FALL 2014 ISSUE

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Welcome!

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We next describe PQRS changes for 2015. It appears that the 3 measures CAP has been working to get approved will finally be in place.

On the coding front, we highlight the -59 modifier which is sometimes used inappropriately in pathology: e.g. for a component code that is actually part of a primary code.

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Next we look at “site neutral payments.” Or, we should say, attempts to achieve site neutral payments—from several different directions. While nothing is imminent in this area, the tea leaves suggest that the pressures to have the same rate, regardless of site of service, will continue to build.

Following that, we highlight “patient engagement.” Engaging patients is at the foundation of nearly every current trend in healthcare and one of the most important components of health care reform. Studies now show that engagement results in improved outcomes and lower costs. We describe the benefits and the hurdles that remain.

I hope that you recently saw our announcement of new Compliance Support services. If not, you need to read “Compliance Requirements...Don’t be a Target!”

While on compliance, we have a surprising piece on patient demographics and how easy it is to run afoul of HIPAA requirements.

One final note: we’ve improved the “Print” functionality (works nicely to print or create a PDF of a single article) and added a “Download Current Issue” button. The latter provides a PDF of this entire issue if you prefer to read or share it in that form.

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Bill Gilbert

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Bill Gilbert
Clinical Decision Making and Patient Centric Care

Much has been written recently about the state of pathology and clinical labs in an environment where cost-cutting is at the forefront. Per a DarkDaily article, “Labs are experiencing one of the toughest financial squeezes in two decades.” Hospital admissions are down at the same time they are being paid less per inpatient. This results in pressures on hospital departments and clinical laboratories to trim their costs.\[1\]

At the same time, both labs and pathology groups have experienced reduced reimbursement for many lab tests as evidenced by the reduced payments for many molecular and genetic tests after the new molecular CPT codes were introduced last year, the 0.75 percent reduction in the 2014 Clinical Laboratory Fee Schedule, and payment bundling.

Many suggestions have been made for cost cutting including hiring consultants who are experienced in quality management, and adopting the use of Lean, Six Sigma, or ISO 9001/ISO 15189 and other process movement methods to streamline costs. (see our article in the Winter 2014 edition of The Leading Edge)

But as this cost-cutting pressure and lower reimbursements are affecting hospitals, laboratories and pathology groups, health care reform is forcing these same entities to raise the value of the care they deliver. In order to do this, two strategies are presented to laboratories and pathology groups – become more involved in improving the quality of clinical decision making and move towards patient centric care.

Clinical Decision Making

It is evident in the number of studies that have taken place over the last few years that poor clinical decision making is a major cause of misdiagnosed patients in a variety of locations, causing harm and death of patients. Few pathologists and clinical laboratory scientists would dispute this statement because they see the best and worst of how physicians use medical laboratory tests each day.

In a 2013 paper published by the College of American Pathologists (CAP)[2], a look at several studies showed the following results:

- The majority of diagnostic error cases are not due to pathology, laboratory, or radiology mistakes but to diagnostic errors in the clinics, where error rates average 15%. These errors include delayed, missed, and inaccurate diagnoses.
- The costs attributable to medical errors in the US in 2008 were estimated to total $19.5 billion, with a $13,000 price tag per error. Medical errors cause between 44,000 and 98,000 deaths annually.
- Doctors in the US are failing to follow up on results of up to 62% of laboratory tests and up to 35% of radiology tests. As a result, they are missing critical diagnoses, including cancer, and causing delays in treatments for many conditions.
- Nearly one in five hospital patients are harmed during a hospital stay, and nearly two-thirds of that harm is preventable.
- An estimated 4.5 million preventable hospital-acquired conditions occur each year in the US, costing approximately $8.75 billion. An estimated 1.7 million hospital-
associated infections lead to about 100,000 deaths.

And according to a U.S. News Health story published last year, the incidence and cost of misdiagnoses coming from medical malpractice settlements is 35 percent of all settlements. An analysis of 350,000 claims over a 25-year period determined that wrong diagnoses made up the bulk of U.S. malpractice payouts of $39 billion during this period.

How do these studies affect pathologists and clinical laboratories?

Pathologists and laboratory scientists have the knowledge, skills, and experience necessary to provide effective clinical consultations with physicians and other providers in ways that can measurably reduce diagnostic errors in healthcare.

The rapid advancement of medical knowledge and technologies has created levels of complexity that challenge the effectiveness of clinical decision-making. CAP says pathologists can offer hospitals multiplicative increases in value by upgrading clinical decision-making through collaboration with pathologists. Pathologists have the expertise, technologies, and data to manage this complexity, help improve clinical decision making, and substantially elevate hospitals’ value yields. [3] These same qualifications allow pathologists to offer primary care and referring physicians the same expertise in suggesting the proper laboratory tests to be ordered to properly diagnose their patients.

Pathology-supported decision-making strategies entail pathologists sharing their expertise with clinicians and implementing these strategies using a range of tools and services that include hospital IT system applications, institutional programs and consultative services. Pathologists’ knowledge can essentially navigate the clinical complexity for providers and guide them in:

- Selecting the optimal tests, including genomic tests, and treatments.
- Accessing and managing patient test results, ensuring results are not missed.
- Integrating and interpreting results across therapeutic areas and modalities.
- Planning treatment regimens and follow-up.

Patient-Centric Care

Under pressure from health care reform, hospital leaders are adopting strategies to not only contain costs but to also raise the value of the care they deliver using best practices including care coordination, care management, provider integration, clinical pathways adoption, and performance management with data analytics.

In light of health care reform and the introduction of patient-centered homes and Affordable Care Organizations, pathology and clinical laboratory organizations must also change how they think – from “how does it affect me and my organization?” to “what is best for the patient and society including the impact on health care costs and patient access”. [4]

Several ways have been suggested to improve the value of pathologists’ services.

