May 2010 Volume 1, Issue 3

WCH Bulletin

Welcome back our readers!

WCH Billing Manager Certified CPC

We are committed in providing our clients with professional and reliable services. WCH staff is working hard to accomplish these results. We are proud to announce that our Billing department manager, Olga Mirolyubova has passed Certified Professional Coder exam administered by American Academy of Professional Coders.

Olga Mirolyubova, CPC

A CPC's abilities include:

- Proficiency in adjudicating claims for accurate medical coding for diagnoses, procedures and services in physician-based settings
- Proficiency across a wide range of services, which include evaluation and management, anesthesia, surgical services, radiology, pathology and medicine
- Sound knowledge of medical coding rules and regulations including compliance and reimbursement. A trained medical coding professional can better handle issues such as medical necessity, claims denials, bundling issues and charge capture
- Knowing how to integrate medical coding and reimbursement rule changes into a practice's reimbursement processes
- Knowledge of anatomy, physiology and medical terminology necessary to correctly code provider diagnosis and services

WCH Service Bureau, Inc Is the proud member of the following professional organizations

ACCREDITED BUSINESS

American Academy of Professional Coders

Member of AHIMA
http://www.ahima.org/

National Association of Healthcare Consultants

Member of AMBA American Medical Billing Association

EMPIRE WHO'S WHO

Member of NAMSS
http://www.namss.org/

Inside this issue:

Care Core— Cardiac Care : Authorizations

Care Core requires that the following outpatient procedures obtain authorization: Nuclear Stress Tests, Echo Stress Tests, Echocardiograms, and Coronary CT Angiograms. Authorization can be obtained online, by fax, or by phone: (866) 803-8909. Once an authorization is issued you will be notified. You can also check on-line in the Authorization Lookup to obtain an authorization number for approved procedures. If your exams are not approved you have the choice of submitting an appeal. Both you and your patient will be notified with the reason for the denial and instructions of the appeal process.

Insurances under Care Core include: Aetna, Affinity, AvMed Health Plans, Empire Blue Cross Blue Shield, GHI, Healthfirst, Healthnet, Health Plus, HIP, Horizon BCBS, Neighborhood Health Plan, Oxford, QualChoice, Wellcare

Source of information obtained from: http://www.carecorenational.com/frequently-asked-questions.asp

ValueOptions Continues to be Green

ValueOptions is no longer mailing paper authorization letters; notices of new authorizations and authorization letters are available on the ValueOptions online provider portal, ProviderConnect. To determine if you have received new authorization letters you must me registered with ProviderConnect. An icon will appear on the ProviderConnect home page letting you know that you have a new authorization letter, You may print the letters or save them to your computer. Even though approval letters are electronic, adverse determination letters and return of incomplete requests will continue to be sent via US mail. Providers cannot opt out of this program, authorization letters will be available online or via fax-back. However, EAP authorization letters will continue to be sent via US mail.

WCH and ValueOptions urge you to register for ProviderConnect if you haven't yet done so. To register go to: http://www.valueoptions.com/providers/Providers.htm

Enrolling in PECOS is Essential for Reimbursement

Enrolling into Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) you save yourself from losing reimbursement opportunities. "Enrolling your physicians and non-physician practitioners in PECOS is essential if you want to get paid by Medicare for covered services, say Cyndee Weston." Not getting paid by Medicare is a good enough reason to enroll, but there are other reasons why it is essential to enroll in PECOS. If you order or refer services and supplies, you need to be enrolled in PECOS. It is important because if you perform services or bill an item that was ordered or referred by another practitioner, your claim must have the referring or ordering practitioner's NPI. If the referring or ordering practitioner is not enrolled in PECOS, you will receive denials as the providing physician. If you enrolled in over 6 years ago with Medicare and have not updated your files, you will not have a current Medicare enrollment record in PECOS, because PECOS did not exist at that time; you will be required to update your enrollment status. The application process takes up to 45 days to process; therefore, you should not wait until the last minute to enroll. WCH can help you get your process started and completed. Please contact Olga Khabinskaya for more information- E-mail: OlgaK@wchsb.com.

"Enrolling your physicians and non-physician practitioners in PECOS is essential if you want to get paid by Medicare for covered services"

Source of information obtained from: The Coding Institute | March 2010, Vol. 10 No. 3, pg 17

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Dealing With Late or No-Show Patients

Patients who are late or no-shows can cost your practice valuable dollars; the good news is that there is a way to handle these kind of situations. Billing no-show visits or charging a late fee will depend on the payers contracts and laws of the state. Practices usually charge a fee (ex: $25) for missed appointments, but there can be other ways to go about before charging a patient, which might just scare way the patient.

- Regular patients who constantly show up late, could be scheduled earlier than the real appointment time.
- Create a policy and post it on the registration form, in the registration area, and in the waiting area. Inform your patients that they will be charged for late coming or missing their appointments by having them sign a copy of the policy.
- Write off the first occurrence as a lesson to the patient.
- Tell late arrivers that you will fit them in as best as possible, but other patients get preference. Give the option of rescheduling a time.
- If the patient misses an appointment , send a follow-up letter.

