WCH TIMES

SPRING 2011 | *Welcome to Spring!* | Issue 16

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ONLINE @ WCHSB.COM

WCH Corner

Dear Providers and Office Managers,

Only four months has passed since the new year has begun and already we're seeing huge changes within the HealthCare industry and at WCH . Providers are being heavily audited, billing guidelines are changing, which is forcing providers to alter the way they do business. WCH welcomes these changes! The year 2011 marks ten years since WCH has been in the healthcare industry and there is no change too big for us to tackle. We take pride in being your "go-to" source for information.

We have completed out Time Management software tailored , which we will be ***offering to our clients for free;*** *we have implemented a new Chart Auditing service to help you get prepared for that dreaded Medicare audit; and we have stepped up our marketing game in order to compete with the best of the best.*

WCH believes in educating our staff, and our clients so that that can face any situation head-on. With all the changes that are ever occurring in our industry, it can be truly overwhelming at times. But please remember that you have a trust worthy and experienced business partner, WCH Service Bureau at your disposal. We will be there to address any concern, and fix any problem that may arise.

WCH, standing strong with our clients!

New debt collection Company hired—Sunrise Credit Services

The Sunrise Family of Companies

WCH is pleased to announce that we have hired a new and reputable company that will now be handling debt collection. Sunrise Credit Services is a family owned business that has been in operation for over 35 years. Located, in Long island, Sunrise has been featured in Forbes magazine and ABC and FOX news, nationally. Sunrise has proven thus far to be a reliable and professional company, and WCH feels quite comfortable allowing them to handle our unresolved collection.

Feeling overwhelmed?

Can't keep track of your employees' time schedules?

Let WCH's Time management software work for you!

WCH would like to thank two of our generous clients, Dr. Patel, and Serge Beck for placing WCH and our services in high regard and referring some very promising clients to our business.

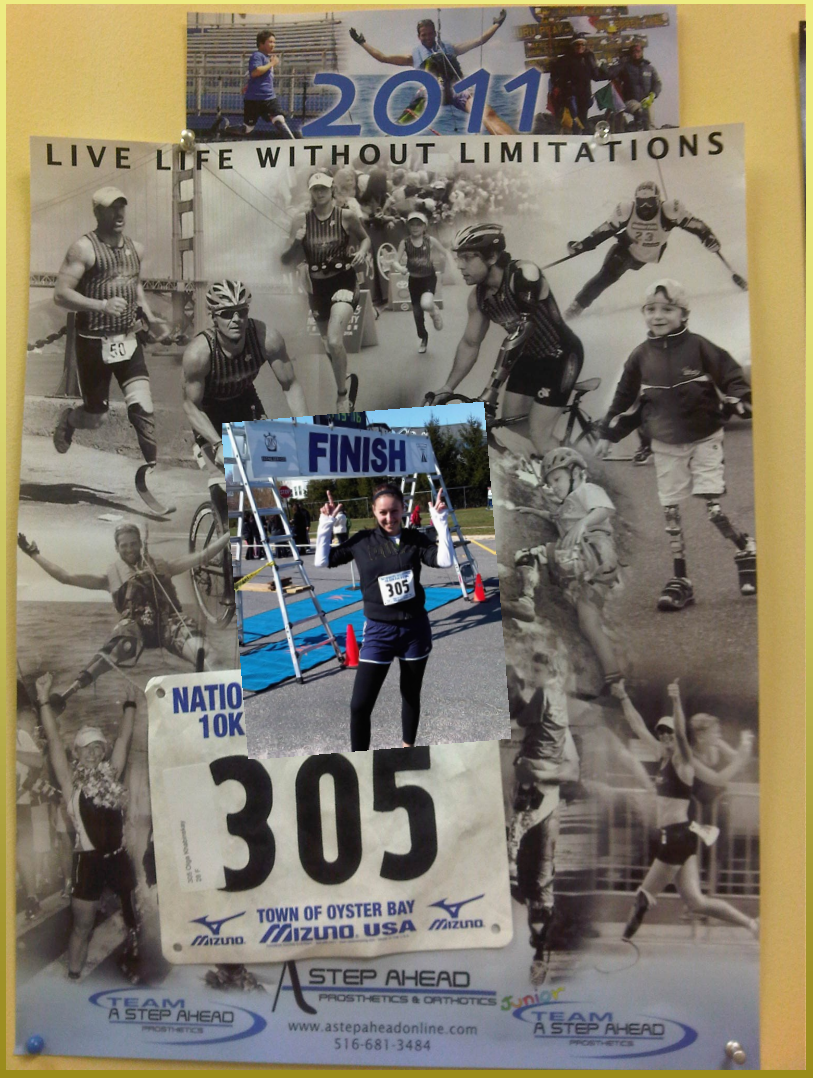
WCH: Number One in Chart Auditing

With our several, experienced *CPC (Certified Professional Coder), CPMA (,Certified Professional Medical Auditor)* on staff your charts are always in good hands.

