Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

www.partbnews.com

February 16, 2015 | Vol. 29, Issue 7

IN THIS ISSUE

All Medicare fees are par, office, national unless otherwise noted.

Coding

Use modifier 59 until Medicare fleshes out its X modifier policy

Many practices are excited to begin using the new X modifiers in place of modifier **59** (Distinct procedural service), but you may want to hold off a little longer, at least for your Medicare patients.

CMS last month advised providers that while the modifiers are considered active, "additional guidance and education as to the appropriate use of the new X (EPSU) modifiers will be forthcoming as CMS continues to introduce the modifiers in

*(see **Modifier 59**, p. 6)*

Front office matters

Pre-screen patients, isolate if needed when infection threat rises

Take simple precautions to make sure your patients don't get sicker when a patient presenting special infection risks comes in for treatment.

The U.S. Centers for Disease Control and Prevention (CDC) is reporting a growing number of measles outbreaks across the United States, and the news has been full of stories about providers refusing unvaccinated patients admission to their practices. The principle also can be applied to other special

*(see **Infection**, p. 8)*

EHR: To attest or not to attest

More than 250,000 practices have been hit with 1% payment penalties for not attesting to meaningful use, but it may be that the penalties have less of an impact than adopting electronic health records (EHRs). Learn how to make critical decisions to improve your bottom line during the webinar **EHR Decision Time: How to decide whether meaningful use penalties are less painful than attesting** from 1 to 2 p.m. (ET) March 11. For more information, visit *http://www.decisionhealth.com/conferences/A2568*.

Patient encounters

Fight your way through murky rules to get paid for physician-led home services

Don't let confusion surrounding Medicare's abbreviated rules for providing home services — and the hefty price tag of approximately $40.5 million in denied claims — stop you from delivering needed services to high-risk patients.

Practices reporting codes **99341-99350** see denial rates as high as 16.1% (99341), with an average of 11.3% for the nine codes across all specialties, according to 2013 Medicare data, the latest available (*see benchmark, p. 5*). With nearly 3 million services rendered in 2013, that means big bucks are at stake to your practice.

Part of the problem stems from unclear Medicare guidance as to what constitutes a homebound patient and therefore the necessity of home-based services, explains Joan Gilhooly, MBA, CPC, president, Medical Business Resources in Cincinnati, Ohio.

While CMS includes a lengthy description of homebound services in its benefit policy manual for Part A home health services, Part B guidelines "aren't as clear and don't give as much detail as to what should be documented [for] demonstrating the need for a visit in the home," points out Kevin Miserez, attorney with Wachler and Associates in Royal Oak, Mich.

In fact, guidelines for "homebound status," contained in chapter 12 of the Medicare Claims Processing Manual, are often a source of confusion. "It says you don't have to be homebound like you do for home health," says Gilhooly, but at the same time "the medical record has to show why the patient couldn't come to the office."

With scant details, providers are left in the lurch at the same moment they're facing increased federal attention, with home-based care becoming "a pretty big target by CMS," according to Miserez, who has seen physicians and home-visit practices "getting audited quite a bit in the past year." The denied dollar amount increased more than $4 million between 2012 and 2013.

You'll want to devise a strategy to avoid denials because you can expect the confusion to continue, predicts Gilhooly, who isn't holding out hope for further federal guidance. "I'm not aware of anything that's in the works. Although it's sorely needed!" she says.

Document to avoid denials, downcodes

- **Specify medical necessity and note external factors affecting the patient.** To get your home service claims through, document the reason for the home visit, why the home visit is necessary and the acuity of the patient's condition. Many practices struggle with "clearly identifying why the patient can't be seen in the office that day," says Gilhooly.