- Ensure patients get the tests and treatments they need and when they need them
without having to undergo unnecessary medical procedures
- Pathologists should be the key source of information about lab testing and help patients and clinicians benefit from their knowledge
- Make themselves more accessible to clinicians in order to provide expertise on which tests to do and when – no one is in a better position to do this than pathologists. With the expansion of test complexity and knowledge, the more generalist the primary care or referring physician, the more he/she needs the pathologist’s review.

Currently, two issues prevent a huge move forward in this direction. The first is that switching from a volume-based business to one that delivers more value is difficult as payers do not yet reimburse the extra time required to perform these value services and second, there is not yet an urgent demand from pathologists’ customers to deliver more value in these new ways.

But if health care continues in the direction of new reimbursement models, pathologists and laboratories will need a new strategy to evolve from a business model that is accession-centric or volume-centric to one that is patient-centric with new ways to get paid. The patient-centric movement for pathologists and laboratories must include efforts to reduce duplicate or unnecessary testing, acceptance of test utilization management, consolidated lab test reporting, and greater attention to improving patient outcomes. [5]

In a paper published by CAP, Michael Laposata, MD, PhD, states that pathologists are creating three complementary approaches to complex laboratory testing, each of which has been shown to improve the quality of care and patient experience while educating clinicians and reducing the over- and underutilization of laboratory tests.[6]

- Multidisciplinary Diagnostic Management Teams (DMTs) – made up of pathologists, clinicians, and informaticists who collaborate to write guidelines for appropriate testing related to specific conditions
- Standardized order protocols, and
- Synthetic test reports – includes a patient-specific narrative paragraph from the pathologist that synthesizes all clinical and laboratory findings, which enable clinicians to understand what tests reveal in the context of each patient’s condition.

Dr. Laposata said he has seen these tools work in complex coagulation testing at Massachusetts General Hospital where 70% of MGH clinicians surveyed had said that interpretive reports had helped to reduce the number of tests ordered and/or helped prevent a misdiagnosis.

Dr. Laposata also cited an 18-month trial at Vanderbilt[7] with test panels for hematologic malignancies. The final results were that out of the 84% of bone marrow biopsies that were evaluated by using pathologist-driven testing, the average cost had dropped by $442 per patient evaluation.

The authors estimated that just for this test in their facility alone, they could save between $522,000 and $1,069,200 per year and based on the estimated national annual bone marrow volume of 666,000 cases, the standard order protocols could save the US health care system between $191 and $392 million annually. Vanderbilt now has teams in six medical areas that operate patient-centered partnerships with DMTs in coagulation, hematopathology, microbiology, and blood transfusion.
In order to make this approach work, those pathologists who do not have extensive education and experience in clinical pathology will need to build upon those skills to participate in the multidisciplinary teams and databases that are required, along with the electronic health record which needs to be part of the education process. The databases are built so that the metrics put everything in context and the pathologist does the rest.

PQRS 2015 Proposed Changes for Pathology

The 2015 Proposed Rule, Revisions to Payment Policies under the Medicare Physician Fee Schedule, published July 11, 2014 via the Federal Register includes the same Pathology measures as 2014 with a recommendation for three new measures. These new measures appear to be the same three measures CAP has been trying to get approved for the last two years. We will provide more information regarding the 2015 Pathology measures as it becomes available.

No pathology measures are proposed to be retired for 2015.

Recommended Measures

The following are recommended PQRS reporting for 2015 for Pathology

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<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Claims Based/Registry</th>
<th>NQS Domain</th>
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<tbody>
<tr>
<td>99</td>
<td>Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade. Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade</td>
<td>CB &amp; R</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>100</td>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade. Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade</td>
<td>CB &amp; R</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>249</td>
<td>Barrett’s Esophagus: Percentage of esophageal biopsy reports that document the presence of Barrett’s mucosa that also include a statement about dysplasia</td>
<td>CB &amp; R</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>250</td>
<td>Radical Prostatectomy Pathology Reporting: Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status</td>
<td>CB &amp; R</td>
<td>Effective Clinical Care</td>
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New PQRS Codes for 2015 for Pathology

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<th>Measure</th>
<th>Description</th>
<th>Claims Based/Registry</th>
<th>NQS Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>251</td>
<td>Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients: This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer</td>
<td>CB &amp; R</td>
<td></td>
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Lung Cancer Reporting (Biopsy/Cytology Specimens): Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report

Lung Cancer Reporting (Resection Specimens): Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non small cell lung cancer, histologic type

Melanoma Reporting: Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

Claims Based/Registry | NQS Domain |
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<td>CB &amp; R</td>
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<td>Communication &amp; Care Coordination</td>
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Use of Modifier 59 in Pathology Billing

Modifier 59 is used to designate that a Distinct Procedural Service is being performed with another procedure. But we sometimes find that this modifier is used inappropriately in pathology billing when practices add a 59 modifier to:

- a component code that is actually part of the primary comprehensive code, or
- a code that is mutually exclusive of the primary code, such as two different lab tests that measure the same factor.

The CPT Manual defines modifier 59: “Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only when there is not another, more descriptive modifier available and the use of modifier 59 best explains the circumstances of the coding service, should modifier 59 then be used.” Please note that documentation must support the requirements of the 59 modifier.

Modifier 59 may also be used when multiple units of the same code are billed on the same day by the same provider such as code 88342 (Immunohistochemistry...per block, cytologic preparation, or hematologic smear). The modifier 59 would only be applied to each code billed in addition to the primary code. On occasion, we see pathology charge tickets where all codes have an appended modifier 59. This is an inappropriate use of the 59 modifier.

The OIG (Office of the Inspector General) along with many of the Medicare Administrative Contractors (MACs) are targeting to review claims for over usage or incorrect use of this modifier. As reported in our “Beware of the 59 Modifier” feature article, CMS will require the use of four new modifiers in addition to the 59 modifier in order to specifically indicate the reason for usage.

Modifier 59 should only be used if there is no other relevant modifier that describes the service better for different encounters on the same day as long as the documentation otherwise supports the requirements of the 59 modifier.