Our exceptional, quality service guarantees that you will never have to feel worried about the state of your charts again.

We will diligently review, assess and correct any mistakes, and leave your charts in tip-top shape; worthy of any audit.

Why not give us a chance to prove ourselves, call us at (718) 934—6714, ext 1215. I promise we won't disappoint.



Olga completes 10K race for Aspire!

On April 3, 2011, our talented and athletic General Manager, Olga Khabinskay completed the annual 10K Race for ASPIRE in Long Island, New York to help raise awareness and funds for young amputees. The race began at 9Am at the H.M. Mattlin Middle school in Plainview, New York. Congratulations Olga on a race well ran!

WCH Credentialing Department specializes in

- IDTF (Mobile)
- Sleep Centers
- Multispecialty group enrollment
- Labs
- Group/Facility Contracting
- Fee Schedule negotiation

Contact our Credentialing department at

(718) 934-6714, ext 1201

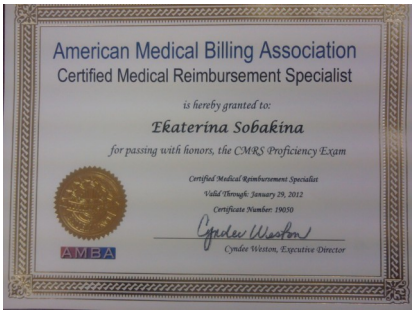
WCH: Bringing You The Best.

It brings us great joy and pride to announce that three of our dedicated staff members, *Elizaveta Bannova, Natalie Leontyeva and Ekaterina Sobakina* have successfully passed the AMBA (American Medical Billing Association) CMRS (Certified Medical Reimbursement Specialist) exam. The WCH staff stands together and congratulates Elizaveta, Natalie and Ekaterina on a job well done!

What Does CMRS mean?

A Certified Medical Reimbursement Specialist is an experienced and knowledgeable individual in the areas of HCPCS coding, Medical terminology, Insurance Claims & Billing, HIPAA, OIG Compliance, Information & Web Technology, Reimbursement among quite a few other things.

Being a certified specialist is not mandatory, but only seeks to improve our level of services and prove WCH's dedication to making our clients' rest easier. Ask yourself, don't you feel relieved knowing that your billing/reimbursements are being taken care of by a certified specialist?



Marcia B. Smith, Esq.

This firm has handled a number of Medicare, OMIG and private payer audits. A knowledgeable legal counsel can be indispensable, particularly when the amounts that the payers are trying to recover are significant. WCH highly recommends the services of this firm.

Contact them at (518) 462-3000

Medicare Enrollment Changes

This spring, there are new Medicare enrollment changes;

- Here's what you *need to know*:

Medicare has created a new enrollment process for newly enrolled and existing providers and suppliers. The new enrollment procedure will screen providers based on three levels; limited, moderate or high. Everyone requiring enrollment with Medicare will undergo this screening. Medicare is proposing to include fingerprinting and criminal background checks. However, this is still being developed.

With the new changes in enrollment, application fees are now being applied to all new submissions of the CMS applications. The fee is $505, and is current until 12/31/2011. The fee is required to be paid before submitting the application. In fact, you will be required to attach a copy of the receipt of payment with your enrollment application. The fee is non-refundable, but there are some exceptions.

WCH credentialing department has been diligently reviewing the requirements of the policies for the new enrollment changes, and WCH is happy to report that even though the process is complicated, not all providers will be impacted.

- Here's what you *need to do*:

If you are considering enrolling in Medicare or making any changes, you need to contact WCH in order to properly submit your enrollment application, using our services.

