WCH TIMES

Summer 2008 Volume 06

WCH Service Bureau is a proud member of the following professional organizations

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

Dear Readers,

Welcome to the sixth edition of WCH TIMES !

A newsletter that is designed to inform you about our company developments, insurance policies, community events, and provide on-going support of current issues taken place in healthcare community. Coeditor for this newsletter was our billing supervisor Marina Bakina.

Enjoy!

Inside this Issue

WCH Corner

Insurance News:

6814 18th Ave. 2 Fl. Brooklyn, NY 11204 / Phone: 718 934-6714 / Fax: 718 504-6072 / wch@wchsb.com / www.wchsb.com

WCH Corner

American Seniors Got a Break!

Since the beginning of July we have been reporting to you the circumstances surrounding the *HR 6331 - the Medicare Improvements for Patients and Providers Act* and the impact it would have had on the healthcare community if it was passed. From Congress to President headquarters and back to Congress the bill was finally override by Senate on Tuesday July 15: the House vote was 383-41, while the Senate voted 70-26 in favor of enacting the bill into law. We cannot forget extensive advocacy made by the physicians and physical therapist which made a great contribution in favor of support to Congress.

This bill had to main purposes but major concern was to cancel a 10.6 percent cut in Medicare payments to doctors that took effect on July 1 and return the extension to physical therapy services if medically necessary for the beneficiaries. As a result that cut was canceled, and the physical therapy services were approved for continuation of care but with a provision. A 18 months extension on the final decision would be again address on December 31, 2009 in regards to physical therapy, occupational and speech pathology services.

In the meantime, the Medicare Physician Fee Schedule (rate of -10.6% has been replaced with a 0.5 %) update, retroactive to July 1, 2008. Medicare is currently working to update their payment system with the new rates.

The Medicare cut in fee schedule could have led some doctors to opt out of the Medicare program for good, and many older Americans would have found it harder to find necessary treatment. Lets hope that the next Medicare reform will be more accommodating and seek to provide higher quality of care to our seniors.

As we continue to progress through the Medicare reforms, WCH will provide you with the most recent changes and monitor important issues impacting your practice.

Did you know?

Approval for Medicare program was originally signed into a law on July 30, 1965 by President Johnson. At the signing ceremony President Johnson enrolled former President Truman as a first Medicare beneficiary and presented him with the first Medicare member card.

Member of NAMSS

http://www.namss.org/

WCH DIRECTORY

Management—x 101
Billing Department— x111
Technical support—x 104
Credentialing—x 112
Billing Supervisor—x111

OUR EMAILS

Alexandr Romanychev
alexr@wchsb.com

Olga Khabinskay
olgak@wchsb.com

Olya Lupu
olyal@wchsb.com

Diana Leonovich
dianaL@wchsb.com

Yuriy Veselov
ura@wchsb.com

Stas Budnikov
stasb@wchsb.com

Oksana Pokoyeva
oksanap@wchsb.com

Darya Feklistova
daryaf@wchsb.com

Olga Lobizova
olgal@wchsb.com

Elizaveta Bannova
lizab@wchsb.com

Slava Kurdov
slavak@wchsb.com

Eugene Talanov
eugenet@wchsb.com

Visit our website
www.wchsb.com
for more updates.

Do you know how to determine whether Medicare is the primary or secondary payer?

As you know Medicare is a Health Insurance Program for people age 65 or older, some disabled people under age 65, and people of all ages with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Medicare is primary most of the time, however there are cases when Medicare would be a secondary payer. Here are most common examples:

- the individual or his/her spouse is currently employed and covered under an employer group health plan as a result of current employment;
- the individual is entitled to Medicare as a result of a disability, the company has 100 or more employees, and/or the individual in question is Medicare entitled due to end-stage renal disease. Medicare is the secondary payer to a group health plan until a 30-month coordination period has ended;
- the individual was involved in an accident (car accident or at the place of employment) and the treatment is related to the accident, then No-Fault or Worker's Compensation career will be primary.

Keep in mind that when a patient is enrolled in Medicare HMO plan, you can bill HMO plan only, **Medicare is not considered secondary**.

Source of information obtained from www.medlearn.com

Do you know what code 94060 (bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) includes?