Subscriber information

Here's how to reach us:

EDITORIAL
Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice president: Tonya Nevin
1-301-287-2454
tnevin@decisionhealth.com

Content manager, medical practices:
Karen Long, 1-301-287-2331
klong@decisionhealth.com

Editor: Roy Edroso, 1-301-287-2200
redroso@decisionhealth.com

Editor: Richard Scott, 1-301-287-2582
rscott@decisionhealth.com

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email to: *customer@decisionhealth.com*

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: *www.partbnews.com*. Also, follow us on Twitter, @partbnews.

CEUs
Part B News is approved, through Dec. 31, 2015, for AAPC CEUs. Credential holders can earn 0.5 CEUs by passing each five-question quiz, for up to 12 CEUs per year. For instructions on how to access the quizzes, log on to *www.partbnews.com/home/ceus_read_more*.

ADVERTISING
To inquire about advertising in *Part B News*, call 1-301-287-2230.

COPYRIGHT WARNING
Copyright violations will be prosecuted. *Part B News* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Steve McVearry at 1-301-287-2266 or email *smcvearry@ucg.com*.

REPRINTS
To request permission to make photocopy reprints of *Part B News* articles, call 1-855-CALL-DH1 or email customer service at *customer@decisionhealth.com*. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Part B News® is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of UCG. *Part B News* is published 48 times/year by DecisionHealth, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $597/year.

Copyright © 2015 UCG DecisionHealth, all rights reserved. Electronic or print redistribution without prior written permission of DecisionHealth is strictly prohibited by federal copyright law.

For a comprehensive medical note, consider more than clinical factors — look to prevailing details as well, such as changes in the patient's environment. For example, consider a patient with severe osteoarthritis. While the patient can safely travel to the office in the summer, winter months may be a different story. Adds Gilhooly: "When you visit a patient in their home in February, what you need to say is: 'Due to severe osteoarthritis, coming to the office with the winter conditions is contraindicated,' or something like that."

- **Carve out a prominent area to explain why the patient was seen at home.** Add a "separate section explaining why the patient is seen in the home in lieu of an office visit on that particular date of service" to the medical note, advises Miserez. Be sure to include pertinent details such as the aforementioned environmental factors, as well as your rationale for establishing medical necessity in this section of the record.

- **Be careful about chronic conditions that change over time.** If you visit a patient in their home every month for treatment of the same condition — and the monthly notes are repetitive — it could be a problem. "What I tell doctors is, you don't want to have the same thing [in the documentation] every time," notes Gilhooly. Consider a patient with congestive heart failure (CHF). If the patient has recently gotten over an episode of CHF and fatigues easily, it may be medically necessary to see them in the home. But once they're back to baseline, "a chronic condition of CHF doesn't necessarily contraindicate them from coming into the office," explains Gilhooly.

- **Use the Part A definition of "homebound" as a rule of thumb, but don't settle there.** "If you meet the Part A definition, you should easily meet the Part B definition," explains Miserez. *(See sidebar, p. 3.)* But don't blindly adhere to the Part A definition, despite the lack of an alternative — after all, while the Part A definition can be a guide, auditing bodies such as zone program integrity contractors (ZPICs) are not bound to use the Part A definition when assessing your Part B claims. Still, meeting Part A requirements "theoretically" clears you of Part B squabbles, according to Miserez. Just don't let the strict Part A requirements stop you from billing home services when you've met medical necessity for your Part B patients. (See Section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual for updated "confined to the home" requirements.)

- **Make sure your notes derived from electronic health records (EHRs) are clear and precise.** If you're EHR-equipped, take a moment to cut out clutter that your electronic system may push into the medical record, advises Miserez. "EHRs can flood the record with far too much information," creating inconsistencies in the medical record. Your EHR, for instance, may swamp the record with information pertaining to a visit or service "that may or may not have been performed on that particular date of service," he says. This can lead to an increased potential of an audit if CMS can't make any sense of what was done on that specific date of service, so watch out for information overload. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- Medicare Claims Processing Manual, Chapter 12: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*

Patient encounters

Homebound criteria

Though regulations for what constitutes a patient who needs a physician home visit can be vague, providers can look to rules for home health homebound status for guidance (*see story, p. 2*).

