways to publicize physician fees as a way to control spending and market their products. Two such features offered by insurers are Cost Estimators and Tiering.

COST ESTIMATORS - Several of the large insurance carriers such as Cigna, Aetna and United Healthcare, among others, offer "cost estimators." These are online tools designed to help members understand their out-of-pocket costs prior to proceeding with medical treatment; there are even mobile versions for iPhone and Android.

Depending on the health insurance carrier, the tools:

Review and compare health care costs for a specific procedure or service, based on where the procedure/service is performed, such as hospitals, laboratories and diagnostic imaging centers.

View the contracted rate that the insurer pays a doctor for a particular service

Explore different treatment options, which may assist members in having an informed conversation with their physicians about alternative treatments

TIERING - Under a tiered provider network structure, employees pay different cost-sharing rates for different tiers of providers. Tiered provider networks allow employers and insurers to include all or most hospitals and health systems in their plan, allowing them to move away from the limited provider networks that characterize many traditional health maintenance organizations.

An example of one of these insurers is Tufts Health Plan in Massachusetts. Tufts offers either a 2-Tier or 3-Tier plan called "Your Choice." It groups PCPs, specialists, hospitals and free standing medical centers into tiers based on cost and quality measures and an integrated approach to member health care. The cost-share for members varies with each tier. Tier 1 lists doctors and hospitals that offer quality services and are the most cost-efficient, resulting in the employee paying the lowest cost share of co-payments, coinsurance and/or deductibles.

advanced diagnostic imaging exam has been scheduled, an AIM representative will review the authorization from the referring provider. If the services can be performed at a lower cost, AIM will call the patient and tell them they can lower their out-of-pocket expenses by scheduling the exam at another approved imaging site. If the patient agrees, AIM tries to make the transition as seamless and easy as possible: e.g. they will make the new appointment and navigate obtaining the exam order from the referring physician and any prior relevant exam reports.[2]

Save On Medical

Save On Medical is a patient tool similar to Expedia for travelers. The website allows patients to price shop, compare and book radiology procedures online. Patients are able to search for services by price, quality and convenience with the help of the SOM Docometer. It offers average prices in any zip code for radiology services like X-rays, CT scans and ultrasounds. Prices are based on a variety of data pulled together by algorithms and researchers. In certain markets, currently New York City, most of Florida and parts of 19 other states, Save On Medical is contracting directly with radiology centers and letting patients book appointments online. **http://www.saveonmedical.com/**

SURGERY

Employer Agreements for Low Surgical Rates

Large employers are making deals for specific surgeries with hospitals that have agreed to a low, fixed rate for surgery and scored well on quality of care.

PHYSICIANS AND PATIENTS

The availability of these new online provider-pricing tools certainly gives patients and employers more information than ever before to shop for medical services. Consumer advocates have for years told patients that the "sticker price" of healthcare is negotiable and provided steps for beginning the discussions."[6] Patients are now becoming savvy about negotiating a deal to pay lower medical fees, especially where the patient is willing to pay cash upfront.

Increasingly, medical providers must be willing to negotiate with patients on the cost of care, particularly when the alternative is the risk of not getting paid at all or losing the patient to another practice who will negotiate. Physicians need to develop policies for these negotiations, subject to the constraints of their payer contracts.

The Healthcare Blue Book and website, (see the sidebar: Transparency Pricing Options) is available to physicians and can help them prepare for patient inquiries. For example, why a given practice charges more than the going rate for a service or procedure and how other factors, such as the complexity of a case, may affect cost.

Making your financial and hardship policies clear and well-publicized also will show patients that you are helping to move healthcare in the direction they want and need: with pricing and quality information available for them to make informed decisions.

[1]Gladstone, Beth Pinsker, "Health Care Reform Effects: What the Decision Means for You," Huffington Post, June 28, 2012, http://www.huffingtonpost.com/2012/06/28/health-care-reform-effects_n_1635130.html
[2]Wiley, George, "Price Disparity + Price Transparency = Imaging Market Turmoil," Radiology Business Journal, February 19, 2012, http://www.imagingbiz.com/articles/view/price-disparity-price-transparencyimaging-market-turmoil
[3]Kohn, Linda T., Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care," September 23, 2011, www.gao.gov/products/GAO-11-791
[4]Brady, Matthew, How Much? Who Knows?," Angie's List, October 2012.
[5] Ibid
[6]Beaulieu, Debra, "Health Comparison-Shopping on the Rise," Fierce Practice Management, April 11, 2012, Health comparison-shopping on the rise

The employers include the price of a flight and hotel if the hospital is not nearby, stating that it is still less expensive than using some of their local hospitals. This steady stream of new patients may also be a good deal for the physicians and hospitals involved.

This year, grocery giant Kroger Co. has flown nearly two dozen workers to Hoag Orthopedic Institute in Irvine, CA and several other hospitals across the U.S. for hip, knee or spinal-infusion surgeries in an effort to save money and improve care. So far, patient satisfaction has been good. In January 2013, Wal-Mart Stores, Inc. will offer employees and dependents heart, spine and transplant surgeries at no cost at six major hospitals systems across the nation, with free travel and lodging.[3]

Surgical Marketing Plan

The Surgery Center of Oklahoma, owned and operated by 40 surgeons and anesthesiologists, posts their surgical fees for patients who will pay cash at the time of surgery, on their website. They market themselves to patients who have high deductibles, are part of a self-insured plan at a large company, considering going to a foreign country to have surgery, or are uninsured, stating they provide quality and pricing that are unmatched.[4]

[1]Health Care Blue Book, http://www.healthcarebluebook.com/
[2]Wiley, George, "Price Disparity + Price Transparency = Imaging Market Turmoil," Radiology Business Journal, February 19, 2012, http://www.imagingbiz.com/articles/view/price-disparity-price-transparencyimaging-market-turmoil
[3]Terhune, Chad, "Companies Go Surgery Shopping," Los Angeles Times, November 17, 2012, http://articles.latimes.com/2012/nov/17/business/la-fi-bargain-surgery-20121117
[4]The Surgery Center of Oklamhoma website, http://www.surgerycenterok.com/index.php

2013 PQRS AND ERX INCENTIVE PROGRAMS

CMS published its PQRS (Physician Quality Reporting System, originally called PQRI) goals and updates for 2013 in the 2013 Medicare Physician Fee Schedule.