Going about this certain issue can take time, but once you have a system it should be no problem for your patients to understand the value of being on time and showing up.

Source of information obtained from: The Coding Institute | March 2010, Vol. 10 No. 3, pg 22

The Steps in the Medicare Recoupment Process

1. Claim is adjusted
2. Demand letter is sent out/account receivables is created
3. Stopping recoupment once a demand letter is revised

Providers choose how to respond to the demand letter: submit a voluntary refund within 30 day, allow recoupment from future payments, or request an extended repayment plan.

Appeal process:

Level 1: Redetermination

Level 2: Reconsideration

Possible outcomes for a redetermination and reconsideration include: Full Reversal, Partial Reversal, or Full Affirmation.

Level 3: Administrative Law Judge

Source of information obtained from: Section 935 Recoupment Basics

GAO Reports Lack of Accountability and Adequate Process in RAC

A March 2010 report from the U.S. Government Accountability Office (GAO) showed that even though CMS has taken steps to improve recovery audit contractor (RAC) there continues to be a lack of accountability and adequate processes for enduring corrective actions are taken. The results show that in most of the RAC-identified vulnerabilities that led to improper payments going unaddressed
GAO stated that CMS implemented corrective actions for only 23 out of the 58 (40%) vulnerabilities listed in the Improper Payment Prevention Plan (IPPP). CMS reported 18 specific medical services totaling $378 million; however, "GAO's analysis of the status of the vulnerabilities related to these overpayment in the IPPP indicates that corrective actions had not been implemented by CMS or MACs for vulnerabilities representing $231 million (61%) of the $378 million in overpayments for these services. More than 90% of the $231 million vulnerabilities that were not addressed were inpatient hospital claims alone."
Read the full GAO report on: gao.gov/news.items/d10143.pdf

Source of information obtained from: news.aapc.com/index.php/2010/04/gao-report-rac-program lacks-follow-through/

Acupuncture Services Potentially Covered by Medicare

Services provided by qualified acupuncturists will potentially be covered under Medicare part B. Qualified acupuncturist services can only be furnished by a qualified acupuncturist (an individual who has been certified, licensed, or registered as an acupuncturist by a State). *(cont.)*

(Cont from previous pg) The amount paid for these service are determined by a fee schedule established by the Secretary for purposes of this clause and the amount will not exceed the fee schedule amount. Effective date for this bill was January 1, 2010, which applies to services provided on or after January 1, 2010. Although, this bill has not yet been deliberated, investigated, and revised by the committees which is why the bill has not yet gone into law. WCH will keep you updated on all possible outcomes.

Source of information obtained from: HR 646, 1st session

Prohibition on Physician Self-referral

The Patient Protection and Affordable Care Act (HR 3590, section 6003), prohibits physician self-referral for some imaging services. "Effective January 1, 2010. physicians must provide patients with a written list of other local imaging suppliers qualified to render the same services for which they are being rendered in -office. "These requirements refer to MRI, CT, and PET. This provision in the health care reform bill changes disclosure requirements for in-office ancillary services. To view the full 1,534 provision please visit: www.govtrack.us/congress/bill.xpd?bill=h111-3590

Source of information obtained from: news.aapc.com/index.php/2010/04/hcr-stark-law-amendment-affects-physicians/

Coverage of Clinical Laboratory Services

All clinical laboratory service need to meet the applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA), as well as be medical reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Clinical laboratory services include: Biological, Microbiological, Serological, Chemical, Immunohematological, Hematological, Biophysical, Cytological, Pathological, and other examination of materials. Covered clinical services are furnished in: hospitals laboratories (outpatient or nonhospital patients) , physician office laboratories, independent laboratories, dialysis facility laboratories, nursing facility laboratories; and other institutions. Medicare does not pay routine screening tests, except for: Cardiovascular screening blood tests, Screening Pap tests, Colorectal cancer screening tests, Prostate Specific Antigen screening blood tests, and Diabetes screening tests.

Payment rates are set depending on the local geographical area, and the fees are based on charges from laboratories in that geographic area. Payment is the lesser of:

- Amount billed
- Local fee for a geographic area; or
- A national limitation amount (NLA)

Each year new laboratory tests codes and corresponding fees are added to the fee schedule.

WCH can help your practice apply and receive CLIA certification and set up a laboratory services, please feel free to contact Olga Khabinskay at olgak@wchsb.com for more information.

Source of information obtained from: Clinical Laboratory Fee Schedule

Next issue look for:

- **Financial Relationship between a Physician and Practice Management System**
- **Chart Coding & Auditing Services**
- **IDFT Credentialing**

Comments, Feedback, or requests for future bulletins?
Please e-mail them to Alenal@wchsb.com

WCH Service Bureau, Inc

WCH Upcoming Projects:

- CoolSite4Me.com
- Electronic Medical Record
- Chart Auditing Services
- Real-time Eligibility

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