According to the national correct coding initiative (CCI) guidelines the following codes are considered a part of spirometry with pre- and post-bronchodilator administration:

- 94010 (spirometry)
- 94200 (maximal voluntary ventilation)
- 94375 (respiratory flow volume loop)
- 94640 (nonpressured inhalation treatment)
- 94664 (aerosol inhalation) and
- 94770 (CO_2 by infrared).

Also spirometry procedure 94060 is considered as a component of post-exposure bronchospasm evaluation, code 94070, and the pulmonary stress-testing procedures, codes 94620 and 94621.

However if the patient has an **acute exacerbation** of asthma or status asthmaticus and the physician must administer an inhaled bronchodilator 94640 (nonpressured inhalation treatment) could be reported in addition to 94060 as a separate and distinctive service. Carriers do not consider the bronchodilator cost as part of the payment for 94060, so you can report the appropriate drug code in addition to 94060.

Source of information obtained from www.medlearn.com and www.codinginstitue.com

How to determine if you can bill consultation code or need to bill regular E/M code?

Due to a large volume of incorrectly billed consultation procedures Medicare is really paying attention to such claims. The first step for the provider to determine if the consultation code could be billed is to identify the following three R's:

Request:	Another physician, provider, patient or private insurer has to request your advice or opinion.
Review:	You have actually evaluated the patient and formulated a plan of care.

Report: You have to give the requesting physician a report of your opinion or advice. In the report, you should mention the request, provide the opinion on the patient's condition, and possibly include a treatment plan.

The next step would be to determine the appropriate level of the consultation based on history evaluation, exam, medical decision making and time spent. For office or other outpatient consultations use the codes 99241-99245.

Keep in mind that as of May 23, 2008 all careers require NPI of the Referring physician and a claim will be rejected if this information is missing.

Source of information obtained from www.codinginstitue.com

Do you know that FDA recalls all product that contain HEPARIN?

FDA has received reports of serious injuries and/or deaths in patients who have been administered Heparin injectable products of other companies containing this contaminant.

The FDA reports could be reviewed at the following link:

http://www.fda.gov/cder/drug/infopage/heparin/adverse_events.htm

Affected heparin products have been found in medical care facilities in one state since the recall announcement. Although product recall instructions were widely distributed, they may not have been fully acted upon at all sites where heparin is used. Please carefully review all drug products that you keep in your office and make sure you removed all heparin products.

For more information, including medical devices that contain heparin go to:

http://www.fda.gov/cdrh/safety/heparin-healthcare-update.html

or contact the Division of Drug Information at 301-796-3400.

Source of information obtained from www.cms.hhs.gov and www.fda.gov

Have you ever heard about Ear Popper?

The EarPopper is designed to treat common ear problems without medication or ear tube surgery. The EarPopper is a safe and simple to use. Middle ear pressure problems, such as Otitis Media with effusion, Eustachian Tube Dysfunction and Ear fullness caused by colds, allergies, sinusitis could be treated with EarPopper.

There are several models of EarPopper:

- EP-3000 Office Version
- EP-2100 Home Version for prescription

The proper CPT code is 69401 and Medicare allowable amount is $ 92.45.

For user instructions and treatment guidelines go to www.earpopper.org .

Source of information obtained from www.earpopper.org

Protect yourself from Identity Theft

Here are some proactive actions that could be taken in order to reduce the possibility of identity Theft:

- Never give your personal information over the phone to unfamiliar email links;
- Protect your computer with firewalls and antivirus programs;
- Verify with people who you give your personal information how they protect it;

- Review your bank and credit card statements for unusual activities;
- Stop your mail service while you are away on vacation: contact the U.S. Postal Service at 800-275-8777;
- Keep an eye on your monthly bills, to identify if you missed a statement;
- Review check receipts, to make sure that they do not show your credit card's expiration date or more than its last five digits.
- Shred papers that have your personal information if you no longer need them, or go paperless by switching to online services.
- Report to policy department, file a complaint with the Federal Trade Commission (FTC), and freeze all accounts once the theft happened.

Source of information obtained from www.nyc.gov

Once again on HIPAA privacy provisions

We hope that you are aware of HIPAA privacy laws and take all necessary steps to comply with them because any violation could have significant consequences. Recently AHIMA journal published an article about a licensed practical nurse from Arkansas who was sentenced with a 10 years in prison and $ 250.000 fine for disclosing a patient's health information for personal gain. So, you should not only realize how serious HIPAA provisions are, but also reinforce it to your office employees.