One goal, suggested by many medical organizations, is to align PQRS with other Medicare programs that have quality reporting requirements, including the EHR Incentive, Medicare Shared Savings and the Value-based Modifier programs. CMS instituted the following provisions to meet this goal.

EHR PROGRAM AND PQRS

- PQRS-Medicare EHR Incentive Pilot extended for 2013
- Reporting criteria for the 2014 PQRS Incentive via the EHR-based reporting mechanism and alignment of the clinical component of EHR meaningful use with PQRS

PQRS/GPRO REPORTING OPTION WITH THE MEDICARE SHARED SAVINGS PROGRAM (MSSP)

- Sharing of measurements
- ACOs within the MSSP can only participate in PQRS using the PQRS GPRO reporting method
- Adoption of MSSP method of assignment and sampling
- Under the MSSP, ACOs successfully reporting measures via the GPRO Web Interface will not be subject to PQRS payment adjustments as long as the ACO satisfactorily reports at least one measure

PQRS AND THE VALUE-BASED MODIFIER PROGRAM

Group Practices consisting of 100+ EPs, beginning in 2013, will be subject to the Value-based Modifier. Those groups who avoid a 2015 VBM downward payment adjustment by satisfactorily reporting in 2013 will also avoid the 2015 PQRS payment adjustment.

CMS also hopes to increase participation in the PQRS program by CY 2015, the first year PQRS will have payment adjustments for non-participation, vs. the current incentives for reporting. (The 2010 Experience Report shows 2010 participation rate at 26%)

THE 2013 PQRS PROGRAM

In 2013, the PQRS Incentive Program will continue to offer monetary incentives for providers who successfully submit

2013 PQRS & ERX INCENTIVE PROGRAMS

DEADLINES

PQRS
October 15, 2013
Administrative Claims Method Election Statement

October 15, 2013
GPRO Self-nomination Statement

eRx
January 31, 2013
GPRO Self-nomination Statement

NEW PQRS MEASURES

C= Report by claims R=Report by Registry

320 - Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonscopy in Average Risk Patients -C,R

321 - Participation by a Hospital, Physician, or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures – C,R

322 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients - R

323 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI) - R

324 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients - R

the appropriate measures to participate in the program. However, non-participants are subject to a 1.5% penalty in 2015, assessed against 2013 Medicare payments. We've outlined the key aspects of the 2013 program here. For more detailed information on these programs for 2013, see the AdvantEdge: 2013 PQRS Guide and the AdvantEdge: eRx Guide located on our website at http://www.ahsrcm.com/about/medical-billing-news.

REPORTING PERIODS AND PAYMENT INCENTIVES

Eligible providers (EPs) who successfully report PQRS quality measures are eligible for a 0.5 percent incentive payment for 2013. 2014 will be the last year to receive the 0.5 percent incentive payments.

The reporting period and methods of reporting remain the same as 2012.

Exception: CMS has also added a 6 month reporting period of July 1, 2013 – December 31, 2013 for the reporting of MEASURES GROUPS by REGISTRY only. This reporting period is only available to individual EPs.

REPORTING PERIODS AND PAYMENT PENALTY ADJUSTMENTS

IMPORTANT – 2013 is the Reporting Period to Avoid the 2015 Payment Adjustment

- To avoid the 2015 payment adjustment (the first year of the penalty adjustment), the reporting period will be January 1, 2013 – December 31, 2013.
- The 2015 penalty adjustment will be 1.5 percent of Medicare allowed charges billed in 2013.

SUBMISSION OF ONE MEASURE OR GROUP MEASURE

In order to avoid the 2015 payment adjustment, CMS will allow EPs or GPROs to submit either one valid measure or one valid measures group in 2013. This reporting will not qualify EPs or GPROs to receive the 2013 incentive payment. It is only to be used to avoid the 2015 penalty. The one measure or measures group may be submitted via claims, registry or EHR-based reporting.

THE ADMINISTRATIVE CLAIMS REPORTING METHOD

This is a "shortcut" method to avoid the 2015 penalty; it does not qualify for incentive payments. This requires an "administrative claims election statement" via the web by October 15, 2013 (the web signup won't be available until the summer).

325 - Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions - R

326 - Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy Measure -C,R

327 - Pediatric Kidney Disease: Adequacy of Volume Management -C,R

328 - Pediatric Kidney Disease: ESRD Patients Receiving

Dialysis: Hemoglobin Level ← 10g/dL -C,R

DELETED PQRS MEASURES

10 - Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports

57 - Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation

58 - Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status

92 - Acute Otitis Externa (AOE): Pain Assessment

105 - Prostate Cancer: Three Dimensional (3D) Radiotherapy

124 - Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

158 - Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy

186 - Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers

After this election statement is filed, CMS will analyze the practice's Medicare claims to determine if providers have met any quality measures. EP/group practices would not have to submit quality data codes on their claim forms.

2013 MEASURES

INDIVIDUAL Measures - 10 new measures and 15 retired measures (see sidebar)
GPRO Measures - 1 new measure and 12 retired measures (see sidebar)
EHR Measures - No measure changes
MEASURES GROUPS - 20 measures groups for 2012 go forward to 2013. 1 new measure group, ONCOLOGY, will be added and 1 measure group, COMMUNITY-ACQUIRED PNEUMONIA will be retired

GROUP PRACTICE REPORTING (GPRO)

CMS changed the definition of a group practice for the intent of GPRO reporting from 25 or more EPs to 2 or more EPs. A GPRO practice is now defined as a single TIN with 2 or more EPs, as identified by their NPI, who have reassigned billing rights to the TIN.

