WCH TIMES

Fall 2007 Volume 04

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National Association of Healthcare Consultants

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EMPIRE WHO'S WHO

Dear Doctors and Office Managers,

Welcome to fourth edition of WCH TIMES a newsletter that provides valuable information about insurance policies, events, and covers hot issues taken place in the healthcare community.

Inside this month

WCH Corner

WCH expanding our services in other states.....2

WCH modified client site office program.....2

Join our WCH Community.....2

WCH Credentialing Services.....2

Understanding Denials on the EOB.....2

Coding News:

2008 Procedure Code changes.....3

Strengthen Debridement Claims.....3

Keep your eyes on time units.....3

Insurance News:

New reimbursement codes for Clinical Psychologists.....4-5

Medicaid and Managed Health Recipients Cannot be Billed for Your Services.....5

NPI must be registered with insurances.....5

Medicaid is Changing Provider Enrollment Applications.....5

Medicare Preventive Services.....6

Charge for Missed Appointments.....6

United Healthcare New Policy Guidelines.....6-7

Aetna Coding Policy Changes.....7

1199 NBF New Imaging Policy.....8

WCH Feedback Form for your comments..... 9

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We invite you to join our WCH Community

Visit our website www.wchsb.com to learn more.

WCH Corner

WCH registering with Notary Public:

At the present time WCH is working towards obtaining Notary Public certification for Aleksandr Romanychev, CEO and Olga Khabinskay, Manager. This cortication will allow us to further educate ourselves about government regulations that deal with confidential documents.

WCH pursuing other Medicare markets:

Last month we had successfully completed testing EDI transmission with NHIC, Corp. (Medicare of California) and First Cost Service Options, Inc (Medicare of Florida). These Medicare contractors assigned WCH with new submitter id numbers to transmit claims electronically and ability to receive feedback in ERA format. Furthermore, we are now in process of registering our billing software on their vendor list.

WCH modified client site office program:

In mid September with collaboration of WCH programmer Yefim Kazakevich, we were able to modify some of the features our clients use in their office program. We had updated the patient track of authorization option in the patient profile and created a report that provide information of patients that did not visit the office in the last six months. We are now working towards updating co-pay payment tracking. We want to hear from you, if you have any suggestions that will make your routine office work easier by adding/updating any of the features on the program, please let us know.

Join our WCH Community:

We had informed you about development of WCH Community http://www.wchsb.com/home/default.asp on our website several months ago. This particular site was developed for the healthcare providers to exchange information, read about important updates and find anything else that will suit your interest. What are you waiting for, it will take you less then five minutes to register and become a happy user. If you need any assistance with signing up, please do not hesitate to contact us.

WCH Credentialing Services:

As most of you aware our credentialing service has been highly recommended through out the healthcare community. Our clients come for Florida, Texas, Delaware, Maryland, New Jersey, Connecticut, and Pennsylvania this just to name few. Not all providers require full credentialing service that can take 3-4 months to complete. Some of you maybe credentialed with insurances, but you are moving, adding location, updating your tax id, or opening a group practice, please know that we can assist you with this process. We provide different pricing packages, depending on your request. WCH experience in credentialing is extensive, we had enrolled: Pharmacy, DME, IDTF, groups and other healthcare provides. If you need help with credentialing please contact Olga Khabinskay directly at olgak@wchsb.com.

Understanding Denials on the EOB:

Frequently we receive calls from clients asking us to explain the reason why the claim was denied. We would like to point out that information about your claim denials appears on the bottom of each statement, you receive from insurance. Each denial reason is coded in alpha numeric/numeric format, definition of the code can be found below of denied claim or at the end of the statement. With certainty, billing company is not required to read clients the reason for the denial; it becomes your job to familiarize yourself with the format of these statements. If you need any assistance with understanding the EOB denial format, please ask us, we will explain.

Wondering about your practice claims history?

Let's imagine, its Saturday morning, you are sitting on the coach with your cup of coffee and stack of bills. But you are not sure what type of payments you will be expecting from insurances in the next several weeks. At the convenience of your home, you can check your claim progress, review payments history and project your future payments in WCH program. WCH is closed on Saturday, but by having our program at your disposal, you don't need WCH to answer these questions. If you are curious about your practice progress, call us and we will set you up with WCH office program. The set up process takes up to 2 hours; we will install all necessary software's and provide you with detail training for the use of the program. WCH charges monthly fee of $50.00 that includes weekly updates of claim history and comfortable apportionment scheduling feature.