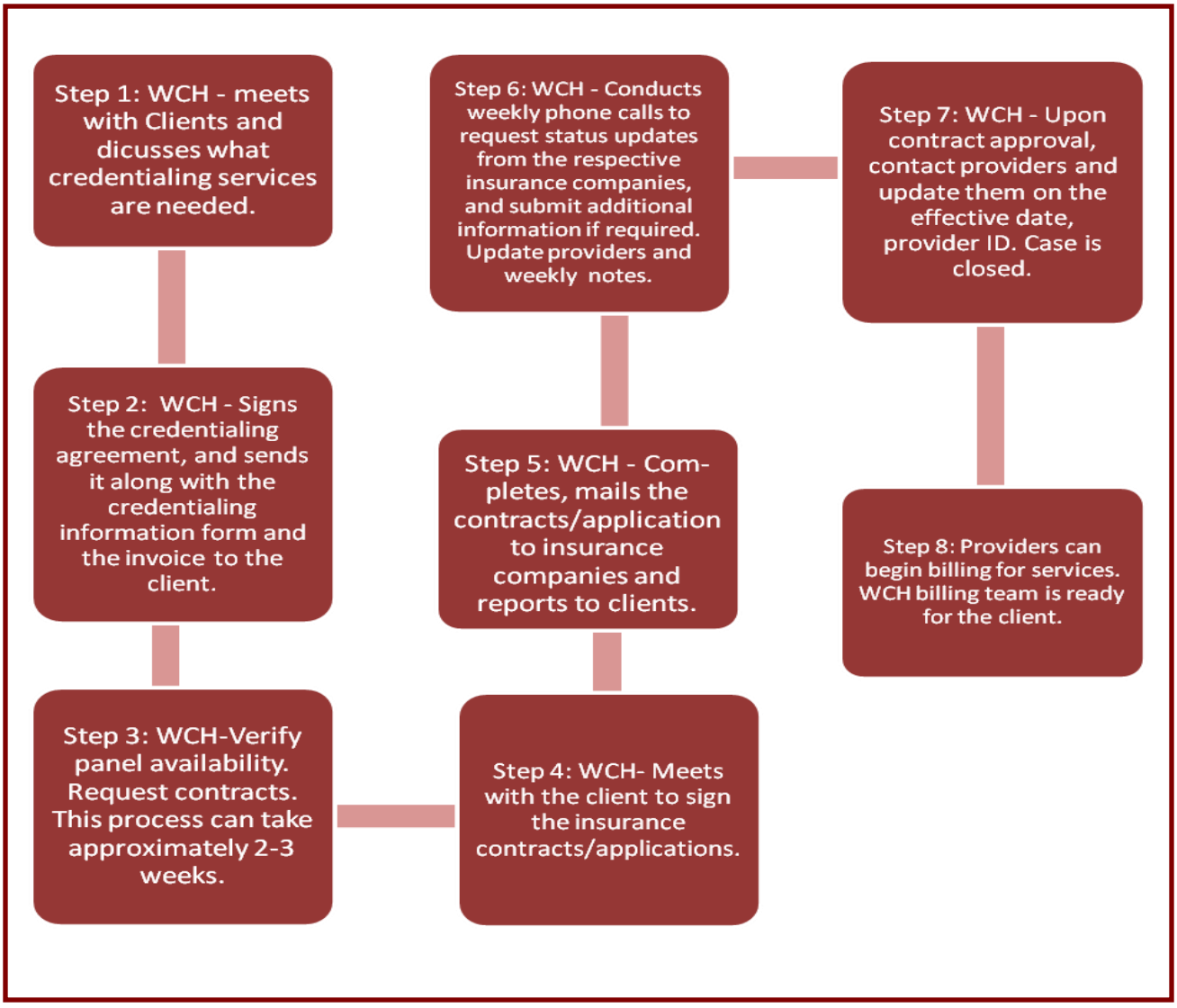
As you know, for the past ten years WCH has been building our credentialing skills and adding to our vast knowledge and expertise in this area. We have provided credentialing services for numerous providers, and we urge you to allow us to manage your Medicare enrollment to avoid loss of time and money.

I need credentialing services, but how does it work?

Many of our providers often approach us and ask, "How does the credentialing process work?" "What exactly is WCH's roll in the process?" In an effort to address both of those questions, we have developed an easy to understand flow chart that explains the credentialing process, and who is in charge of what step. Take a look at page seven.

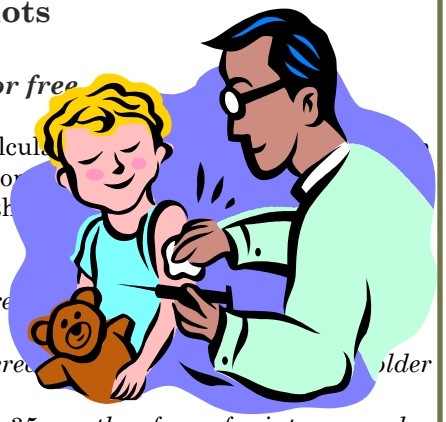
WCH has perfected our credentialing process and knows the ins-and-outs of the credentialing maze like no other entity. We are very proud of the quality and efficiency of our process, and hope that this reflects in our results.