There will be 18 measures available for GPRO reporting including 2 composites for a total of 22 measures. 12 Measures were either retired or replaced by another measure (see sidebar).

In 2013, CMS also expands the reporting options available to group practices to include registry reporting in addition to the web-interface reporting option. In 2014 the reporting options will include EHR-based reporting. The Administrative Claims method will be available for the 2015 PQRS payment adjustment only.

2013 ERX – E-PRESCRIBING INCENTIVE PROGRAM

Most of the requirements for the 2013 eRx Incentive Program remain the same as 2012. The following changes will occur in 2013.

ERX GROUP PRACTICE REPORTING OPTION (GPRO)

Similar to PQRS, the eRx program recognizes Group practices to consist of two or more EPs. GPRO reporting for group practices with 2-24 EPs, the group must report the e-prescribing measure in at least 75 instances during the applicable 2013 eRx incentive or 2014 eRx adjustment period. The reporting requirements remain the same for GPROs of 25 or more EPs.

189 - Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 Days

190 - Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss

196 - Coronary Artery Disease (CAD): Symptom and Activity Assessment

206 - HIV/AIDS: Screening for High Risk Sexual Behaviors

207 - HIV/AIDS: Screening for Injection Drug Use

235 - Hypertension (HTN): Plan of Care

253 - Pregnancy Test for Female Abdominal Pain Patients

GPRO (GROUP PRACTICE REPORTING OPTION) MEASURES

2013 New Measures

PREV-12 Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan

2013 Retired Measures

COPD-1 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

CAD-1 Coronary Artery Disease (CAD): Antiplatelet Therapy

DM-3 Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus (replaced w/ DM-13)

All practices who want to participate in any of the GPRO alternatives must self-nominate and be selected by CMS to participate in this reporting method. The current method to self-nominate is through a web-based system.

EXCEPTIONS:

- Any group practice who participates in the MSSP, Pioneer ACO or Physician Group Practice Demonstration must self-nominate to participate in the eRx GPRO option though an email indicating their intent to participate.
- Any group practice wishing to participate in the eRx GPRO option only (and not participate in the PQRS GPRO) must submit the self-nomination through email and not the web-based system.

January 31, 2013 is the deadline for all GPRO eRx self-nominations.

NEW SIGNIFICANT HARDSHIP EXEMPTION CATEGORIES

- EPs or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods.
- EPs or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

EPs or group practices will not need to affirmatively request an exemption for these categories. CMS will use the information provided in the EHR Incentive Program's Registration and Attestation page to determine whether the exemption applies.

ERX INFORMAL REVIEW FOR THE 2013 OR 2014 ERX PAYMENT ADJUSTMENTS

This review or appeal process will allow providers to contest:

- 2012 and 2013 e-prescribing payments: EPs must submit, via email, a request for review within 90 days of receipt of the respective feedback report
- 2013 and 2014 penalty decisions: EPs must submit a request for review by February 28, 2013 and February 28, 2014 respectively.

CMS will provide a written response to all reviews and their decision will be final. More information on this process will be issued by CMS in the near future.

DM-5 Diabetes Mellitus: (LDL-C) Control in Diabetes Mellitus (replaced with DM-14)

DM-7 Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

DM-8 Diabetes Mellitus: Foot Exam

DM-10 Diabetes Mellitus: Hemoglobin A1c Control (← 8%) (replaced with DM-15.)

HF-1 Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment

HF-2 Heart Failure (HF): Left Ventricular Function (LVF) Testing

HF-5 Heart Failure: Patient Education

HF-7 Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

FEATURED EMPLOYEES: CLIENT FIRST

STATEN ISLAND, NEW YORK OFFICE

ClientFirst Attitude in Staten Island: Neither wind nor rain nor SuperStorm Sandy keeps AHS team members away from taking care of their clients!

While SuperStorm Sandy closed the Staten Island office for a week, several team members found a way to continue working and posting payments for clients. Some were without electricity and had to find a place to work. In appreciation for their dedication during these very trying times, the following employees are recognized for displaying exceptional ClientFirst attitude under extraordinary circumstances: Ro Molinare; Ro DiMaio, Tina Sullivan, LoriAnn DiMaio, Rachel Ildefonso, Cecelia Pucciarelli, Claire DeTullio, and Vaile Bricker. Many thanks to the AHS team members that continued to post payments and keep the work flowing while the office was closed!

In addition, Pattie Heyde became Command Central during the storm, almost single-handedly accounting for each AHS employee and opening up her home to employees who wanted to work but had no electricity. Pattie also set up a series of communications (voicemail messages, texts) that kept Staten Island team members up to date on the closing and reopening of the office.

Recognized by Ray Cassidy, Vice President Operations, Staten Island

LOMBARD, ILLINOIS OFFICE

Shironda Clinton, Customer Service Representative. Sometimes a ClientFirst attitude is displayed by helping patients understand our client's billing and handling calls in an efficient, personal and pleasant manner. Sometimes a ClientFirst attitude can be seen when a team member steps in to help a department. Sometimes a ClientFirst attitude is demonstrated by volunteering for assignments that are over-and-above the job description.

Rarely is it an "all of the above" proposition – which is why we proudly highlight Shirhonda Clinton for displaying a ClientFirst attitude on all fronts!

Shirhonda has worked as a customer service representative for AHS Lombard for two years. She is consistently a top performer in the department, handling a high volume of calls in an efficient, pleasant manner. Recently, when the department experienced an unusual and temporary leave for both the manager and supervisor, Shirhonda rose to the occasion and provided leadership to the group, working with SueAnn Zahrt, Manager of Reimbursements. Shirhonda also volunteers her time on the Employee Input Committee, providing her perspective and suggestions on programs.

Shirhonda has made an impact in her short two-year tenure here at AHS Lombard, and we look forward to her continued contribution!