The Office for Civil Rights (OCR) provides more information on health information privacy and enforcement program, go to http://www.hhs.gov/ocr/generalinfo.html

Source of information obtained from Journal of AHIMA , June 2008.

Insurance News

1199 NBF

1. Do you use Automated System for 1199 NBF?

Just call (888) 819-1199 and have your tax ID number, member ID number and the member's date of birth on hand. You can easily verify patient's eligibility and check claim status.

2. EMG/NCV and Foot Orthotics No Longer Require Prior Authorization

As of January 1, 2008 EMG/NCV (electromyography/nerve conduction velocity studies) and foot orthotics no longer require prior authorization by the Benefit Fund. EMG is covered for up to 2 dates of service per calendar year. Foot orthotics (L3000, L3010, L3020, L3030) can be covered for a specific diagnosis every two years; 2008 is the transition year for this benefit. Children can be covered for a specific diagnosis each year.

3.Physical Therapy, Occupational Therapy and Speech Therapy is limited to 25 Visits Per Year
1199 NBF covers only 25 physical, occupational or speech therapy visits per calendar year. All treatments must be medically necessary and in compliance with established clinical guidelines.

Source of information obtained from http://1199seiubenefits.org

Aetna

If your office uses insurances web site, you must have noticed that Aetna website is no longer active and when you try to login it refers you to a new portal NaviNet. NaviNet portal technology was developed by NaviMedix Inc, and is used not only by Aetna, but also by Cigna, UHC and several Blues Plans. It is considered a very convenient tool for a provider because it has multiple payers, similar interface, so you won't have to get used to it by switching to another payer and all the same options that used to be at the insurance's personal website. There are more than 454,000 physicians use NaviNet and we encourage you to take its advantages as well.

You can register by going to:https://navinet.navimedix.com/Main.asp

GHI

1. GHI Laboratory Network Changes

Effective June 1, 2008 GHI and GHI HMO change its laboratory network. Please make sure you refer your patients to a participating GHI laboratory provider in order to minimize your patient's expenses. The most common ones are:

Quest Diagnostics: www.questdiagnostics.com

Centralized Laboratory Services: www.centralizedlab.com

To find more participating laboratories go to http://psearch.ghi.com/ProviderSearch/

2. New York State Health Advisory on Thimerosal

Effective July 1, 2008 New York State Public Health Law (PHL) issued a law §2112 that prohibits to use vaccines that contain more than trace amounts of thimerosal to children with age less than 3 years and pregnant women. The term 'trace' depends on the type of vaccine. Thimerosal is an organic compound that includes about 49% of ethyl mercury. There is no serious scientific evidence of harm except some redness and swelling at the injection site. However, for the 2008-2009 flu season providers are urged to order enough thimerosal-free or single-dose preparations of influenza vaccine for immunization of children and pregnant women. In case of running out of such vaccine administration of thimerosal containing vaccine is still recommended because the risk of complications of influenza outweighs the risk of vaccination.

Source of information obtained from www.ghi.com

UHC/Empire Plan

Herpes Zoster (Shingles) vaccine

Please be advised that as of July 1, 2008 UHC/Empire plan will start covering the Herpes Zoster (Shingles) vaccine for participating providers only. The maximum allowance fee for this vaccine is $ 162.85 and is subject to the patient's copayment. Keep in mind that it is payable for patients with age of 55 years and older.

Source of information obtained from www.uhc.com

Empire BC/BS

1. Utilization Management (UM) determinations to be made under the name Anthem Utilization Management Services, Inc.

As of July 1, 2008 all Empire UM (authorizations) determinations will be processed under Anthem Utilization Management Services, Inc. (AUMSI) name. AUMNSI policies will be used together with current Empire policies in order to make determinations. Providers will continue to use the processed, just keep in mind that the new name AUMSI will appear on all correspondence.

Source of information obtained from Empire BC/BS Newsletter, Summer 2008

2. Preventive Health Guidelines are not available on the website.

Remind your patients about importance of preventive care. Empire BC/BS made Preventive Health Guidelines available on its website. Go to www.empireblue.com, select "Provider &Facilities" tab, than click "Enter." Choose Health Information and than Preventive Guidelines. Review the policy with the list of all coverable preventive benefits that patients might be eligible for.