To obtain further credentialing information or to sign up contact our General manager, Olga Khabinskay, a ten year Credentialing Specialist, at (718) 934-6714, ext 1201.



WCH's Provider Credentialing Process

Industry News: CMS releases payment Amounts for Flu Shots



Illinois pediatrician sentenced after billing for vaccines she received for free

Forget about digging through the latest Medicare Physician Fee Schedule and calcul to comes to determining your part B reimbursement rate for flu shots. CMS has co article elucidating this information. According to MLN Matters article MM7120, th zations is as follows:

- 90655 *(Influenza virus vaccine, split virus, preservative free, when administere for intramuscular use):* $12.398
- 90656 *(Influenza virus vaccine, split varies, preservative free, when administere older for intramuscular use):* $12.375
- 90675 *(Influenza virus vaccine, split virus, when administered to children 6 to 35 months of age, for intramuscular use):* $6.297
- 90658 *(Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years of age and older for intramuscular use)* for dates of service September 1, 2010 through December 31, 2010: $11.368.

If your MAC reimburses you for either 90660 (FluMist) or 90662 (FluZone High-Dose) the Part B payment amount for 90660 is $22.316, and for 90662 is $29.214. Carriers differ on whether they will cover these types of influenza immunizations.

(**Editor's note**: Annual part B deductible and coinsurance amounts do not apply to these charges, the articles notes. To read the article in its in entirety, visit www.cms.gov/MLNMattersArticles/downloads/MM7120.pdf.)

In other news…

When the CD offers you free vaccines to administer to uninsured patients, don't even think about billing insurers for the products. That's the lesson learned from the recent sentencing of an Illinois pediatrician who accepted free vaccines intended for uninsured or under-insured children. The doctor admitted that she billed the insurers for the vaccines (which she received as part of the Vaccines for Children program) as if she has paid for them on her own. The HEAT Task Force, which is part of the government's initiative to combat health care fraud, discovered the wrong doing, and the doctor was subsequently ordered to serve a three0year term of probation, with the first six months taking place under home confinement.

Editor's note?: To read the Department for Justice's press release in the sentencing, visit www.stopmedicarefraud.gov/aHEATnews/illinois.html#oct-06-2010)

SOURCE: Medicare Compliance and Reimbursement

WCH's Online Provider Credentialing Application

Our Simplified approach, "*Fill out once—Use always and everywhere*"

With our clients' time consuming and busy schedules in mind, WCH has developed and implemented a smooth and efficient way to initiate the credentialing process – **An online provider Credentialing Application.**

Simply log onto our website at www.WCHSB.com, and follow these three easy steps to access the application:

- Select the **SERVICES** option at the top of the page,
- Select **Provider Credentialing,** and lastly
- Select **Credentialing Application** at the middle of the page. After you have done this, complete the application with the required information.

Completing the online application is easy and convenient, and saves you the hassle of travelling to our offices when you can easily provide us with all your information online from the comfort of your home or office.

Visit our website today, and access the simplest application there is!

Radiology Payment Cuts in 2011 Could Hurt Many Specialties

Multiple imaging procedure reduction will impact all practices that perform imaging.

If your practice depends on revenue from imaging services, please take note that pay for imaging visits has dropped this year. Some providers were hoping that congress will step in and fix the conversion factor, which is $25.5217, but even if that did happen, CMS has changed the multiple imaging procedure cuts, which began on January 1, 2011.

"*In 2011, when you perform multiple radiological procedures that are within the same family (for instance multiple ultrasounds, or multiple MRIs) you'll collect 100% of the global fee for your primary study, but not for you second and subsequent studies*, " says Michael Ferragamo, MD, FACS, Clinical Assistant professor of urology at the State University at Stony Brook. "*For the second study, you'll be paid 100percent of the professional component, but 50 percent of the technical component. That's down from what we've collected in 2010, which was 75 percent of the technical component*," he says.