Recognized by SueAnn Zahrt, Manager of Collections & Reimbursement

NEWARK, DELAWARE OFFICE

Both of these Delaware employees were recognized by people outside our office for outstanding service: specifically a patient and one of our clients

Eilis Rodriguez, Ambulance Account Representative. Eilis is an Account Representative in our Ambulance department and has been with the company for 9 years. She handles phone calls and billing for a large number of ambulance companies. Despite the volume, she is very diligent and organized in following up on her accounts.

We recently received a letter from a satisfied patient, complimenting Eilis for providing him with excellent service. "Her knowledge, professionalism, organization, and courtesy in handling what's often a tense situation (payment of disputed invoices) was remarkable and totally refreshing".

Eilis is a team player, always willing to help out wherever needed. She is a valuable member of the Ambulance department and an asset to the company.

Recognized by Danielle Parag, Ambulance Supervisor

Debbie Whorl, Private Practice Account Representative. Debbie is a member of our Private Practice department and has been with the company for 12 years. Although Debbie handles many accounts, she devotes time and energy to each one to make them feel they are the only client that she services.

We recently received a written letter from one physician, highlighting how "very pleased" she is with Debbie's work as her Account Representative. Debbie scores high marks for her "excellent, prompt, courteous, and caring service". The physician writes, "Her caring for me as a client is truly impressive". The physician went on to express her gratitude for Debbie's persistence in resolving a difficult billing issue that took a great amount of Debbie's time. "I can not speak highly enough of Debbie's professionalism, her persistence, and her 'going the extra (several) miles' for me. "

Recognized by Susan Donovan, Client Manager

PORTLAND, MAINE OFFICE

Peter Albert, of the Clerical Team, always puts the ClientFirst. On numerous occasions, without being asked, Peter has changed his schedule and stayed late to help his team complete projects. He is a real team player who goes above and beyond. You can always count on Peter to help.

Recognized by Sarah Durfee, Operations Supervisor

SALEM, NEW HAMPSHIRE OFFICE

Nancy Rodriquez , Customer Service Representative. Nancy is a strong team player, with many great qualities. Currently, she is our only Spanish speaking representative in the Customer Service department and is always willing to assist her teammates, as well as other departments, with bilingual calls and correspondence. Nancy also assists with training new hires.

One of Nancy strengths is her ability to effectively communicate with customers, answering patients' questions while educating them at the same time. Nancy is articulate, listens well, is empathic, and courteous to both her fellow workers and patients.

Recognized by Cynthia Ard, Customer Service Team Leader

DID YOU KNOW?

OPERATING RULES FOR HIPAA TRANSACTIONS

New rules are going into effect for 2013 that require the same standards across all insurance carriers for insurance eligibility verification and claim status electronic transactions. The objective is to reduce costs. Billing companies and practices should have one type of request for all insurers and get a more detailed response when they ask about the status of a claim submitted to a health plan.

Other standards, with the same objectives, are planned for next year and thereafter.

January 1, 2013*
- eligibility for a health plan
- health claim status

January 1, 2014
- electronic funds transfers (EFT)
- health care payment and remittance advice (ERA)

January 1, 2016
- health care claims or equivalent encounter informa tion (health care claims attachment standards must be adopted)
- coordination of benefits
- health plan enrollment/disenrollment
- health plan premium payment
- referral certification and authorization transactions

*For more information on the operating rules effective January 1, 2013, see the article in our Washington News - December 2012.

CHAMBERSBURG, PENNSYLVANIA OFFICE

NEW EMPLOYEES JOIN CHAMBERSBURG

This fall, the Chambersburg office added four new employees; all with many years of medical billing or coding experience. Please welcome the most recent new hires to the Chambersburg Office.

RYAN THOMPSON - Process Integrity Manager. Ryan currently works out of his home in Augusta, Georgia and has 6 years' experience in anesthesia billing and management.

BRIDGET ORTEGA - Coder. Bridget currently works out of her home in Crystal Lake, Illinois and has an extensive background in anesthesia and pain management coding.

TAMMY KELLY - Customer Service Representative. Tammy works in the Chambersburg office and comes to AHS with over 10 years' experience in the customer service industry.

CHELSEA MILLER - Customer Service Representative. Chelsea works in the Chambersburg office and has 8 years of customer service experience.

FREEZE OUT BREAST CANCER

The Chambersburg office celebrated Breast Cancer Awareness Month by freezing it out. On Wednesday, October 24th the office met in the lunchroom dressed in their best PINK attire in hopes of winning the best PINK outfit fashion show. All enjoyed ice cream provided by Goose Brothers Ice Cream Shop in Shippensburg, Pennsylvania.

The office raised $109.55 in donations to benefit The American Cancer Society's Relay for Life – The Hearts with Hope Team, which is lead by the Chambersburg office's own Traci Hull.

The contest winners for best PINK outfits went to:
1st Place - Jan Group
2nd Place - Carrie Hann
Honorable Mention - Victoria Kern

The Ice Cream Social Coordinators in the attached picture are Maegan Hess (on the left) and Traci Hull.

DID YOU KNOW?

MEDICARE SPENDING AND FINANCING

- Medicare covers 50 million elderly and disabled Americans
- In 2012, Medicare spending is 15% of the federal budget
- In 2012, Medicare benefits are expected to total $556 billion
  - Hospital Inpatient Benefits – Part A - 26%
  - Skilled Nursing facilities – Part A - 6%
  - Physician Payments – Part B - 14%
  - Hospital Outpatient Services – Part B - 6%
  - Medicare Advantage – Part C – 22%
  - Outpatient Prescription Drugs – Part D – 11%
  - Home Health – Part A & B - 4%
  - *Other Services – Part A & B - 13%

*(Does not add up to 100% due to rounding. Excludes administrative expenses and is net of recoveries)

Total Medicare Spending is projected to double from $560 billion in 2011 to $1.1 trillion in 2022 due to growth in the Medicare population and sustained increases in health care costs (CBO, August 2012)

Between 2012 and 2022, Medicare's share of the federal budget is projected to increase from 15.4% to 19.3%