CMS offers specific criteria to define a "patient confined to the home" in Chapter 7 of the Medicare Benefit Policy Manual. For criteria one, the patient must either:

- "Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or
- "Have a condition such that leaving his or her home is medically contraindicated."

If a patient meets one of the two criteria in set one, they must also meet two additional requirements, says CMS. The requirements state:

- "There must exist a normal inability to leave home" and
- "Leaving home must require a considerable and taxing effort."

Resource:

- Medicare Benefit Policy Manual, Chapter 7, 30.1.1: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf*

Practice management

7 small steps — including wellness visits, registries — with big P4P rewards

Use easy lay-ups such as annual wellness visits (AWVs) and clinical documentation improvement as a springboard to meet for pay-for-performance models that HHS says are coming soon.

HHS plans by the end of 2016 to tie 85% of traditional Medicare payments to quality or value, according to a Jan. 29 HHS announcement (*PBN 2/2/15*).

The biggest practices are already on board via private Medicare Advantage plans with a pay-for-performance component, points out Tom Giannulli, M.D., chief medical information officer for Kareo, a cloud-based software services provider located in Irvine, Calif. Now HHS is pressuring the smaller ones to follow.

"Given this value-based landscape, providers should ask, 'what does my organization need to look like one, three and five years from now?'" says Carrie Nixon, CEO of Healthcare Solutions Connection and managing member of the Nixon Law Group in Vienna, Va. "If you're not thinking hard about a plan, you run a danger of being left out in the cold and having your financial viability take a hit."

P4P steps for beginners

If CMS doesn't have a pay-for-performance program with your name on it, take some of the smaller steps that lead to competence for performance pay, advises Stacey Counts, process leader, population health and quality improvement at Mosaic Life Care in St. Joseph, Mo., one of the more successful accountable care organizations (ACOs) in CMS' Shared Savings program. Get acquainted with these concepts:

- **Start the process to become a patient-centered medical home (PCMH).** PCMH certification is a must for ACOs and a good-to-have for primary care providers who want to collaborate with outside health organizations. "We do have several private payers with shared-risk contracts now, and they are requiring Level 3 NCQA certification," she says. But you don't have to go through the recognition program right away. Adopting NCQA's standards and guidelines, such as its specific requirements for the activities of the patient care team, and taking its free training is a good start.

- **Have a clinical documentation improvement expert.** Many pay-for-performance plans require exceptionally thorough patient health statistics to populate their risk tables (*PBN 2/10/14*). Therefore, "always, always enhance by making sure doctors aren't missing out on the details of the underlying condition," Nixon says. She recommends carefully training your providers to ICD-10-level documentation — which you should be doing to prepare for the Oct. 1 code changeover — and having at least one coder who's trained and certified in clinical documentation improvement.

- **Join a clinical integration program**. These programs, which promote cooperation between practices and hospitals without merging them, "really have some legs with commercial contractors who are very much turning their attention to value-based contract arrangements," says Nixon. "We're seeing an enormous increase in this — and not just with large groups, either." She cites the insurer Cigna, which initially had a Collaborative Accountable Care program that focused on large practices but which last year turned into Cigna Collaborative Care, which now also targets smaller practices and specialists. Ask your private payers about these.

- **Send non-physician practitioners (NPPs) on home visits.** As each patient's overall care becomes more important to payment, you may see licensed practical nurses (LPNs), physician assistants (PAs) or registered nurses (RNs) doing home visits, says Nixon. "I'm seeing models now where they go to homes of high-risk or chronic cases and are really looking at the risk situation and making recommendations. There's a company called Advance Health, for example, that sends nurses to at-risk patients — their clients are mostly Medicare Advantage plans now, but I can see a model where we'd be into the provider realm, with ACOs certainly." (*For tips on billing home visits properly, see story, p. 2.*)

- **Use wellness visits to compile patient data.** Nixon says at last year's NAACOs (National Association of ACOs) conference, attendees were buzzing about annual wellness visits as patient assessment tools. "They say now their physicians are using the [AWV] protocol to ask questions they wouldn't necessarily ask, and those answers often reveal things that actually play a significant role in their overall health care profile," she says.