For example: Suppose the surgeon performs an abdominal sonogram (76700) and a bladder sonogram (76857), Ferragamo suggests. "You'll be paid 100 percent for the 76700, but for 76857 you'll get 100 percent of the professional component and 50 percent of the technical component." If the surgeon then adds a renal sonogram afterward 76775), "assuming the procedures aren't bundles by the payer, you'll get 50 percent for the technical component of that too, since its another subsequent following the abdominal sonogram," Ferragamo adds.

Tip: Dr. Ferragamo suggests that you place the higher RVU procedure first on your claim, as the insurer will most likely adjust only the lower-paying procedures. That way you will ensure that you receive the fill payment for the highest RVU service.

According the Medicare Fee Schedule, radiologists are set to lose 14 percent on average in Medicare reimbursement. Dianne M. Nakvosas, ACS-RAD from Compubill in Orlando park, Ill, ahs created a chart showing how Medicare has reimbursed practices for code 71020 over the past eleven years.

CPT - 71020		
YEAR	Medicare Allows	Medicare paid
1999	$12.12	$9.70
2000	$12.48	$9.99
2001	$13.06	$10.46
2002	$12.00	$9.60
2003	$11.79	$9.43
2004	$11.98	$9.58
2005	$11.96	$9.57
2006	$12.24	$9.80
2007	$11.46	$9.17
2008	$11.08	$8.87
2009	$11.95	$9.56
2010	$12.00	$9.60

The 2011 Fee Schedule also indicates that Work RVS has remained the same as they were last year. With radiologists already stretched thin, the impacts of cuts could be even more troubling in 2011.

SOURCE: Part B Insider, News and Analysis on Part B Reimbursement and Regulation; November 2010

HEALTH CARE NEWS

Extra Scribbles can Lead to Fines, Jail Time

Make sure doctors date all new entries on patient records

If you suspect that someone in your practice has been rewriting history, you need to get to the bottom of it immediately.

When someone improperly revises patient documentation, it can create huge compliance problems as well as jeopardize payments, say attorneys.

Analysts tell Part B Insider that there are several situation where improper revisions could cause problems for a physician practice. Two examples follow:

1) An administrator at a practice required doctors to route all charge slips through his office before they went to the billing department. Eventually the practice discovered that the administrator was up-coding the CPT codes on the charge slip by raising each evaluation and management visit by one or two levels. Then when the payments came in from Medicare, he was skimming and embezzling the difference between the E/M level the physical had marked down and the higher level the carrier had paid.

The practice found out and called in an attorney, then performed a self-disclosure to state and federal officials. The practice was able to point to the bad guy , and the administrator served some jail time after a plea bargain. Lucky for the investigators, the administrator had kept two sets of books—one with the E/M levels as the physician had coded them, and one with the levels as he's revised them.

2) A physician as out on post-payment review and asked for medical records for an identified sample of patients. The physician decided to come in on the weekend and supplemented his notes for those patients. He wasn't trying to falsify the records, merely flesh out his recollections. This would have been fine if the doctor remembered to date the new notes so that it would be clear he'd added them later. Instead, hew left the new notes undated. He didn't realize that the carrier staff had already examined some of those patient records, and thus recognized immediately that he's added information. Instead of merely repaying those claims the physician ended up paying civil monetary penalties, and was lucky to not have to face criminal charges.

Client's Rights

NYS Healthcare Provider Rights

Many of our clients often ask us, "Why are your services better, compared to other companies?" The reason WCH's services are better 5than the alternative, is that we work by the state rules and regulations, ad we force the insurance companies to do the same.

Every state has a Bill Of Rights for HealthCare Providers, which insurance companies neglect to follow, this is called Public Health Law.

The Insurance Law and Public Health Law include important protections for health care providers with respect to network participation, provider contracting, claims processing, and prompt payment for health care services. Some protections apply to all HMO and insurance coverage, while others apply only to HMO coverage and to managed care contracts offered by insurers (which most insurers do not offer).

Did you know?

OIG Launches Most Wanted List: Just two weeks prior to the government's massive health care fraud takedown, the U.S. Dept of Health & Human Services' (HHS) Office of Inspector General (OIG) launched its *Most Wanted Fugitives List*, at http://oig.hhs.gov/fugitives/, to highlight to the public those individuals sought by authorities on charges of health care fraud and abuse. The list includes a photo and profile of each fugitive, with an online tip form and 24 hour hotline number for reporting information related to a fugitive. Two of the fugitives have since been captured.