Source of information obtained from Empire BC/BS Newsletter, Summer 2008

Health Net of the Northeast, Inc.

Revised PPO Prior Authorization Requirements

As of July 1, 2008 Health Net PPO updated its prior authorization requirements. Some of the procedures were added, so removed. For the complete list of the procedure go to www.healthnet.com.

Here are some services that will require prior authorization:

- Chiropractic services - Landmark;
- Osteopathic manipulation - Landmark;
- Rehabilitation services (PT/OT) – through OrthoNet;
- Hyperbaric oxygen therapy and etc.

Source of information obtained from www.healthnet.com

AmeriChoice

NYC DOH Primary Care EHR Project

You should be aware by now the importance of an Electronic Health Record (EHR) system. AmeriChoice by UHC is working with the New York City Department of Health (DOH) to make EHR available for providers at a reduced cost. If you are a PCP participating provider you can check with AmeriChoice if you are eligible to participate in their program. Visit www.nyc.gov/pcip to complete an eligibility application. You can also send an e-mail to pcip@health.nyc.gov to request an application or for more information.

Source of information obtained from AmeriChoice by UHC Newsletter, Spring 2008

Medicare Update

1. New Waived Tests

Do you perform laboratory tests in you office? Then you should keep an eye on new tests approved by the Food and Drug Administration. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. Tests are categorized as waived, moderate complexity or high complexity. Moderate and high complexity tests are collectively referred to as "non-waived" testing, and CLIA number is required in order to perform these test. CLIA waived tests usually include test with a low risk of error, however they require CLIA Certificate of Waiver. The requirements for Certificate of Waiver are:

- Enroll in the CLIA program (CLIA application form, CMS-116);
- Pay applicable certificate fees biennially; and
- Follow manufacturers' test instructions

For the list of CLIA waived tests:

http://www.cms.hhs.gov/CLIA/downloads/CR5913waivedtbl.pdf

For the recently FDA approved waived tests go to:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5913.pdf

Source of information obtained from www. cms.hhs.gov

2. ABN form

Recently we received a lot of phone calls from out clients questioning the new Advance Beneficiary Notice (ABN) form. This form is used in order to protect providers as well as beneficiaries in the situations when you expect the denial from Medicare for rendered services. The reasons for the denial are either Medicare won't consider services as being medically necessary according to its policy or such services are explicitly excluded from Medicare coverage

(such as hearing aids which is not payable by Medicare even if medically necessary). ABN is not required for services that are excluded from Medicare coverage. Plus ABN applies only to straight Medicare, not to HMO plans.

If a patient does not sign an ABN and services are denied by Medicare as not being medically necessary the patient is not obligated to pay for them. The only way to get paid for the services would be to file an appeal with medical documentation that proves medical necessity. However, in the case when a patient is notified of a possible denial by signing an ABN form, then he/she will have to pay for services provided if Medicare does not pay.

Here are some key changes that have been made to the current ABN:

- Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);
- Has a mandatory field for cost estimates of the items/services at issue; and

Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

All providers must start using the new ABN form no later than September 1, 2008. The form is available in English and Spanish. For other languages a verbal assistance should be provided in order to help beneficiaries to understand the notice and a note on such assistance with translation should be documented in the "Additional Information" section of the notice.

For the revised ABN and instructions go to: www.cms.hhs.gov/bni.

Source of information obtained from www.cms.hhs.gov

3. Medicare Part B - New Jersey Providers

Due to consolidation of Medicare data Centers and transition of Enterprise Data Center (EDC) the Interactive Voice Response (IVR) system won't be available from Friday August 8, 2008 at 4:30 p.m. through Monday August 11, 2008. It will resume its normal operations at 6:00 a.m. on Tuesday, August 12, 2008

Source of information obtained from www.ngsmedicare.com

4. PT policy changes

As of July 1, 2008 National Government Services implemented a new policy for PT/OT services, which incorporated previous NGS policy, other Medicare contractors' policies and comments from provider. The complete policy could be found at the following link:

http://www.ngsmedicare.com/NGSMedicare/nyorkpolicya/draft/l26884_lcd_final_ngs.htm

The policy describes medical necessity, authorized/not authorized personal, supervision levels, coding and documentation requirements, non-covered services.