Caution should be used when modifier 59 is used to bypass the NCCI edits in order for the claim to be reimbursed. Modifier 59 should not be used to bypass these edits unless criteria for modifier 59 are met. Accurate use of modifier -59 requires a knowledge of which codes normally cannot be listed together based on Correct Coding Edits published in the National Correct Coding Policy Manual for Part B Medicare Carriers. These edits list code pairs that are excluded based on two relationships:

1. One code is comprehensive and includes the service of the other, component code; or
2. The two codes are mutually exclusive, such as two different lab tests that measure the same factor.

Within the list of code pairs in the Correct Coding Edits, you will notice the use of superscript numbers 0 or 1 on some codes.
- 0 – means that a modifier would not be appropriate for that code pair under any circumstances.
- 1 – means that a modifier is allowed, if appropriate.

Providers and coders must check the current version of Correct Coding Edits to obtain the complete lists of excluded and allowed code pairs.

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Medicare Advantage is Growing, not Shrinking

In 2010 (when the ACA was enacted), the CBO projected that ACA payment reductions for Medicare Advantage (commonly called Advantage or MA) would result in 7 million fewer seniors enrolling by 2019.[1] But according to 2014 statistics, the number and percentage of Medicare Advantage beneficiaries are increasing and business for insurance carriers who host Advantage plans is booming.

In fact, nearly a third of Medicare beneficiaries are in an MA plan vs. traditional Medicare and the percentage seems likely to increase. While there are major differences between traditional Medicare and MA, from a patient’s perspective, they come down to “how much is the premium?” and “is my doctor in the MA network?” MA plans almost always offer a lower premium (often much lower) but with a limited selection of providers vs. traditional Medicare.

Several factors are contributing to the growth in MA. First, baby boomers new to Medicare are more used to managed care products and working the internet to obtain coverage. Second, the growth in major corporations moving their retiree healthcare to private exchanges[2] provides access to MA plans as well as more traditional MediGap plans. Third, despite ACA language to the contrary, CMS payments to MA insurance providers have actually increased in the past two years. Finally, insurers are beginning to use MA HMO-type plans as a means to control costs.

As a result, physician groups and hospitals need to evaluate their status with payer MA plans to see if they are “in network” and, if not, whether they should be. This is becoming increasingly important since some MA insurers have recently narrowed their networks by dropping major provider groups. With the cost pressures on MA insurers (see below), it seems likely they will continue to narrow their networks as much as possible.

Per the Kaiser Family Foundation Fact Sheet released in April 2014:

- In April, 15.7 million seniors were enrolled in Advantage plans, almost 30% of the 54 million Medicare beneficiaries
- Since the ACA was introduced in 2010, there has been a 41% increase in Advantage enrollees (from 11.1 million in 2010)
- MA enrollment has tripled since 2003 when 5.3 million seniors were enrolled
- 64 percent of the MA beneficiaries are enrolled in an HMO product and 23 percent are in local PPO
- Medicare payments to MA plans are projected to total $156 billion in 2014, accounting for 30% of total Medicare spending

Medicare Advantage Insurers

The MA market is dominated by large insurers: Humana, UnitedHealth Group, Aetna, Cigna, Wellpoint and Kaiser Permanente. Together these six plans control more than half of the Advantage market with 9.2 million enrollees. No other insurer covers more than 400,000 Advantage customers.[3] The larger companies are growing their Advantage plans and over the years, smaller plans may struggle to keep their Advantage rates low, resulting in mergers or the larger companies buying their Advantage plans.
Insurers who do a good job of keeping costs down while providing quality care, should be able to keep and add to their Advantage beneficiary base. Per a study performed by HealthPocket, plans can obtain more money from CMS by improving their star rating. Beginning in 2015, only plans that receive at least four stars will be eligible for CMS bonuses. In 2014, 38 percent of Advantage plans received at least four stars, up from 28 percent in 2014.

Recent changes have affected at least three insurers and their beneficiaries this year and into 2015.

- **UnitedHealth** has recently dropped providers in Alabama stating they do not consider their restructuring to fall into the narrow network category but that UnitedHealth is building more “focused” networks. The drop came in the middle of the year leaving many patients scrambling to find new coverage. Last year patients and physicians were angry when UnitedHealth reduced some networks causing many customers to lose access to their doctors resulting in lawsuits filed against the insurer in two states.

- **Humana** lost a large provider contract in Minnesota when the practice shared the concerns of Minnesota’s Attorney General that Humana was overcharging its beneficiaries and inappropriately denying claims.

- **MVP Health Care** is discontinuing two of its five plans which could affect 17,000 beneficiaries. The three remaining plans will require higher co-pays and, depending on which plan is chosen, could have substantially higher premiums.

**How does Medicare Advantage work?**

Advantage is still an attractive option for millions of seniors and disabled Americans because it offers comprehensive coverage, and generally, a more generous benefits package than traditional Medicare. By law, Advantage plans must provide at least the same benefits as traditional fee-for-service (FFS) Medicare Parts A and B. But unlike traditional Medicare, Advantage plans must also put a cap on beneficiaries’ out-of-pocket costs.

Advantage also provides patients with a variety of plans (ranging from managed care and private fee-for-service plans to “special needs plans”); a network of doctors, hospitals, and other medical professionals (usually more limited than traditional Medicare); along with catastrophic coverage protection and a wider array of health benefit options, such as drug or vision coverage. Advantage plans have also been proactive in offering care coordination and case management services. These plan offerings have resulted in higher enrollee satisfaction and significant savings for seniors, particularly on out-of-pocket medical costs.[4]

**Medicare Advantage premiums**

Medicare pays Medicare Advantage plans a capitated (per enrollee) amount to provide all Part A and B benefits plus a separate payment for providing prescription drug benefits under Medicare Part D. Federal payments to Advantage plans have always exceeded payments to traditional Medicare for the same mix of services. Since 2006, Medicare has paid plans under a bidding process based on estimated costs per enrollee for services covered under Medicare Parts A
and B. The bids are compared to benchmarks which are the maximum amounts Medicare will pay a plan in a given area.