HHS Adopts Enrollment Rules Targeted at Fraud: The title of new HHS rules that become effective March 25, 2011, says it all: *Medicare, Medicaid, and Children's Health Insurance Program: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*. Although intended to target those who are unqualified to enroll, the rules affect all currently enrolled providers and suppliers, including provisions allowing for payment suspension during an investigation of a "credible allegation of fraud." The rule is available at: http://www.federalregister.gov/articles/2011/02/02/2011-1686/medicare-medicaid-and-childrenshealth-insurance-programs-additional-screening-requirements.

HHC Reports Theft of Personal Health Information: On February 9, 2011, the NY City Health & Hospitals Corporation (HHC) began notifying 1.7 million patients, staff, contractors, vendors and others about a reported theft of computer backup tapes of electronic records containing personal information, protected health information and personally identifiable employee medical information. The individuals were provided services at Jacobi Medical Center, North Central Bronx Hospital, or their offsite clinics, during the past twenty years. As yet, there is no evidence that the information has been inappropriately accessed or misused, but HHC is providing information and credit monitoring services to all affected individuals. All of the information on the tapes is still contained in the records at the North Bronx Healthcare Network. See www.nyc.gov/hhc for more information. Both federal and NY law require data breach reporting and notification by most health care providers.

Source: Stat Law Update 2011, A Publication of Kern Augustine Conroy and Schoppman , P.C.

HEALTH CARE NEWS

WCH Service Bureau — *your trusted source for all your medical billing needs. It's a promise you can depend on — Guaranteed!*

What does it mean to be "par" in Medicare?

Medicare physicians, practitioners and suppliers eligible to accept assignment of Medicare benefits for covered services may enroll in the Medicare Participation Program. Under the participation agreement, the physician or supplier agrees, in writing, to provide all covered services for all Medicare Part B beneficiaries on an assignment basis. This means the provider agrees to accept the Medicare-approved amount as payment in full for each covered service.

Incentives for participation include:

- Reimbursement if 5 percent higher than the reimbursement rate for non-participating providers.
- Placement in directory of participating providers (MEDPARD).
- Patient referral service by hospitals.
- Medicare payment paid directly to the provider.
- Charges are not subject to limiting charge.
- Automatic Medigap crossover (Medicare sends claims to the secondary insurance company).

Participating providers can only bill the beneficiary for any unmet deductible and the copayment (20 percent of the Medicare allowable) on any non-covered services.

For complete information about the benefits of participation and which services require mandatory assignment, refer to the additional links provided under Resources.

Source: http://www.trailblazerhealth.com/Provider%20Enrollment/Par%20Enrollment/Default.aspx?DomainID=1

What does "scope of practice" mean?

As a matter of law, physicians have an unrestricted scope or practice. That is they are legally authorized to perform any and all medical tasks. However, legal authority must be distinguished from the physician's scope of competence. That is, one might have the legal authority to perform a medical task but lack the competence to perform it.

As such, the physician in the case that you describe is authorized by law to perform the task. Whether or not he/she is competent to perform that particular task is a professional judgment question that the practitioner must make and which is subject to review if a complaint were received.

Please note further that Medicare may place limits on what they will reimburse such that even though a physician is authorized to perform a task Medicare may decide that they will only reimburse the service if performed by a board certified practitioner. When they refer to "in accordance with scope of practice," I think they are making the distinction between the legal scope of authorized practice (unlimited) and the scope of competence in any particular area of medicine as I described above.

Source: Walter Ramos, R.N., J.D. Executive Secretary, NYS Board for Medicine, Veterinary Medicine, Dietetics and Nutrition, Athletic Training and Medical Physics

UnitedHealthcare Transition Information and Materials for Providers

Since July 2009, Health Net has distributed communications and articles via Online News regarding the acquisition of Health Net of the Northeast's (HNNE's) licensed subsidiaries (Health Net of Connecticut, Inc., Health Net of New York, Inc., Health Net Insurance Company of New York, Inc., and Health Net of New Jersey, Inc.) by UnitedHealthcare (UHC). These communications and articles are archived and available for providers to view and print in the Provider Library, under the Updates and Letters and Online News sections.

To date, Health Net has transitioned all of its Medicare membership to UHC and continues to maintain select functions through the claims run-out period. Most recently, Healthy Net distributed provider update 10-388, Health Net's Medicare Advantage Membership Transition, which contains provider operational information regarding administrative and medical management processes and contacts for the transition of Health Net of Connecticut, Inc. Medicare Advantage (MA) membership, effective January 1, 2011. Information included in the update pertains to:

- Prior authorization
- Continuity of care assistance
- Claims submission
- Appeals and grievances

Specialty service providers

For information or questions regarding UHC's acquisition of HNNE, contact the Health Net Provider Services Center by email at HNNE.ProviderServices@healthnet.com, through the Health Net provider Web site, or by telephone at (800) 438-7886. You may also contact the UnitedHealthcare Provider Services Center at (877) 842-3210 or online at www.unitedhealthcareonline.com.