WCH educational seminars:

The healthcare industry is changing rapidly, procedures change, coding process always re-designed, if you have any questions that require detailed presentation. We can prepare a small seminar at our company headquarters to address different topics and answer your questions. Do you have questions about authorization approvals, eligibility, referrals or understanding of the EOB, we can help. WCH staff is certified by American Academy of Professional Coders, American Medical Billing Associations, AHIMA and many other private sector organization that strive for excellence in the billing arena. If you are interested, please let us know, we are here to help. A separate fee will be accessed for this presentation.

Coding News

ICD-10-CDM almost around the corner:

On February 15, 2007 Senate introduce new bill S.628, if passed, it would provide provisions to implement ICD –10-CM and ICD-10-PCS as replacements to the three volumes of the international Statistical Classification of Disease ICD-9-CM. The bills states, "Adoption of ICD-10-CM and ICD-10-PCS will occur no later than October 1, 2008 and compliance of such rule shall apply to transactions occurring on or after October 1, 2011.

2008 Procedure Code changes:

The New Year will bring great changes in the coding industry: 242 new procedure codes will be provided, 298 codes will be revised and 364 will be deleted. WCH will update all superbills you are currently using to reflect new changes. We are in process of updating ICD-9-CM codes which are effective as of October 1, 2007. New CPT codes are scheduled to go in effect as of January 1, 2008.

Strengthen Debridement Claims:

Many healthcare providers perform debridement services, but a recent OIG audit indicated that 64% of surgical debridement services performed in 2004 did not meet Medicare's policy requirements. This resulted in overpayment of about $64 million to these providers. The OIG found that 39% of these claims were miscoded, 29% were not documented and 1% were services not deemed medically necessary. Please let us know if you need to review the policy and guidelines for debridement services.

Keep your eyes on time units:

Physical therapy practices are accustomed to many of the PT codes stating, each 15 minutes. So if the therapist performs therapeutic exercise with the patient 45 minutes, the practice should bill three units of 97110. But not all PT codes are time based. In the recent OIG audit the following problem was investigated, code 97010 (hot/cold packs) is not a time code, but an office billed 97010 for every 15 minutes that the patient sat with an ice pack in his leg. Usually code descriptors will indicate whether a code should be reported with one unit per amount of time spent (such as 97110 – 99144) or one unit per specified dose such as J0895 for deferoxamine mesylate, which is billed at one unit of service for every 500 mg administered. When you are reporting your service to WCH please make sure you are keeping your eyes on the units.

Source of information obtained from AAPC coding edge July /September 2007

Coding Physical Therapy can be tricky:

If you are unaware about procedure codes and supervised requirements for physical therapy, you can make your life a lot harder. Some therapy procedures require "supervised" attendance, meaning that the therapist does not have to have constant one-on-one patient contact. This range of code includes 97010 – 97028; the therapist is not re-

quired to provide full attention to the patient. Alternatively, other codes such as 97032- 97039 require constant attendance by the therapist. Also because some therapy services include procedures based on particular time frame, you should know CMS eight minute rule. Under this rule physical therapist should not bill for services performed for less than eight minutes. The therapist should always document in the chart the time they spent with the patient. The eight minute rule is not a national standard, it's simply a schedule intended to provide assistance in rounding time into 15 minute. It does not imply that any minute until eight should be excluded from the total count. Information presented below will be very handy when coding your next visit.

CMS 8 Minute Rule

1 Unit	> 8 min	to < 20 min
2 units	> 23 mins	to < 37 mins
3 units	>38 min	to < 52 mins
4 units	>53 mins	to < 67 mins
5 units	>68 mins	to < 82 mins
6 units	>83 mins	to < 97 mins
7 units	> 98 mins	to <112 mins
8 units	> 113 mins	to < 127 mins

Source of information obtained from CMS, APTA; 2007 coding" Payment Guide for PT; 2007 CDR; CHS

Insurance News

UPIN Replacement:

CMS had discontinued assigning UPIN's on June 29, 2007. Current UPIN registry website will function until May 23, 2008. After this date NPI will replace UPIN id for all providers nationwide.