Enrollees pay the difference between the benchmark and the bid in the form of a monthly premium, in addition to the Medicare Part B premium unless the bid is lower than the benchmark. In this case, the plan and Medicare split the difference between the bid and the benchmark; the plan’s share is known as a “rebate,” which must be used to provide supplemental benefits to enrollees. Medicare payments to plans are then adjusted based on enrollees’ risk profiles.

Advantage premiums, like most others, have been rising but not spiking. Actually in 2014, the Advantage plan premiums were less than 2013. In 2014, the average monthly premium is $49, down from $51 in 2013 and many Advantage plans require no premium. However, the average cap on out-of-pocket costs has increased by more than 10% for 2014, to an average of $4,797; 41 percent of plans have out-of-pocket limits of $5,000 or more.[5]

In 2010, the ACA tried to bring Medicare Advantage plans into line with the cost of traditional Medicare by revising the methodology for paying plans and by reducing the benchmarks. For 2011, benchmarks were frozen at 2010 levels and reductions in benchmarks were slated to be phased-in between 2012 and 2016.

**Medicare Advantage costs taxpayers more**

Before the ACA, Advantage plans received federal funding that averaged 14% more than the cost of treating the same patients enrolled in traditional Medicare. But since 2012, with the ACA cuts, these payments have dropped from an average of 7% higher to 4% higher than traditional Medicare fee-for-service payments.[6]

This projected reduction in funding caused many, particularly conservatives, to say that Medicare Advantage plans were threatened and seniors would no longer have affordable access to the plans. Insurers who led intense lobbying campaigns against payment reductions said the Medicare Advantage plans would sustain far deeper cuts when other factors are taken into account, such as Medicare cuts made as a result of budget sequestration and the health law’s tax on health insurance premiums.

As noted, the original ACA plan was to reduce the benchmarks and pay less to the private insurers who hosted the Advantage plans in order to reduce Medicare spending. However for the second year in a row, instead of cutting funds to Advantage plans, the Obama administration increased funding. On April 7, 2014, the administration turned a proposed 1.9 percent cut to 2015 Medicare Advantage health plans into a .4 percent increase after heavy lobbying from insurers and Capitol Hill. It was the second-straight year that the Medicare agency transformed a proposed rate cut into a raise. (In 2012, the administration initially proposed cuts of 2.2 percent for 2014, but reversed the cuts and increased the rate 3.3 percent.)

However, despite last year’s increase, insurers say they still saw their Medicare Advantage reimbursements shrink about 6 percent in 2014 plans. And Moody’s Investor Service said even after this April’s payment boost, the final 2015 rates are a “credit negative” for Medicare Advantage insurers, who are anticipating an average reimbursement reduction between 3 percent and 4.5 percent next year.[7]
Even with the "credit negative," the large insurers hosting Advantage plans are doing well and projections show continued increases in MA enrollees over the next few years.

Will the Boom Last?

Some speculate that if the Advantage plans are cut for 2016, costs to seniors will continue to go up, their benefits may be reduced and they may have fewer choices of providers and fewer coverage options. This could send beneficiaries back to traditional Medicare or cause many to change their Advantage plans. Consumer advocates say Medicare Advantage works only if seniors shop for a new plan each year because the plans change so often. But too often, seniors stay with same plan which leads them to pay more than they need to.[8]

The major tradeoff that insurers and consumers face is the makeup of each Medicare Advantage network. Too narrow and consumers won’t sign up. Too broad and premiums could be too expensive. Consumer advocates hope that the growth in exchanges will lead to more MA competition. Based on recent experience, most observers expect to see a continued expansion of MA plans with a continued growth in the "market share" of Medicare Advantage.

Site-Neutral Payments Are Still on the Table

If you thought the attempts to institute site-neutral payments were going away, think again. You may remember that in the proposed 2014 Medicare Physician Fee Schedule (MPFS), CMS wanted to limit the amount paid for a service in the physician office setting to the amount paid for the same services when provided in a hospital outpatient department or ambulatory surgery center (ASC). However, after many negative comments from the health care community, CMS did not finalize that proposal nor did it mention the topic in the 2015 Proposed Medicare Physician Fee Schedule.

However, the interest in identifying and addressing the site payment differences continues. The Robert Wood Johnson Foundation published an excellent health care policy brief [1] in July explaining the origin of these differential payments and the debate over the very different approaches that have been proposed for developing site-neutral payments. Much of the information in this article is taken from that brief – see footnote below.

Medicare uses several different payment systems to set payment rates for Medicare services, and location of services is one of them. As Medicare and the whole health care system looks for ways to reduce costs and provide quality of care, tackling the payment differences, which are sometimes substantial, for the same services performed in different site types could be still be an important line item reduction in Medicare’s books.

The controversy around site-neutral payments stems from recent shifts of services from the physician’s office to the hospital out-patient department. MedPAC, in their March report to Congress, stated that the share of physician visits (evaluation and management services) and certain diagnostic cardiology procedures (particularly echocardiograms) performed in a hospital outpatient department setting increased by 8 percent between 2010 and 2011 and by 9 percent between 2011 and 2012. Because these are higher paid services in the outpatient department setting, this increases Medicare spending and at this time, with no proof that the quality of care is any better. At the same time, the share of those services administered in free-standing physician offices decreased by 1 percent each year.

The two main entities involved in Medicare rate settings are The Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC). Although, in many cases they are on the same page with reimbursement issues, they are taking very different approaches to eliminate differential payment for certain services.