Senate bill looks to expand EHR use for mental health providers

A Senate bill calling for expanded health IT incentives for adoption of electronic health records (EHRs) by mental healthcare, behavioral healthcare, and substance abuse treatment providers and facilities was introduced this week by Sen. Sheldon Whitehouse (D-R.I.).

"Mental healthcare is a critical component of our healthcare safety net, and allowing these providers access to cost-saving, quality-enhancing advances in health information technology will improve the care that millions of American receive," Whitehouse said in a statement.

Expanding the use of EHRs also would give mental health professionals access to more comprehensive and up-to-date medical histories, and help reduce medication errors, he added.

The bill (S. 539), the Behavioral Health Information Technology Act of 2011, would extend eligibility for Medicare and Medicaid incentive funding for those who demonstrate meaningful use of certified EHRs. In addition, he said the bill would:

- Expand the types of providers eligible for Medicare and Medicaid incentives for EHR use to include licensed psychologists and clinical social workers.
- Expand Medicare hospital incentive funding eligibility to include inpatient psychiatric hospitals.
- Expand Medicaid hospital meaningful use incentive funding eligibility to include community mental health centers, mental health treatment facilities, psychiatric hospitals and substance abuse treatment facilities.
- Clarify eligibility of community mental health centers, psychiatric hospitals, behavioral and mental health professionals, substance abuse professionals, mental health treatment facilities, and substance abuse treatment facilities for technical assistance from one of the 62 regional extension centers.

Whitehouse's bill has been referred to the Senate Finance Committee.

Source: *http://www.fierceemr.com/story/senate-bill-looks-expand-ehr-use-mental-health-providers/2011-03-17?utm_medium=nl&utm_source=internal. Article written by Janice Simmons, March 17, 2011.*

Evaluation and Management Coding Review

CIGNA will review Evaluation and Management (E&M) coding in 2011. We review the use of E&M coding practices to monitor for potential upcoding as part of our ongoing focus on helping to improve health care quality and affordability. Upcoding is the practice of consistently using billing or revenue codes that describe more extensive services than those actually performed, as defined by the Centers for Medicare and Medicaid Services (CMS). CIGNA expects physicians, consistent with standard industry practice, to select the CPT code that best represents the level of service performed when submitting claims for payment.

CIGNA has developed a process for monitoring physician billing practices specific to E&M coding. As part of this process, claims are evaluated and physician billing practices are compared to the claims of the physician's peers. Statistical analysis is conducted and physicians whose billing practices differ from the peer group are evaluated further. Physicians who differ from the peer group may be contacted by CIGNA for further evaluation. This additional contact may be in the form of a letter and report, a telephone call or a meeting request. In some cases, chart review may be requested and performed. For most CIGNA-participating health care professionals, this program will not result in additional communication or interactions beyond this article.

Questionable Billing For Medicare Outpatient Therapy Services

To determine how billing for outpatient therapy in high-utilization counties compared to national billing, we calculated the average Medicare payments and number of services per beneficiary in Miami-Dade County, in the other 19 high-utilization counties combined, and nationally. We also calculated the average payment and number of services per provider serving beneficiaries in a county. We compared both averages for Miami-Dade County and the other 19 high-utilization counties combined to national averages.43

We used the National Provider Identifier Directory to identify providers that received over $1 million in total Medicare payments for outpatient therapy. We calculated these providers' total payments for outpatient therapy. We then determined how many of these providers were located in Miami-Dade County and the other 19 high-utilization counties.