Medicaid

Compliance News:

For the next five years, Congress is providing $ 100 million per year to CMS and the OIG to reduce the Medicaid error rate and fight fraud. They expect a return of $1 billion in checks from hospitals, health systems, and other providers and suppliers. At the present time, provider's claims are under close Medicaid audit study. When your office received request for medical records, please address the issue promptly and correctly.

Source of information obtained from AIS Health: NMCN 02/087

New reimbursement codes for Clinical Psychologists:

As of September 01, 2007 three new procedure codes is reimbursable to clinical psychologist. The fee for each of these procedures shown below is $150.00.

96111 -Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

96116 - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

96118 - Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

In order to bill for these procedures, you must provide proof of board certification from ABPP /ABCN or eligibility to participate in the board examination in Clinical Neuropsychology to Medicaid Provider Enrollment Department. For more information please contact CSC provider department.

Source of information obtained from New York State Medicaid Monthly Update.

Electronic Funds Transfer (EFT):

Medicaid provides option for your payments directly to be deposited into the checking or savings account that you designate. You don't have to wait for your check to arrive in the mail. For more information how to set up EFT, please contact WCH.

Provider Manuals:

Once you became participating provider with Medicaid, it becomes your responsibility to familiarize yourself with provider manuals offered by Medicaid. All provides manuals created for a particular category of service. For example, Dentists have specifically designed manual for their category of service, the same applies to psychologist and other providers. However, under the category of Physician, this provider's manual contains full information for medical doctors only. This includes specialties for Internal medicine, family practice, psychiatrist and much more. Provider manuals are available online at: http://www.emedny.org/providermanuals/index.html.

Source of information obtained from New York State Medicaid Newsletter Volume 23, Number 8

Medicaid and Managed Health Recipients Cannot be Billed for Your Services:

This is a big topic that is quite often being misinterpreted by providers. Once a provider joins Medicaid program, provider accepts all rules and regulations specified by Medicaid in the provider manual. This rule similarly applies to all managed care plan and in Family Health Plus (ex: Fidelis, NY Presbyterian, Health First) covering the patient services. The provider is **prohibited** to charge the patient for services if the claim submitted by the provider was denied for reasons other than that the patient was not Medicaid eligible on the date of service. A Medicaid enrollee, including Medicaid managed care patient, cannot be referred to collection agency for unpaid bills.

There is a way to address this issue without loosing money for the services provided by you. A provider may charge Medicaid recipients and managed care plan patients, "only when both parties have agreed prior to the rendering of the service that the enrollee is being seen as a private pay patient". This consent between patient and provider must be voluntary and mutual. The patient must sign consent to be treated as private pay patient, the same information must be reflected in the chart. For more information about this policy, please contact Division of Managed Care and Program Evaluation at 518-473-0122.

Source of information obtained from New York State Medicaid newsletter Volume 23, Number 7

National Provider Identifier (NPI) must be Registered:

All Medicaid providers must register their NPI with Medicaid Program. Individual providers must register their NPI with their individual Medicaid provider number and organizations must follow the same guidelines.

Medicaid is Changing Provider Enrollment Applications:

As of October 14, 2007, CSC is releasing new provider enrollment applications. If you are using WCH credentialing services then leave your enrollment concerns to us. However if you are performing the process on your own, please make sure you are following all requirements stated in the new application. Old forms received on or after October 15, 2007 will be returned to you.

Source of information obtained from New York State Medicaid Update September 2007

Medicare News

Chiropractic Services:

Such services as X-rays or other diagnostic or therapeutic services provided or directly ordered by chiropractors will be denied as not covered and would be patient responsibility. As we had mentioned in previous newsletters, your patients must sign ABN that will make them responsible for the denied charges. Chiropractors may refer patients for consultations to appropriate providers.

Source of information obtained from Empire Medicare New York News

Medicare Preventive Services:

The chart below serves as a reference for some of the Medicare covered preventive services.