The CMS Proposal

CMS states that Medicare typically pays more for the same services when it is provided in a hospital outpatient department than in a physician’s office and justifies it because hospitals incur higher costs to maintain 24/7 operations and must meet legal obligations to provide care to people needing emergency medical treatment. However, the separate methodologies (the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (HOPPS)) have produced rates for some 200 procedure billing codes where the physician fee schedule rate is higher than the outpatient rate: CMS believes these rates are the result of inaccurate data used to determine costs under the MPFS.
The MedPAC Proposal

MedPac recommends limiting payments to hospital outpatient departments stating that “Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries.” MedPac proposed to set payment rates for evaluation and management services and other types of services in hospital outpatient departments at the same rate that is paid under the MPFS. They also offered an alternative approach of equalizing payment rates between hospital outpatient departments and ambulatory surgical centers for certain services.

Other indications of the continued discussions on site-neutral payments were evidenced this year:

- In March, MedPAC, in its annual report to Congress, evaluated 450 ambulatory payment classifications and found 66 that did not require emergency standby capacity, did not have extra costs associated with greater patient complexity and did not need the additional overhead that comes with services that must be provided in a hospital setting. They concluded that aligning HOPPS payments with MPFS rates for these services would reduce Medicare and beneficiary cost sharing by $1.1 billion.

- In April, the OIG (Office of Inspector General) recommended CMS reduce hospital OPPS rates for ASC-approved procedures to ASC levels for low-risk patients stating that move could save Medicare as much as $15 billion from 2012 through 2017. The Lower OPPS rates could also save beneficiaries $2 billion to $4 billion in copays and coinsurance during the same time period. CMS did not concur with these recommendations.

- Congress is requiring that long-term care hospitals be paid a rate comparable to the inpatient prospective system rate for patients that do not meet certain criteria. This rate adjustment will take place in 2016 and CMS should include details about how the adjustment will be applied in its rulemaking next year.

CMS may still be able to revisit its issue with reducing office based rates: as part of the Protecting Access to Medicare Act of 2014 on April 1, 2014 (“the SGR fix”), Congress expanded the types of information CMS can use to determine costs under the physician fee schedule. CMS could also attempt to change the office rates via the “potentially misvalued codes” provision of the physician fee schedule.

Patient Engagement

Engaging patients is at the foundation of nearly every current trend in healthcare and one of the most important components of health care reform. Health Affairs defines patient engagement as a “concept that combines patient activation (patient’s knowledge, skills, ability, and willingness to manage his or her own health or care) with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly.” [1]

The EHR Incentive/Meaningful Use program lists patient engagement as one of its core tenets by developing measures to ensure patient accessibility to their health records. And with the introduction of smartphone healthcare apps and mobile fitness and health monitoring devices, the wave of patient engagement or consumerism in health care is growing. Access to these devices and the internet to find out more about managing their health has led to patients’ increasing desire to communicate and receive personal health data from their providers wherever and whenever they choose.

A 2013 Health Affairs article stated a “growing body of evidence demonstrates that patients who are more actively involved in their health care experience better health outcomes and incur lower costs.” The Robert Wood Johnson Foundation has reported that patients not engaged in their own care can cost 21 percent more than “highly engaged patients.”[2] In truth, it all centers on each point of the healthcare triangle: reducing costs, improving outcomes, and better engaging patients. The reality is that the first two are inherently tied to the third.[3]

In addition to the EHR program, new payment and delivery models, such as risk-based contracts, Patient-Centered Medical Homes and Accountable Care Organizations are springing up across the country – all programs designed to lower health costs and provide patient accessible quality healthcare. By taking on risk with bundled payments, providers must be able to affect patients’ behavior after they leave the office, or they will exceed the reimbursement rate for their care.

Medical practice has been gradually increasing its focus during the past decade from a more authoritative/paternal model to a more collaborative/consumer model. Hospitals, doctors and public-health officials are calling upon patients as consumers to become more active in their own care decisions by keeping track of their medical data, seeking preventive care and staying on top of chronic conditions.

Consumers now have a greater personal financial state in their healthcare as well. The public health insurance marketplace, created by the Affordable Care Act, as well as the private insurance marketplace, enable consumers to annually choose from multiple health plan options and provider networks. But understanding these health plan options is complex and demands much more consumer evaluation of costs, what they are getting for the cost of their coverage and if their preferred providers are in the plan’s network.

In order to accommodate this patient interest and engagement in their healthcare, medical practices must implement strategies to engage patients and include them and their families in decisions about their health.
Technology will be part of these strategies. One strategy is to make sure people have easy access to their medical records online. Reading and understanding one’s own health record enables patients to have more informed conversations with their physicians. With all the new fitness and health apps, consumers can now plug in data from their own medical record, such as generating a fitness regimen that takes into account a knee injury, weight and blood pressure.[4]

Web-based patient portals have been installed in many health care institutions allowing patients to book appointments, obtain referrals, request prescriptions, pay their medical bills, obtain lab results, radiology reports, physicians’ notes and see their own medical records. Many systems allow patients to check their data to make sure it’s accurate.

It has been suggested that organizations should strongly consider open systems that can integrate with their current financial and clinical system, but also capture data from unaffiliated entities and patients. “Providers that are first to integrate the various information sources – from pharmacists, ambulatory centers, clinics, and so forth – will find themselves central to a consumer’s health and will be rewarded with increased loyalty and more effective interactions with patients.”[5]

All technology must be simple to use and understand. The portals should have a dedicated mobile application that allows users to access their PHI and perform common tasks such as appointment scheduling or requesting a prescription renewal.

Yet, according to a survey from consulting firm Technology Advice, 40 percent of people who had seen a primary care physician within the last year did not know whether that doctor offered a portal. Only 9 percent said their physicians followed up with them after the visit via a portal, and 48 percent stated there was no follow-up. Certainly providers must provide patient education concerning the availability and usage of patient portals and other devices offered by the provider or institution.

However, significant barriers exist for many patients to access and understand their patient health information. The National Assessment of Adult Literacy (NAAL), which measures the health literacy of adults living in the United States, reported that only 12% of the population is considered proficient in healthcare literacy. A patient’s degree of engagement may be affected by such factors as cultural differences, sex, age, and education.