Benchmark of the week

Look to patient status, medical necessity to avoid denials of home service codes

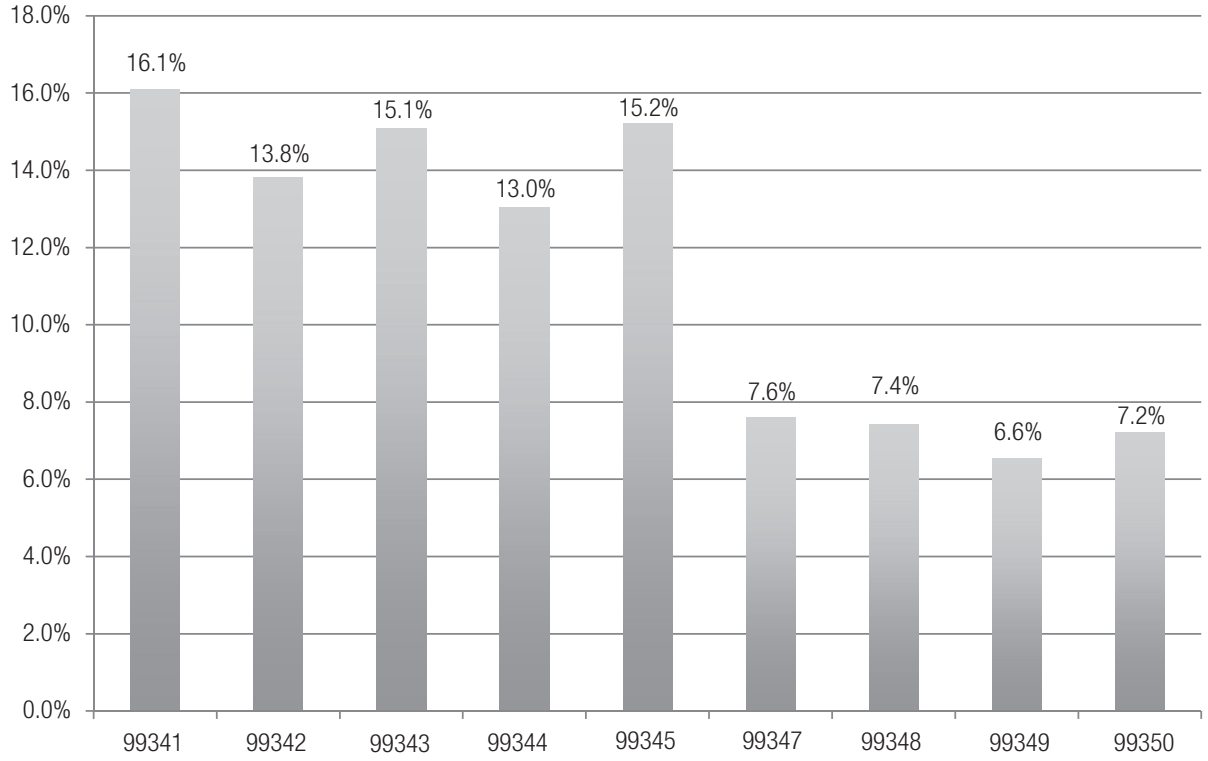
Home service codes **99341-99350** see an average denial rate of approximately 11%, with denied dollar amounts north of $40 million annually, according to an analysis of 2013 Medicare data, the latest available.