Type of Service	Who is Covered	Frequency
Initial Preventive Physical Examination (Welcome to Medicare Physical Exam)	All Medicare beneficiaries whose first Part B coverage began on or after 01/01/2005	Once in a lifetime (must be provided no later then 6 months after the effective date of coverage)
Diabetic Screening Test	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes	- 2 screening tests per year for diagnosed pre-diabetes - 1 screening per year if before tested but not diagnosed or never tested
Bone Mass Measurements	Medicare beneficiaries at risk for developing Osteoporosis	Every 24 month
Influenza (flu shot)	All Medicare beneficiaries	Once per flu season in the fall or winter
Screening Mammography	- Females Medicare Beneficiaries age 40 or older - Females Medicare Beneficiaries ages 35-39	- Annually - One baseline

Source of information obtained from CMS Medicare Learning Network: ICN # 006559

Charge for Missed Appointments:

CMS policy allows providers to charge Medicare beneficiaries for missed appointments. But Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare. Your office must create policy that will inform patients, that if they miss appointment without prior cancellation, they will be billed a set fee. The same fee should be billed to non-Medicare patients.

Source of information obtained from Empire Medicare Matters News: MM5613

United Healthcare News

All three plans provide significant information to providers through online services. WCH recommends using all features available to save administrative time for your practice. On https://www.unitedhealthcareonline.com/, https://www.oxhp.com/

and http://www.americhoice.com providers can verify eligibility and benefit information. Online you can also obtain authorization and review claim history of seen patients.

United Healthcare advise all providers to charge patients for co-payments, deductible and coinsurance, because United Healthcare will not pick up this balance. As a participating provider you are also allowed to collect payment from members for benefits not covered by patient's plan. In addition, you are allowed to charge patients for missed appointments or completion of camp/school forms, which is not covered by United Healthcare.

New Accreditation policy for imaging services:

Effective March 1, 2008, providers performing outpatient imaging studies must obtain accreditation for the following procedures: CT, CTA, MRI, MRA, Nuclear Medicine/ Cardiology, PET and Echocardiography. Failure to comply with this protocol will result in non-payment for these services. The accreditation process can take from 6-9 months, we urge you to begin the process right away. Application must be submitted with one of the following accreditation agencies:

American College of Radiology (ACR) – www.acr.org

Intersocietal Commission Accreditation of CT – www.icactl.org

Intersocietal Accreditation Commission – www.intersocietal.org

Intersocietal Commission Accreditation of Magnetic Resonance Labs (ICAMRL) – www.icamrl.com

Intersocietal Commission Accreditation of Echocardiology Labs – www.icael.com

Intersocietal Commission Accreditation of Nuclear Medicine Labs – www.incanl.org

This accreditation protocol has been established to ensure that all outpatient facilities meet nationally recognized safety and quality standards. Some of the insurances already began implementing this policy in their network. For example, HIP begun last year by restricting none accredited office to provide Echocardiogram to their members. Please comply with United Healthcare request by March 1, 2008.

Source of information obtained from Physician, Health Professional guide 2007/2008

Aetna News

Coding Policy Changes:

Aetna has announced that effective November 12, 2007 coding and payment policy will be changed to reflect new guidelines. Below are some important procedure and policy that will change:

Procedure	**New Changes on November 12, 2007**
Office consultation by PCP	If members PCP bill a consultation for other than a surgical consult, the consultation evaluation and management code will be allowed at the rate of the appropriate established E&M code.
Vaccine Administration	Vaccine administration codes submitted without an immune vaccine code will be denied, except the case of state-supplied vaccines.
Evaluation of speech, language, voice, communication and/or auditory processing	Will be allowed once within any 180 day period
Administration codes billed with ineligible drug codes	Charges for administration of drugs will not be reimbursed when the drug itself is considered to be experimental or not effective.

Source of information obtained from August 2007 Aetna Office Link Update

1199 SEIU

New policy for diagnostic testing:

Effective October 1, 2007, certain outpatient diagnostic testing requires authorization approval from the fund. The following procedure must be approved prior to providing services on or after October 1, 2007.

- EMG/NCV
- MRI
- Neuropsychological Testing
- PET
- CAT scans

To obtain authorization for these services, please contact 1199 authorization department.

Source of information obtained from 1199SEIU Fall 2007 provider news update

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Please use next page for any suggestions, your feedback or specific topics you would like us to discuss in the next issue in Winter 2008.

You can send your requests by email to

OLGAK@WCHSB.COM

We hope you had enjoyed WCH Fall 2007 Newsletter!

WCH Feedback Form

Please use this form for your suggestions and comments.

Your Name

Email Address