So, it is not only important for healthcare entities to provide access to their patients’ health information but providers may need to understand that specific competencies, such as language skills or an awareness and understanding of religious beliefs may be required on the part of physicians to effectively engage patients with diverse cultural backgrounds and socioeconomic status. Physicians should be ready to take on the role of educator. Shared-decision making offers an option for better educating patients about their conditions. Participation in the EHR meaningful use program assists physicians because its requirements include engaging patients and families in decision making and providing them with their health records and clinical summaries they can view and share with other physicians. The requirements also specify that a percentage of patients must actually use the information, which gives physicians a reason to encourage them to do so.

Besides taking the time to review findings and outcomes of tests, physicians must understand
where the patient is coming from and what they want to do. The patient needs to be engaged with personalized information and advice but challenges remain in figuring out two way communications will work through portals and other electronic means.

Healthcare organizations that install technology and provide strategies and workflows designed to assist patients in understanding their health care and condition will be competitive and will survive in this new health care age. The time is now to jump on the patient engagement bandwagon if you have not already done so.

Resources

Here are some resources that can be used by physicians and/or recommended to their patients.

The Blue Button

The Blue Button first appeared in 2010 on a patient portal where veterans could log-in and download their health records. Since then, many other organizations including physicians, hospitals, health insurance plans, retail pharmacies, labs, etc. have implemented Blue Button to make it easier for people to access their vital health information online.

Blue Button allows patients to see, download and keep their personal health data by clicking the “Blue Button” on a secure Internet site. Patients can then choose to share their data with their physicians or family members or make it available if emergency treatment is needed. Blue Button downloads are delivered in text files that can be downloaded, read, stored and printed on any computer without special software. Patients can also authorize use of a Blue Button transfer of their medical data from a treating physician to another medical provider.

In the Spring of 2013, The Centers for Medicare and Medicaid Services launched the Blue Button Connector which allows patients to download their health information to their computer or their mobile device.

Medicare beneficiaries can also view and download their Medicare claims through the Medicare Blue Button which now covers three years of a patient’s health history, including claims information on services covered under Medicare Parts A and B, and a list of medications that were purchased under Part D. This service is also available to Veteran’s services and the Indian Health Service.

National Coordinator for Health IT Karen DeSalvo announced at the 2014 Consumer Health IT Summit this September that there will soon be a new Blue Button campaign, that’s “gonna really explode.”[6]. A new Blue Button toolkit was also unveiled at the event.

Payers including UnitedHealthcare, Aetna Inc. and Humana Inc. offer a Blue Button link that lets members download personal health records into a single file, and retail pharmacy chains are in various stages of using Blue Button to let customers download prescription histories.


This guide provides a list of patient-friendly materials to help people chose high-quality care, manage their health care conditions, and make informed decisions regarding hospital and
emergency care. The guide also provides clinicians with resources to engage patients in their own care and involve them in other aspects of health care delivery.

The article in the Wall Street Journal listed the following two products that providers can recommend to their patients to assist them in monitoring their health.

**Partners Health Care – Wellocracy** (website to help people review the health trackers and mobile apps on the consumer market.)

**Healthwise, Inc.** – offers solutions to physicians to share health education solutions, technology, and services with their patients. One of the popular products is “information prescriptions” in the form of a video, brochure or interactive decision tool to help patients deal with a health problem.

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Compliance Requirements... Don’t be a Target

Many of our clients routinely ask about their compliance responsibilities. Many clients believe that their written compliance plan (that complies with Office of Inspector General, CMS for Medicare and Medicaid and HIPAA Privacy and Security regulations) fulfills their obligations. Let me assure you that this is not the case.

It doesn’t matter whether your compliance plan (the document) was professionally done by an attorney or whether you developed one internally; the compliance plan must be an “effective compliance and ethics program”. What does that mean to you? There are a number of activities needed to bring your compliance plan to life.

Developing the compliance plan document, and then putting it on the shelf, will work against you in the event of a federal or state government review of your practice (due to patient complaint, whistle blower, or other third party entity). Oh, and don’t forget that these plans should be updated as regulations change. If you have a written compliance plan; in what year was it completed? Has it been updated? Compliance guidance states that compliance plans should be reviewed and updated as necessary, at least annually, or as regulations change.

An effective compliance and ethics program protects your practice by detecting and preventing improper conduct and promoting adherence to your practice’s legal and ethical obligations. In 1991, the U.S. Sentencing Commission established the most recognized standards for an effective program within its Sentencing Guidelines Manual. These Guidelines are closely aligned with the principles provided in OIG’s Compliance Guidance for Physician Practices. While there is no “one-size-fits-all” program for every practice, there are 7 core elements that must exist in an effective program. They include:

- Compliance officer
- Written plan (policies and procedures)
- Training and education
- Lines of communication
- Auditing and monitoring
- Exception/incident procedures
- Response and corrective action

What can you do to promote compliance in your practice if you don’t have an effective compliance program or a written compliance plan? A simple and effective way to begin is to engage in professional compliance training which will immediately raise compliance awareness for staff and physicians, and it fulfills one of the 7 core elements of an effective compliance program.

AdvantEdge offers a Web-based Compliance Training Program that can be accessed from anywhere at any time and it fulfills the annual training obligations. It is subscription-based so there is no software to purchase or system to maintain. The educational curriculum is always up-to-date eliminating home-grown compliance educational program development challenges. Upon completion of training, you will print out a proof of training certificate which demonstrates that you have completed annual training requirements.

How much will this cost? The subscription considers the number of users (administrative staff,
physicians, non-physician practitioners) that will receive training.

- 1 to 10 users – $1,050 per year
- 11 to 50 users – $3,050 per year

If we use an example of a 5-user subscription, it will cost $210 per user/year or calculated another way $87.50 per month for up to 10 users.