Questionable billing characteristics. By using past OIG work on Medicare billing and in consultation with representatives of the Medicare PSCs, we identified six billing characteristics that may indicate fraud in outpatient therapy services. For example, a high prevalence of these characteristics may indicate inappropriate billing, such as providers' billing for services that were unnecessary or not provided. These characteristics were:

- Average number of outpatient therapy services per beneficiary that providers indicated would exceed an annual cap. According to therapy fraud experts within the PSCs, the KX modifier is often overused and/or used inappropriately**. We calculated the average number of services per beneficiary that had the KX modifier.**
- Percentage of outpatient therapy beneficiaries whose providers indicated that an annual cap would be exceeded on the beneficiaries' first date of service in 2009. Providers should use the KX modifier only when providing services that are expected to exceed an annual cap. This is unlikely to occur on the beneficiary's first date of service in a new calendar year. **We identified beneficiaries whose providers billed Medicare using the KX modifier on the beneficiaries' first date of service in calendar year 2009**.
- Average Medicare payment per beneficiary who received outpatient therapy from multiple providers. This characteristic raises concerns about stolen Medicare identification numbers or "professional beneficiaries" who exchange their identification numbers for kickbacks from providers. **We identified beneficiaries who received outpatient therapy from more than one provider in 2009 and calculated the average reimbursement per beneficiary in 2009.**
- Percentage of outpatient therapy beneficiaries whose providers were paid for services provided throughout the year. Therapy services are appropriate for improving the beneficiary's functioning level, but not for maintaining an existing level of functioning. **We identified beneficiaries who received outpatient therapy during all four quarters of 2009**.
- Percentage of outpatient therapy beneficiaries whose **providers were paid for services that exceeded one of the annual caps**. We identified beneficiaries who received either a combination of PT and SLP services or OT services, excluding those provided in hospitals, for which Medicare allowed more than $1,840.

Article continued on next page...

Article continued from previous page

- Percentage of outpatient therapy beneficiaries whose providers were paid for more than 8 hours of outpatient therapy provided in a single day. According to PSC representatives, **providing more than 8 hours of therapy to a beneficiary in** a single day is usually medically unnecessary and/or infeasible because of the characteristics of the Medicare population and the nature of services provided. We identified HCPCS codes for which the unit of service represents a specific amount of time (typically, 15 minutes) spent in direct contact with the beneficiary on any single calendar day. We then determined how many of these services a beneficiary received on the same day.

We determined the incidence of the 6 characteristics in Miami-Dade County, in the other 19 high-utilization counties combined, and nationally. We calculated the levels of the characteristics nationally and for the 19 high-utilization counties by combining all outpatient therapy claims in each of these two groups. For example, to determine the average number of services per beneficiary billed with the KX modifier, we identified the total number of services billed with the KX modifier in each group and divided these sums by the total number of outpatient therapy beneficiaries in each group. The approach we used resulted in weighted averages based on county size. See Appendix B for the incidence of the six characteristics within each high-utilization county.

Please visit http://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf, for a complete view of this article.

Source: *Questionable Billing For Medicare Outpatient Billing Services, Daniel R. levinson, Inspector general. December 2010. http://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf*

Got A question? Then WCH has the answer!

Question: Considering that a doctor has never seen a patient and only bills for interpretation of a test, is this doctor required to have the patient sign the ABN or can the doctor use the ABN form signed by the patient where the test was rendered? What is the legal way of doing this according to Medicare?

Answer: When multiple entities are involved in rendering care, it is not necessary to give separate ABNs. Either party involved in the delivery of care can be the notified when:

- There are separate "ordering" and "rendering" providers (e.g. a physician orders a lab test and an independent laboratory delivers the ordered tests);
- One provider delivers the "technical" and the other the "professional" component of the same service (e.g. a radiological test that an independent diagnostic testing facility renders and a physician interprets); or
- The entity that obtains the signature on the ABN is different from the entity that bills for services (e.g. when one laboratory refers a specimen to another laboratory which then bills Medicare for the test).

Regardless of who gives the notice, the billing entity will always be held responsible for effective delivery. When the notified is not the billing entity, the notified must know how to direct the beneficiary who received the ABN to the billing entity itself for questions and should annotate the Additional Information section of the ABN with this information. It is permissible to enter the names of more than one entity in the header of the notice. "

Source: Medicare Claims processing manual. Chapter 30 – Financial liability protections. https://www.cms.gov/BNI/Downloads/RevABNManualInstructions.pdf page 5-6

Question: Can you explain the difference between diagnostic and therapeutic injections or nerve blocks? How does the provider decide which to do?

Answer: Physicians use diagnostic nerve blocks to determine sources of the patient's pain. These blocks typically contain an anesthetic with a known duration of relief. Therapeutic nerve blocks contain local anesthetic to control acute pain, once the physician confirms the source and cause of discomfort.

But payers may want to know whether the block is diagnostic or therapeutic. Specifying such can be a criterion of coverage. Educate your physicians on the importance of documenting whether the patient receives a diagnostic or therapeutic block.

Source: Part B Insider, November 2010. The Coding institute

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