Between 2012 and 2022, Medicare spending as a share of the GDP (growth domestic product) is projected to grow from 3.5% to 4.3% (does not take into account additional spending that is likely to occur to avoid reductions in physician fees scheduled under current law)

Source: Medicare Policy Fact Sheet, November 2012, Kaiser Family Foundation, http://www.kff.org/medicare/7305.cfm

LOMBARD, ILLINOIS OFFICE

AHS PARTICIPATES IN LOCAL SCHOOL'S PROGRAM ADVISORY COMMITTEE

Chris Walters, Manager of Coding, and Barbara Lewis, Manager of People Services, recently attended a Program Advisory Committee meeting at Everest College in Burr Ridge. The Committee is comprised of area businesses and medical providers that participate in Everest's externship program. The group was given a tour of the facilities, followed by a presentation from faculty members regarding curriculum, texts and coursework. After the presentation, it was the participant's opportunity to offer suggestions on improvements for the curriculum, externship program, and career services programs. During the presentation, AHS was cited by the Externship Coordinator as one of Everest's top partnerships, with a program that has hosted more than four dozen graduates over the past two years.

Chris was impressed by how open the faculty members were regarding curriculum changes. "I suggested that they include information and training on Medicare EOBs and denials, and the faculty coordinator appeared ready to make the change immediately." Barbara was impressed with the depth of coursework. "Our relationship with Everest has been successful because the graduates have invested time and money in the industry and are enthusiastic, well-trained and ready to learn."

Everest Burr Ridge is one of four locations in the AHS partnership. Other locations include Marionette Park, Bedford Park, and Melrose Park.

CAREER ACCOMPLISHMENTS

Congratulations to DeWayne Thompson, Voucher Analyst at AHS Lombard, for being named valedictorian during the October graduation exercises at Everest College. DeWayne completed the MIBC (Medical Insurance Billing and Coding) program with the highest grades and scores among all MIBC graduates!

PORTLAND, MAINE OFFICE

THANKSGIVING FOOD PANTRY COLLECTION

In November, the Portland office Employee Activity Committee led a food pantry drive in support of the Good Shepherd Food-Bank to provide food to those in need during the Thanksgiving holiday. The office held a "sculpture" contest in which teams competed to create a design with all of the donated goods.

The teams had a lot of fun putting together the displays and more importantly collected a hefty amount of non-perishables to assist those in need. This is something fun other locations might want to do.

The winning team was treated to breakfast.

HALLOWEEN IN PORTLAND

To get in the spirit of Halloween, the Portland office held a contest where each team decorated their work area to be judged by Managers and others. The teams had a great time decorating their area with spooky decorations and some really got into the spirit with costumes. There was great participation and a lot of laughs. Check out these great pictures!

STATEN ISLAND, NEW YORK OFFICE

"MAKING STRIDES" FUNDRAISER BRINGS STATEN ISLAND TEAM MEMBERS TOGETHER!

Staten Island AHS team members participated in the American Cancer Society's Making Strides fundraiser during the month of October. The entire month featured a series of fundraisers, including bake sales, craft sales, and 50/50 raffles. The five AHS team members shown in the picture then participated in the 5K walk on October 21. This was the first year that AHS participated as a company, but several members have been participating for over five years through the Staten Island University Hospital fundraising activities.

Efforts paid off: The group raised over $2,700 after the AHS contribution. According to members of the group, this success will only raise the bar for next year's fundraiser, and AHS team member participation will likely be an annual event!

CALENDAR WINTER 2013

January 1 - 2013 PQRS & eRx Incentive Programs begin

January 1 - New Year's Holiday: AHS is closed

January 21- Martin Luther King, Jr. Birthday: AHS is closed

January 27-29 - ASA Conference on Practice Management, AHS Exhibiting

January 31 - Deadline to Submit Request for 2013 eRx Hardship Exemptions

February 18 - President's Day: AHS is closed

March 3-7 - HIMSS Annual Meeting - New Orleans, LA

March 9-11 - American College of Cardiology Annual Meeting, San Francisco, CA

COMPLIANCE CORNER: A COST OR AN OPPORTUNITY?

Not everyone knows that the Affordable Care Act includes a requirement that all providers establish a compliance program "as a condition for enrollment in Medicare or Medicaid." While CMS has not issued specific timeframes for most physicians, the direction is very clear. As we have for many years, AdvantEdge encourages each client to have its own Compliance Program and we stand ready to assist where we can—recognizing that the AdvantEdge Compliance Program and procedures do not replace the need for the practice to have its own program.

With that in mind, we found a recent article by Mark Weiss to be both timely and on point. He cogently makes the argument for treating compliance as an opportunity, not a cost or a burden.

PROFITING FROM MANDATORY COMPLIANCE

-By Mark F. Weiss, Advisory Law Group

Section 6401(a) of the Patient Protection and Affordable Care Act, Obamacare, imposes a requirement -- a mandatory requirement -- that physician groups adopt compliance programs.

These programs are not simply plans that you document, toss into a notebook and keep on a shelf -- they must be living, breathing programs revisited on an ongoing basis.

Undoubtedly, most medical groups will view their compliance efforts as completely divorced from their operational issues. Accordingly, in connection with their mandatory compliance program, they'll in essence erect a wall between compliance and operations and proceed on each of those tracks independently.

But the better performing groups -- those that I call the strategic groups -- will use a different approach, Operational Compliance, in which compliance efforts are intertwined with a deep and thorough review of the group's operations in order to address both the need to maintain an ongoing compliance program -- that's the risk management side -- and to wring efficiency and profitability out of the group's business -- that's the operational side.

Looking at this another way, traditional compliance work is generally viewed by medical groups as a "cost" -- it's money spent, well spent, managing risk, but it's certainly seen as spent.

But in Operational Compliance, a significant portion of the funds devoted to the effort is an investment in identifying potential areas of profit: For example, the framework of your program can be used proactively to examine and optimize the billing and coding process, minimize billing mistakes, drive faster completion of billing materials and speed of the billing cycle, examine the efficiency of outsourced or in-house billing and collection operations, and examine options for post-billing service collections.