You don’t want to be the practice that makes the headlines. It is not the boldly non-compliant physician that always makes the news. There are many innocent mistakes that become compliance issues because the regulation states “or you should have known.”

Sample of course content: Understanding the False Claims Act vignette (opening conversation)

Closing Summary of Understanding the False Claims Act vignette
Below are two examples of innocent non-compliant HIPAA activity:

**Physician Revises Faxing Procedures to Safeguard PHI**
Covered Entity: Health Care Provider
Issue: **Safeguards**

A doctor’s office disclosed a patient’s HIV status when the office mistakenly faxed medical records to the patient’s place of employment instead of to the patient’s new health care provider. The employee responsible for the disclosure received a written disciplinary warning, and both the employee and the physician apologized to the patient. To resolve this matter, OCR (Office for Civil Rights) also required the practice to revise the office’s fax cover page to underscore a confidential communication for the intended recipient. The office informed all of its employees of the incident and counseled staff on proper faxing procedures.

**Private Practice Revises Access Procedure to Provide Access Despite an Outstanding Balance**
Covered Entity: Private Practice
Issue: **Access**

A complainant alleged that a private practice physician denied her access to her medical records, because the complainant had an outstanding balance for services the physician had provided. During OCR’s investigation, the physician confirmed that the complainant was not given access to her medical record because of the outstanding balance. OCR provided technical assistance to the physician, explaining that, in general, the Privacy Rule requires that a covered entity provide an individual access to their medical record within 30 days of a request, regardless of whether or not the individual has a balance due. Once the physician learned that he could not withhold access until payment was made, the physician provided the complainant a copy of her medical record.

Two examples of improper billing activities (regulatory compliance) that resulted in fraudulent
claims being submitted to payors:

**Provider was fined $400,000** and permanently excluded from participating in Medicare by overstating face-to-face time with patients. Providers have been known to consider face-to-face time as time required to document the medical record which is not correct.

**Provider paid $435,000** and entered a 5-year Integrity Agreement for submitting claims that were not supported by accurate patient medical records. How many times have you heard from government authorities “not documented; not done.”

Not having an effective compliance program (an on the shelf compliance plan or no plan at all) may result in the following:

- Increased fines and penalties
- Exclusion from Medicare and Medicaid programs
- Probation, home confinement or incarceration

We can help make regulatory and HIPAA compliance a reality for your practice by arming you and your staff with the latest information and educational resources to ensure that you are knowledgeable, well-prepared, and current with healthcare regulations including HIPAA and federal and state laws. See our brochure and consult with your AdvantEdge Client Manager or call Jeanne Gilreath directly at 908.279.8104 or email jgilreath@ahsrcm.com for further information.
HIPAA Breach Awareness: Patient Demographics

Are You Validating Your Patient Demographics EVERY TIME?...If not, you may be putting your practice under the HHS microscope for HIPAA breach disclosures. Consider this scenario; Mary Smith does not feel well and visits her longtime local internist. The receptionist recognizes Mary, welcomes her and advises that someone will be out shortly. No validation of address or insurance information is performed. Mary meets with Dr. Sweet who determines that Mary is truly ill and needs further testing. Mary is referred to laboratory and imaging facilities. Mary finishes with Dr. Sweet and obtains a follow up appointment with the receptionist, then pays her co-pay for today’s visit.

Within days Mary’s insurance company is sent a claim that is processed, with a balance due of $75. A statement is generated to Mary’s address on file. Unfortunately, Mary moved across town the month before her doctor visit. She never mentioned the move and the receptionist never asked during the two face-to-face opportunities to do so.

Mary is very busy and pays most of her bills online, so she never thought to advise the Post Office of an address change, after all – she does not need any more junk mail! But sadly, this is the only address the doctor has on file.

The new tenant in Mary’s old apartment receives mail Saturday afternoon and inadvertently opens it; coincidently he is also a patient of Dr. Sweet. He realizes this mail is not intended for him so he asks a neighbor in the building if they ever see Mary, because he has a bill for her. Monday morning Mr. New Tenant phones the doctor’s office to let them know Mary doesn’t live there anymore.

In the meantime, Mary had been grocery shopping Sunday evening and ran into the old neighbor, who asks how Mary is feeling. “What? I’m OK, why do you ask?” On and on and on... you can see how this simple wrong address scenario can get out of control quickly and how a patient may get upset.

Mary was very upset when she found out that her old neighbor knew she went to the doctor. Mary also phoned the office on Monday and threatened to sue and advised that she was going to report the doctor for disclosing her medical visit. All of this could have been avoided if the receptionist had asked Mary to state her demographic information so she could verify it with what was in the system.

(Note: We realize that Mr. New Tenant should not have opened mail that did not have his name on it, but it did have his address, and it was his doctor’s office also. He didn’t notice that the name in the window was not his.)

The scenario above is, unfortunately, not unique. Worse, it is a reportable breach to the Office of Civil Rights (OCR) at the Department of Health and Human Services! Mary believes she has been caused significant harm by the release of her PHI to a non-authorized person. It is a breach of non-secured PHI and it also necessitates a mini risk analysis by the covered entity. Situations like this, at a minimum, show the need for practices to have established patient demographic validation procedures performed each and every time a patient steps into the
office or while making the appointment. Hospital-based groups need to be aware of their hospital’s admit process for capturing demographics and assure that their downstream billing and other patient contact processes (e.g. copies of reports) carefully verify demographics.

Registration/check-In errors can lead to HIPAA breaches, lost revenue, denied insurance claims, returned mail, aging A/R for self-pay balances and additional staff time. These inaccuracies, whether intentional or not, have a big impact on all healthcare organizations.

Under the new HIPAA Final Omnibus Rule, covered entities and business associates responsible for violating HIPAA privacy and security rules by failing to safeguard patient protected health information can face up to $1.5 million in annual fines.