The home service codes that pertain to new patients — 99341-99345 — lead the way in denial rates, with an average denial rate of about 14.5%. While Medicare's potentially ambiguous definition of what constitutes a homebound patient may be contributing to home service denial rates, so too may be the simple fact that your patient isn't new, says Joan Gilhooly, MBA, CPC, CPCO, president, Medical Business Resources in Cincinnati, Ohio. (*For more on homebound status, see story, p. 2.*)

"A mistake that practices many make is thinking: 'This is the first time I'm seeing the patient in the home, therefore the patient is new,'" explains Gilhooly. That's not always the case. Instead, make sure you or your colleagues haven't seen the patient for a specific length of time. You should ask yourself the following question: Have I, or has anyone else in my specialty working in the same practice, seen the patient at any point in time in the last three years? If the answer is "no," you're in the clear to bill the service as a new patient code.

Billing for established patients results in a lower denial rate but much higher total denied costs — about $31 million in 2013. Whether billing new or established codes, pay close attention to medical necessity and document it accurately.

Denial rates for physician-based home service codes 99341-99350



Source: Part B News *analysis of 2013 Medicare data*

For example, it might reveal signs of dementia unrecognized by the patient as such, the progress of which can be slowed by early intervention.

- **Use registries and electronic health records (EHRs) to sort patient statistics** in a way that will be useful when you enter into agreements with insurers who do pay-for-performance or if Medicare starts requiring it. "You're going to need a good registry and a high-functioning EHR that will support population health workflows," says Counts — that is, that can help you identify appropriate patients, engage them, manage their care and measure it for success. "Hard-wiring evidence-based care protocols within your practice that (as appropriate) match the value-based measurement

systems the payers have put in place will position your practice well for success under the future reimbursement models," she says.

- **Reach out to outside partners.** Even if you aren't ready to enter formal agreements with them, "start developing partnerships with your post-acute and acute care providers and getting back those discharge summaries, medication lists, etc.," says Counts.

This is a good way to make sure your "hibernated" patients — that is, the ones you haven't seen for a while — "are as connected as your active, seriously ill patients." You can add your partners' data on the patients to your records and take action if their outside treatment suggests an impact on the health profile, she adds.

New models on the horizon

HHS' revved-up timeline doesn't necessarily mean you'll be pushed into an ACO.

The fall-off in the Pioneer ACO program is a sign that the program might be losing momentum, says Chester A. Speed, vice president for public policy at American Medical Group Association (AMGA). "If ACOs are the main example [of alternative payment], there are some operational challenges that need to be made before that works," he says (*PBN 9/29/14*).

Alternative models besides ACOs will be the means by which HHS herds practices toward their goals, Nixon expects.

Some of these have already emerged from CMS' Innovation Center. For example, Comprehensive ESRD Care Initiative creates ESRD Seamless Care Organizations (ESCOs), says Nixon. "You can think of this as an ACO specifically for Medicare beneficiaries with ESRD, where the ESCO is comprised of nephrologists, dialysis centers and the like," she says. Nixon expects CMS to come out with more such multidisciplinary initiatives that pay clusters of providers related by treatment of complex-care patients based on those patients' progress.

"I have to believe they're working to develop similar programs that focus on the chronic diseases that encompass so much of the spend," Nixon says. — *Roy Edroso (redroso@decisionhealth.com)*

Modifier 59

(continued from p. 1)

a gradual and controlled fashion," according to MLN Matters article SE1503.

The agency promises "additional descriptive information about the new modifiers," including "situations in which a specific X (EPSU) modifier will be required."

The modifiers — **XE** (Separate encounter), **XP** (Separate practitioner), **XS** (Separate structure) and **XU** (Unusual non-overlapping service) — have stirred a great deal of interest among payers too, with Medicare

Please pass this coupon to a colleague who could benefit from a subscription to *Part B News*.

☐ **YES!** I want news and guidance to accurately bill and code for physician services so my practice gets the full, correct reimbursement that it's due. Please enter my one year subscription at $597.