A compliance program also is a pivot point around which to design additional business relationships. In this light, compliance prohibitions are highly useful "negative guides" for what can be done.

The fact is that you have to have a compliance program.
Do you want to have one that's merely a "cost" incurred for the laudable reason of managing risk, or do you want go the rest of the way and leverage a portion of what's already being spent into an investment providing operational ROI -- return on investment -- to your group -- an upside over and above the simple management of risk?

- Mark F. Weiss is an attorney who specializes in the business and legal issues affecting anesthesiology, radiology and other physician groups. He holds an appointment as clinical assistant professor of anesthesiology at USC's Keck School of Medicine and practices with Advisory Law Group, a firm with offices in Los Angeles and Santa Barbara, Calif. Educational materials are available for complimentary download at www.advisorylawgroup.com. He can be reached by email at markweiss@advisorylawgroup.com and by phone at 800-488-8014.

PATHOLOGY INSIGHTS

PATHOLOGY AND INDEPENDENT LABS: FEE CHANGES IN 2013

In the 2013 Medicare Physician Fee Schedule (MPFS), CMS took the hatchet to pathology fees as they revalued the technical component (TC) of several important pathology codes. In addition, they reduced fees by 1% to cover the cost of the primary care fee increase, and applied another 1% reduction as part of the last year of the 4 year transition to the Practice Expense (PE) RVUs implemented by the Physician Practice Information Survey (PPIS). Per CMS' calculations, these changes reduce pathology fees as a whole by 6% and independent lab fees by 14%. The largest contributor to the fee reductions is the technical component revaluation of codes 88300-88309, particularly code 88305, which was reduced by 52%. Code 88305 was on CMS' misvalued code list as it had not been reviewed in over 10 years and it is a high volume code. According to the 2012 AP Market Report in Laboratory Economics:

- Medicare payment for CPT 88305 increased an average of 3.5% per year from 1999 to 2012
- The Professional Component (PC) of CPT 88305 has decreased by an average of 1.7% per year since 1999
- The TC of CPT 88305 increased an average of 10.3% per year since 1999
- Part B carrier payments for CPT 88305 (after denials) rose at an average annualized rate of 3.7% per year between 2005 and 2010

CMS originally flagged both the TC and PC of this code for review, but CAP (College of American Pathologists) successfully argued that the 88305 PC was reviewed in April 2010 and should not be reduced further. An $18 fee was originally suggested for the technical component by CMS in 2012's proposed rule but CAP was able to submit data on direct medical inputs to CMS, who agreed that $18 was too low. The PC was increased by 2% and the global rate reduced by 32%.

The following chart shows the changes in fees for these surgical pathology codes as well as three other high volume codes if the conversion factor remains the same in 2013 (i.e. the 26.5% SGR reduction and the 2% sequestration reduction do not occur).

2012 to 2013 RVU and Fee Change									
Using 2012 Conversion Factor - $34.0376									
CPT	Mod	Description	2013 RVU	2012 RVU	2013 RVU Change		2013 Fee	2012 Fee	2013 Fee Change
88300		Surgical path gross	0.43	0.83	-48%		$14.64	$28.25	-48%
88300	TC	Surgical path gross	0.3	0.7	-57%		$10.21	$23.83	-57%
88300	26	Surgical path gross	0.13	0.13	0%		$4.42	$4.42	0%
88302		Tissue exam	0.91	1.64	-45%		$30.97	$55.82	-45%
88302	TC	Tissue exam	0.71	1.45	-51%		$24.17	$49.35	-51%
88302	26	Tissue exam	0.2	0.19	5%		$6.81	$6.47	5%
88304		Tissue exam	1.31	1.82	-28%		$44.59	$61.95	-28%
88304	TC	Tissue exam	0.98	1.5	-35%		$33.36	$51.06	-35%
88304	26	Tissue exam	0.33	0.32	3%		$11.23	$10.89	3%
88305		Tissue exam	2.07	3.11	-33%		$70.46	$105.86	-33%
88305	TC	Tissue exam	0.99	2.05	-52%		$33.70	$69.78	-52%
88305	26	Tissue exam	1.08	1.06	2%		$36.76	$36.08	2%
88307		Tissue exam	8.74	6.89	27%		$297.49	$234.52	27%
88307	TC	Tissue exam	6.33	4.57	39%		$215.46	$155.55	39%
88307	26	Tissue exam	2.41	2.32	4%		$82.03	$78.97	4%
88309		Tissue exam	13.21	10.44	27%		$449.64	$355.35	27%
88309	TC	Tissue exam	8.95	6.36	41%		$304.64	$216.48	41%
88309	26	Tissue exam	4.26	4.08	4%		$145.00	$138.87	4%
88342		Immunohistochemistry	3.4	3.10	9%		$115.73	$105.52	10%
88342	TC	Immunohistochemistry	2.16	1.90	12%		$73.52	$64.67	14%
88342	26	Immunohistochemistry	1.24	1.20	3%		$42.21	$40.85	3%
88365		Insitu hybridization (fish)	5.24	4.87	7%		$178.36	$165.76	8%
88365	TC	Insitu hybridization (fish)	3.54	3.21	9%		$120.49	$109.26	10%
88365	26	Insitu hybridization (fish)	1.7	1.66	2%		$57.86	$56.50	2%
88368		Insitu hybridization manual	6.82	6.50	5%		$232.14	$221.24	5%
88368	TC	Insitu hybridization manual	5.01	4.70	6%		$170.53	$159.98	7%
88368	26	Insitu hybridization manual	1.81	1.80	1%		61.61	61.27	1%

CAP participated as a Pathology Advisor in the AMA/Specialty Society RVS Update Committee (RUC) process and provided RUC with direct medical inputs for the entire pathology code family, including clinical labor time, medical supplies and medical equipment. RUC then reviewed the information and made recommendations to CMS for use in their rate setting methodology. Unfortunately, CMS did not consider several of the direct inputs that were recommended by CAP and the RUC, including equipment maintenance costs (courier transportation, lab information system, software, etc.) and specimen, solvent, and formalin disposal costs, among others issues.[1]

CMS intends to review further the number of paraffin blocks used to create some of the direct inputs. CMS accepted the recommendation based on the number of interim blocks for 2013 but is seeking additional evidence regarding the appropriate number of blocks for each service. CMS is concerned about the accuracy of the number of the blocks assumed for each CPT code and if these concerns are not addressed, then CMS could apply further reductions in 2014 and beyond.