A Covered Entity or a Business Associate must report HIPAA breaches to the OCR, at a minimum, once a year within 60 days from the end of the calendar year (45 CFR 164.402, 404 and 408).

But...Does a Billing Statement Really Contain Enough Information to Get Me in Hot Water?

You may wonder if the above scenario isn’t a little bit of a stretch … what information REALLY needs to be compromised to create a HIPAA breach. Two more simple scenarios help us understand:

1. A provider sends a patient a letter that includes the patient’s name and address, patient number, admission date, account balance, and the provider’s name.

2. A provider sends a letter that includes the patient’s name and date of birth, patient number, date of service, medical record number, and the provider’s name.

If one of the above letters is sent to someone other than the patient, is this considered a breach of PHI that requires patient notification? The short answer is “Yes”.

PHI is defined as individually identifiable health information. A strict interpretation and an “on-the-face-of-it” reading would classify the patient name alone as PHI if it is in any way associated with the provider. (Pursuant to 45 CFR 160.103, PHI includes demographic information received by a healthcare provider relating to the provision of healthcare). If the name of an individual is associated with a medical group and/or provider that delivered healthcare, it is demographic information and is considered PHI.

The additional information confirms that the content of the letter is PHI even though the letter does not specifically mention the health condition of the patient.

The regulation does not require a data set to include a certain number of identifiers to be considered PHI. It specifically states that if information identifies an individual, it is PHI.

The information included in the two example letters is clearly PHI. Sending the letter to the wrong individual would be considered a breach of unsecure PHI. After conducting a risk assessment to determine whether sending the letter to the wrong individual will cause harm to the affected patient, the provider would be responsible for determining whether to notify
the patient. **The provider must document its actions regardless of whether the incident is a notifiable breach (45 CFR 164.400–164.414).**

Over the past few years we have observed that many more patients are on the look-out for fraud. There have been instances where a seemingly ‘simple’ wrong address has led to patients notifying Medicare/HHS/OCR/OIG believing they are being targeted in a scam or some sort of deceptive billing practice. Patients are more educated than ever and are picking up the phone and making complaints to agencies before ever contacting the billing company or provider’s office.

**Don’t Forget State Privacy Requirements**

Beyond HIPAA there exists another universe of breach notification requirements in the 46 states that have data breach notification laws. Risk assessments must therefore include not only HIPAA requirements, but also the requirements of an organization’s respective state laws.

**Conclusion**

The patient check-in process (and check out where applicable) at a physician office or a hospital is an opportunity to update and collect information about the patient. This face-to-face time with the patient should be utilized each and every time to validate demographic information. Covered entities and business associates must stay on their toes and evaluate not only what will constitute an inappropriate use or disclosure of PHI but also what can be done to ensure that appropriate policies and procedures are in place to avoid inquiries and reprimands from government agencies.
Beware of the -59 Modifier as of January 1, 2015

Although we have published this latest CMS announcement in our recent newsletters, we want to ensure that everyone is aware of the -59 modifier change, effective January 1, 2015. Since it is widely-used, improper use can have a significant impact on reimbursement (from delays or denials).

CMS has recently announced changes to the use of the -59 modifier which could impact medical billing submissions and provider reimbursement. Per CMS, due to chronic overuse of modifier -59 (Distinct Procedural Service), they have created a new series of modifiers which provide more specificity of the distinct procedural service. The -59 modifier is the most widely used HCPCS modifier and is used in a wide variety of circumstances, such as to identify:

- A separate encounter;
- A separate anatomic site; and
- A distinct service

However, CMS states the -59 modifier often overrides the edit in the exact circumstance for which it was created in the first place, and is used;

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment and so, effective January 1, 2015, CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 :

- XE Separate Encounter, a service that is distinct because it occurred during a separate encounter
- XS Separate Structure, a service that is distinct because it was performed on a separate organ/structure
- XP Separate Practitioner, a service that is distinct because it was performed by a different practitioner
- XU Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. It is unclear at this time if other payors will adopt the new modifiers.

For our physicians who code their own services, it will be important to understand and use the four new modifiers to describe your services. For those clients who submit medical reports to AdvantEdge for coding, please include in your dictation information that will allow our coders to distinguish which modifier should be appended to your services if applicable.

References: MLN Matters® Number: MM8863 & CMS Transmittal 1422.
ICD-9 to ICD-10 Conversions: Stress Factor of Other Bone

**Diagnosis:** Stress Fracture of Other Bone

**ICD-9 Code(s):** 733.95 – Stress fracture of other bone

**Listed Under:** Diseases Of The Musculoskeletal System And Connective Tissue 710-739 → Osteopathies, Chondropathies, And Acquired Musculoskeletal Deformities 730-739 → Other disorders of bone and cartilage 733-

**ICD-10 Code(s)** M48.40 – M48.48

**Listed Under:** Diseases of the musculoskeletal system and connective tissue M00-M99 → Spondylopathies M45-M49 → Other spondylopathies M48-

There is one ICD-9 code for a stress fracture of the bone. However, in ICD-10, there are 9 sets of codes describing each region of the vertebra.

- Unspecified site
- Occipito-atlanto-axial region
- Cervical region
- Cervicothoracic region
- Thoracic region
- Thoracolumbar region
- Lumbar region
- Lumbosacral region
- Sacral and sacrococcygeal region

In addition, the correct encounter must also be listed, creating four more codes for each region by adding a 6th and 7th digit.

- XA – initial encounter
- XD – subsequent encounter for fracture with routine healing
- XG – subsequent encounter for fracture with delayed healing
- XS – sequel of fracture

*Diagnoses in shaded areas are titles only and are not billable*
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<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>ICD-10 Description (if different)</th>
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<td>M48.41</td>
<td>Fatigue Fracture of Vertebra, occipito-atlanto-axial region</td>
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<td>Sequela of fracture</td>
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<td>ICD-10</td>
<td>ICD-10 Description (if different)</td>
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<td>Fatigue Fracture of Vertebra, lumbosacral region</td>
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