Name: _____

Org: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

Email: _____

www.partbnews.com

Payment enclosed. Make checks payable to *Part B News;* (TIN: 26-3622553)

☐ Send me an invoice (PO _____)

☐ Charge my: ☐ MasterCard ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

Card #: _____

Exp. Date: _____

Signature: _____

Mail to: **Part B News**
Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 200,
Gaithersburg, MD 20878-7364 | 1-855-CALL-DH1

PAS 2015

administrative contractors (MACs) as well as commercial payers releasing their own guidance and payment policies for the modifiers.

The first thing to do is confirm that a given MAC or private plan recognizes the modifiers, recommends Margie Scalley Vaught, CPC, coding consultant based in Chehalis, Wash.

"Before you jump into using these X modifiers, make sure a given payer or carrier has put instructions on their website telling you to use them," she advised during a recent DecisionHealth webinar on the topic. Otherwise, "claims may come back denied because they're not recognized in the system."

MAC medical directors have said that providers will be contacted about required use of X modifiers in place of 59 (*PBN 12/8/14*).

One coder's experience billing X modifiers

As one who has begun to use the modifiers, coder Ruby Woodward, CPC, says she first confirmed with her payers that they were accepting them, and most are.

"I have yet to hear if we have seen any denials from any of the health plans," says Woodward, who is quality and data specialist at Twin Cities Orthopedics in Golden Valley, Minn.

Woodward says she has used XE a few times, for example "when we have a non-surgical patient seen in the clinic earlier in the day who then returned to our urgent care in the evening." However, for many of her foot procedures, she still finds modifier 59 is most appropriate, Woodward says.

But she also has run up against uncertainties over how the X modifiers are to be used. "I have primarily used the XS and XU modifiers," she says, but she remains concerned about the lack of definition for the modifiers. For example, what constitutes a "separate structure" (XS modifier)? Is "the entire foot a structure or is each joint a structure or each bone?"

Such decisions were "carrier driven," according to a response Woodward received from the National Correct Coding Initiative (CCI) contractor, Correct Coding Solutions LLC in Bloomington, Ind.

Prior inconsistency in MAC policies

Many Medicare contractors appear to have pulled their independent X modifier guidance after CMS issued SE1503, in apparent anticipation of authoritative guidance from Medicare central.

Prior to that, however, guidance from the MACs has been inconsistent at best. While some of the contractors, such as Noridian, issued Q&As on how the X modifiers are to be used, others, such as WPS, released virtually identical "fact sheets" about each one that give little guidance beyond the original modifier descriptions.

Private payers, meanwhile, have in some cases issued detailed policies for the modifiers. United Healthcare Community Plan added the X modifiers to its radiology multiple imaging reduction policy. The policy instructs providers to append XE or 59 when imaging services must be done on the same patient at two separate points during the same day.

In a separate policy, UHC tells practitioners to report either XS or 59 for "rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally." One example of that might be when a major joint injection is done on the hip and the knee on the same side in the same encounter. Even though both hip and knee injections have the potential to be billed bilaterally, that would not be appropriate in such a case.

More X modifier coding guidance

- **Use X modifiers interchangeably with modifier 59.** That means coding rules that pertain to 59 also apply to the X modifiers. You should not append them to E/M codes, for example. In addition, you would not append both modifier 59 and an X modifier. Use one or the other.
- **Append X modifiers to the component code to unbundle a CCI code pair.** Don't append the modifiers to both codes in the pair and don't append the X modifiers, or modifier 59, when CCI has no claims edits bundling the code.

Resources:

- CMS MLN Matters article SE 1503: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1503.pdf*
- UHC Community Plan radiology policy: *http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/Radiology-Multiple-Imaging-Policy-(R0085)-1-5-11.pdf*
- UHC timeline for introduction of X modifiers by specialty: *http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/X_Modifier_Policy_UHCCS102.pdf*

Editor's note: *Get more guidance on proper modifier use with the webinar on CD,* ***CMS' X Factor: Get ready for 4 big changes in 2015****. Learn more at https://store.decisionhealth.com/Product.aspx?ProductCode=MPW-A2564CD-15.*

Infection

(continued from p. 1)

fears of contagion, as was experienced during the U.S. Ebola outbreaks last year and may be seen in some patient populations in what is reported to be a tough flu season, especially with flu-shot effectiveness dropping to 23%, per the CDC (*PBN 10/20/14*).