Medicare Clinical Laboratory Fee Schedule (CLFS)

For fiscal year 2013, under the Medicare Clinical Lab Schedule, fees are scheduled to be changed as follows:[2]

- Consumer Price Index (CPI) +1.70% (Change from 7/1/2011 to 6/30/2012)
- Productivity Adjustment -0.90% (PFS Final Rule)
- Reduction from health reform (ACA) -1.75% (3rd of 5 annual reductions)
- Reduction from short-term SGR fix -2.00% (Passed February 2012)
- TOTAL: -2.95% (To take effect on January 1, 2013

This formula does not include the potential SGR reduction of 26.5% or potential sequestration reduction of 2%.

Along with these cuts, clinical labs may see future price increases, again depending on Congressional action, for medical devices, supplies, kits, and reagents due to the 2.3 percent excise tax that the healthcare reform law imposed on medical device manufacturing starting in 2013 and applicable to gross sales receipts in excess of $5 million.

On November 15, owners of independent clinical laboratory companies (at least 25 labs), organized by the National Independent Laboratory Association, went to Capitol Hill to meet with their respective Senators and House Representatives. They presented results of a recent survey conducted by Washington University that supported their contention that the cuts to the Medicare Part B clinical lab test Fees scheduled for 2013 will push some independent clinical lab companies into negative profit margins and any additional cuts by Congress, including the SGR, sequestration, etc. will compound their losses.

[1] STATLINE, CMS' Scrutiny on Costs Intensifies in Final 2013 Fee Schedule, November 21, 2012, Volume 28, No. 24
[2] Dark Daily, "Capital Hill Hears Message from Independent Clinical Laboratory Owners; Additional Medicare Cuts in 2013 Can Be Financially Devastating, November 21, 2011,

BILLING FOR RETRIEVAL OF ARCHIVED SURGICAL PATHOLOGY CASES

88363 Examination and selection of retrieved archival (i.e., previously diagnosed) tissue(s) for molecular analysis (e.g., KRAS mutational analysis).

In 2011, CPT code 88363 was created to capture a pathologist's findings following the identification and selection of appropriate tumor tissue from a previously diagnosed surgical pathology case. This article is a reminder that code 88363 can be billed, subject to some very clear rules:

- 88363 cannot be billed if the Pathologist just retrieves the case report, blocks, and/or slides from storage; the pathologist must identify and pick proper tumor tissue from a prior surgical specimen as the identification and selection is necessary for the success of subsequent gene mutation analysis.

- The pathologist must review the initial report and initiate any necessary block or slide preparation of the chosen tissue to forward for molecular testing.

- 88363 may be billed whether an in-home molecular lab or an outside reference lab performs the molecular analysis.

- Codes for molecular cytogenetics (88271-88275) and in-situ hybridization (88365) may be billed, although CPT 88363 does not provide direction on this matter.

- 88363 should be used for every archive specimen examination/selection episode, irrespective of the number of molecular tests to follow.

- 88363 may be used for signed out cases. The number of days between the original case and the 88363 does not matter.

CPT's use of the term "archival tissue(s)" and Medicare's definition of "archived specimen" are not the same. To bill code 88363, the case is archival after the pathologist has released the case report and sent the slides/tissues to be stored. 88363 may not be billed if the pathologist or treating physician decides to prep tissue for a molecular test such as KRAS prior to the pathologist completing the main case and signing it out.

Code 88363 is reported once for each selection episode. The number of molecular tests ordered or performed on the archived material is not a factor. An addendum to the original report describing the service provided and the results of the molecular studies is one way to report the service or a separate report is acceptable.

Per Medicare's National Correct Coding Initiative 17.0, code 88363 will bundle with outside consultation codes 88321-88325 as it includes the consultation with the ordering physician or the lab that may be performing the testing. It also bundles with microdissection codes 88380-88381. Medicare carriers for selected states have put Local Coverage Determination (LCD's) in place for this code. The LCD's are guidelines for selected CPT codes with a list of ICD-9-CM codes that can only be reported to support medical necessity.

There is no professional (PC) and/or technical (TC) split for this code, so modifiers 26 and TC may not be used. The code is paid based on the location of the service, whether it be a non-facility (non-hospital patients) or facility (hospital patients), with the non-facility location receiving a higher payment. The payment difference represents the technical component of the service, such as sectioning blocks chosen by the pathologist for molecular testing.

When an independent lab supports the pathologist's function and uses 88363 with place of service 11(medical office) or 81 (independent lab), the lab will receive the higher payment.

NEW BCBS GUIDELINES CHANGE LAB BILLING

This past year all Blue Cross Blue Shield (BCBS) programs made changes to their Blue Card plans that affect how independent clinical laboratories must bill to be paid for their claims.

The Blue Card plan is a national program offered through the BCBS Association that enables members of one Blue Plan to obtain healthcare benefits and services while traveling or living in another Blue Plan's service area. Providers and laboratories that provide the service bill their regional BCBS who, in turn, forwards the claim to the member's own BCBS plan to be adjudicated. The claim is paid directly to the provider/lab at the member's in-network rate, as long as the lab is a participating BCBS provider.

However, for laboratory services effective October 14, 2012, BCBS now requires that laboratories bill the BCBS Home plan, which has been defined as where the pathology specimen was drawn. This change has no impact if the specimen is drawn in the same region as the laboratory. However, for laboratories that process out-of-state specimens, this policy change can present substantial issues.