Assuming that you would prefer to see rather than bar patients, experts suggest these precautions to protect your staff and patients and to offer appropriate treatment to all patients to the extent possible:

- **Separate waiting areas.** Many pediatricians have separate "sick-child" and "well-child" waiting rooms in different locations of the office, notes David Fleming M.D., president of the American College of Physicians and a practicing internist. If you have a concern, reserve an exam room for patients suspected of having a certain infectious illness, such as childhood diseases or even the flu. "Though admittedly this may be logistically difficult in some clinics, having protective isolation areas for unimmunized patients is a consideration," Fleming says.
- **Do full phone triage.** The information shortfalls that were so disastrous during the Ebola case in Dallas show how important it is to get relevant information up front, says Michelle Katz, LPN, author of *Healthcare Made Easy* and other books. "One of the things they teach you in nursing school that many forget is, always ask the patient with an illness if they have traveled outside the USA recently or have been exposed to anyone who has," she says. "This usually helps with some of those 'mysterious illnesses'" with which some patients present.

"A patient doesn't just show up in a doctor's office like an emergency room; they usually call first," says Amesh A. Adalja, M.D., senior associate at the Center for Health Security of the University of Pittsburgh Medical Center and School of Medicine. "So there's an opportunity for a screening. … Elicit some symptoms. If it sounds infectious — fever, rash, travel history or exposure — you can decide whether or not they're suitable to see the doctor in the office. If they tell you, for instance, that 10 days ago they were in Sierra Leone, you might want to call your local health authority and be directed to a facility capable of isolating them as needed." If the risk is less intense but still a concern, inform the patient that he or she may be asked to wear a surgical mask at the practice.

- **Have an infectious-patient protocol.** Once you've established that a potential major infection risk will enter the office, you should make staff aware "so they can segregate that patient from others in the waiting room and don the appropriate personal protective equipment," such as protective gowning and masks, which you should already have on hand, says Adalja.

If you decide not to treat certain patients

Arguably, providers who refuse these patients are within their rights — just as they would be if they perceived less microbial threats to patients and staff from certain patients, such as violent behavior, and "fired" them for that reason, says William Maruca, a partner at Fox Rothschild in Pittsburgh (*PBN 5/27/13*). "Physicians can decide who they want as their patients as long as they do not discriminate on any prohibited basis or against any protected class such as age, gender, race, religion, disability," says Maruca. "I don't think the decision not to vaccinate puts anyone into a protected class."

However, check your state licensure requirements to make sure your providers have that leeway, suggests Robert Markette, health care attorney with Hall Render Killian Heath & Lyman in Indianapolis. Also, be prepared for a civil action of the grounds of patient abandonment.

Fleming sees both sides: "As members of a free society, we are all required by law to adhere to certain behaviors that prevent us from harming others, such as following speed limits, wearing seat belts and not discharging firearms in public." Nonetheless, he's concerned that "when we tell immunized patients they are not allowed in when they seek health care, … we may be discriminating against patients who might otherwise be willing to be immunized or whom we could convince. Also, if we bar unimmunized individuals from clinic, are we forcing them to go elsewhere, thus putting other patients and other practices at risk?" — *Roy Edroso (redroso@decisionhealth.com)*

How did you get this email?

It is illegal to forward **Part B News Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Part B News Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk,** not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Steve McVearry at 1-301-287-2266 or email him at *smcvearry@ucg.com*. Copyright violations will be prosecuted. And **Part B News** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Part B News Online** or photocopying of our newsletter.