For example, a patient from Florida has a specimen drawn at their local physician's office. The specimen is sent to a lab in Georgia for processing. Before October 14, 2012, the Georgia laboratory sent their claim to their local GA BCBS plan which would process the claim via reciprocity with the beneficiary's plan (FL BCBS). GA BCBS paid the laboratory directly at the in-network rate as long as the Georgia laboratory was a participating provider with Georgia BCBS.

Here is what the changes mean for this example. Effective October 14, 2012:

1. The GA lab must now bill the regional/state BCBS plan where the specimen was taken, in this case, the Georgia lab must bill Florida BCBS.

2. Unless the Georgia lab is a participating provider with FL BCBS, FL BCBS will pay the lab at out-of-network rates.

The burden is on the laboratory to identify the correct BCBS plan for billing based on the state where the specimen was taken. This is done by identifying the state of the referring physician and billing that state's BCBS plan. The NPI number of the referring physician must be on the claim.

The laboratory must contract with the BCBS plans of the states where the referring physicians draw specimens. If the lab is not participating with those states, patients will be responsible for higher out-of-network co-payments.

It has been noted that many BCBS plans will not contract with out-of-state laboratories and that some carriers have ignored the patient's assignment of benefits and have paid the patients directly, causing numerous problems for both labs and patients.

AHS billed for labs during 2012 who accept out-of-state specimens and has informed these clients of the billing and reimbursement issues. We have also worked with our clients to identify the correct BCBS entity for billing and assisted clients in credentialing with the out-of-state BCBS programs.

MOLECULAR PATHOLOGY CODES: 2013 REIMBURSEMENT

In the 2013 Medicare Physician Fee Schedule (MPFS), CMS ruled that the new molecular pathology codes will be paid under the Clinical Laboratory Fee Schedule (CLFS) because these services do not ordinarily require interpretation by a physician to produce a meaningful result. Most of the laboratory processes involved in performing these tests are automated and CMS took the position that, when interpretation of tests is needed, it can be done by laboratory personnel or other specialists, such as geneticists.

CMS had two pricing methods to choose from: gap-filling and cross-walking. CMS chose gap-filling which means that local Medicare contractors will set the fees for 2013 based on local pricing patterns, e.g. what labs currently charge for the tests including discounts, what other payors reimburse for the same test, and what contractors pay for similar tests. After a year of gap-filling reimbursement, CMS will review the contractor-specific amounts to determine a national reimbursement rate for each code.

INTERPRETATION CODE WILL BE PAID UNDER MPFS.

CMS acknowledges that in some cases, a physician interpretation of a molecular pathology test may be medically necessary to provide a clinically meaningful, beneficiary-specific result. In these cases, CMS has created a new HCPCS G-code, **G0452 – Molecular pathology procedures; physician interpretation and report**, to describe a medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results. In these cases, the interpretation;

- Must be requested by the patient's attending physician
- Must result in a written narrative report included in the patient's medical record, and
- Requires the exercise of medical judgment by the consultant physician.

The G-code replaces code 83912-26, which has been deleted for 2013. G0452 will carry an RVU of .55, the same as 83912-26, which last year reimbursed $18.38 based on the 2012 conversion factor. CMS will monitor the use of this code and intends to assess whether this HCPCS code will be necessary in the future, and if so, CMS will determine which molecular pathology tests will support its usage.

There has been no information published yet as to whether commercial carriers will honor the G0452 HCPCS code in 2013. AHS will bill the G-code to all carriers and will report our experience billing this code to commercial carriers.

PATHOLOGY ICD-9/ICD10 CODING

DIAGNOSIS – HEMATURIA

ICD-9 Code(s)
Listed Under: Diseases of the Genitourinary System, (580-629.9) → Other Diseases of Urinary System (590-599)

There are three codes for hematuria in the ICD-9 coding system.
599.70 – Hematuria, unspecified – R31.9
599.71 – Gross Hematuria – R31.0
599.72 – Microscopic hematuria – R31.1, R31.2

ICD-10 Code(s)
Listed Under: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) → Symptoms and signs involving the genitourinary system (R30-R39)

R31.0 – Gross Hematuria
R31.1 – Benign essential microscopic hematuria
R31.2 – Other microscopic hematuria
R31.9 – Hematuria, unspecified

The following codes for hematuria with underlining conditions will be available under ICD-10 but have no corresponding cross-walk in ICD-9. It will important for dictation to include the specific wording for correct coding under ICD-10.

Listed Under: Diseases of the Genitourinary System, (N00-N9) →, Other Diseases of Urinary System (N30-N39)

N30.00 – Acute cystitis without hematuria
N30.01 – Acute cystitis with hematuria
N30.10 – Interstitial cystitis (chronic) without hematuria
N30.11 – Interstitial cystitis (chronic) with hematuria
N30.20 – Other chronic cystitis without hematuria
N30.21 – Other chronic cystitis with hematuria
N30.30 – Trigonitis without hematuria
N30.31 – Trigonitis with hematuria
N30.40 – Irradiation cystitis without hematuria
N30.41 – Irradiation cystitis with hematuria
N30.80 – Other cystitis without hematuria
N30.81 – Other cystitis with hematuria
N30.90 – Cystitis, unspecified without hematuria
N30.91 - Cystitis, unspecified with hematuria

Listed Under: Diseases of the Genitourinary System, (N00-N9) → Glomerular Diseases (N00-N08)

N02 Recurrent and persistent hematuria with:
(not a billable code)

N02.0 - minor glomerular abnormality
N02.1 - focal and segmental glomerular lesions
N02.2 - diffuse membranous glomerulonephritis
N02.3 - diffuse mesangial proliferative glomerulonephritis
N02.4 - diffuse endocapillary proliferative glomerulonephritis
N02.5 - diffuse mesangiocapillary glomerulonephritis
N02.6 - dense deposit disease
N02.7 - diffuse crescentic glomerulonephritis
N02.8 - other morphologic changes
N02.9 - unspecified morphologic changes

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