Here are some points that we would like to bring your attention to:

1) Review documentation requirement:

Initial Evaluation

Plan of care

Re-evaluations

Progress reports

Treatment notes

Discharge notes

Certifications and re-certifications

2) Accounting for Treatment and Assessment Time.

3) Identify and record skilled treatment and its medical necessity.

4) Referral, plan of care, signature of the referring provider that the treatment plan was established or reviewed in the 30 days period after the initial evaluation and re-certification at least every 90 days.

Source of information obtained from www.ngsmedicare.com

5. Filling an appeal to Medicare

It is very important to understand your rights to appeal Medicare decision in case if you are disagree with the denial or believe that the service was improperly paid. Medicare Part B administrative appeals process includes the following levels for appeal:

First Level of Appeal—Re-determination: requests for re-determination must be filled within 120 days of the original claim determination and there is no minimum monetary amount.

Second Level of Appeal—Reconsideration**:** requests are filled in case if you are still disagree with the re-determination decision. This level of appeal is reviewed by another company other than National Government Services. Request must be filled within 180 days of the date of receipt of the re-determination.

The provider is responsible to provide all necessary information needed to support payment of its claim. It is the provider's decision to determine which documentation should be sent in order to support the appealed claim. The more relevant information and documentation you submit with the initial appeal the better chances are that additional information will not be requested and you will not have any delays.

Recently some of our clients were receiving requests from Medicare for medical records. Here is some basic documentation that could be submitted to Medicare for review for certain procedures:

Biofeedback: progress/office notes, history, and physical

Extensive/unusual services (modifier 22): Include office records, test results, operative notes, and/or hospital records to substantiate the extenuating circumstance. This information should be included when the original claim is submitted. If this information is not included, processing of your claim will be delayed, or the claim will be denied.

Halter monitoring: history and physical or consultation notes, test results for date of service in question, and test results for any prior or subsequent dates of service

Nerve conduction velocity (NCV) studies, electromyography studies: patient history, NCV worksheet or report of results of studies, reports for any prior and subsequent studies, if any

Noninvasive arterial and/or vascular diagnostic studies: notes for the date of service in question; notes for studies on prior and/or subsequent dates of service, if any

Source of information obtained from www.ngsmedicare.com

6. Changes Revoked for Incident-to Billing

Earlier this year CMS posted update for Incident to Policy, which we mentioned in the our previous newsletter issue. However on May 30, 2008 CMS retracted this transmittal and informed that a new transmittal will be issued any time soon.

Source of information obtained from www.ngsmedicare.com

7. Clarification of Medicare Bad Debt Policy

As a Medicare provider you should be aware that such Medicare allowances as deductible and coinsurance are included in your total revenue. However, it is not always possible to collect these amounts from patients. There are certain criteria under which you are allowed to write off uncollectible amounts from your revenues. In order to deduct uncollected deductible and coinsurance amounts from your income they should be determined as bad debt.

To be classified as bad debt the following criteria should be met:

1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

2) The provider must be able to establish that reasonable collection efforts were made.

3) The debt was actually uncollectible when claimed as worthless.

4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

A reasonable collection effort is considered a provider's effort to collect deductible and coinsurance amounts from Medicare patients as much as they try collect it from non-Medicare patients. It should include issuance of a bill(s), follow-up letters, reports of telephone and personal contact, etc. Everything should be documented and available upon request. If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

There are situations when Medicare patient is seemed indigent, some of them are Medicaid patients. It is the provider who decides if a patient could be considered indigent. All patient's resources should be taken into account, plus other partied that might be legally responsible for this patient's expenses. Supporting documentation that confirms the decision of the patient's indigence should be kept in patient's file.

Source of information obtained from www.cms.hhs.gov

Medicaid Update

1. Notice of Impending Action for Failure to Register NPI.

Currently NYS Medicaid NPI implementation is scheduled on September 1, 2008. Failure of the provider to register his/her NPI with Medicaid prior to September 1, 2008 will result in termination of provider's participation contract with the NYS Medicaid Program.

As a courtesy WCH staff will register all its clients' NPIs with Medicaid in order to avoid future delays and denials. You can verify you registration by visiting eMedNY website (www.eMedNY.org).

2. NYS Office of the Medicaid Inspector General

Office of the Medicaid Inspector General conducts audits and reviews on behalf of the NYS Department of Health to make sure the payments made by Medicaid Program are correct. There audits and reviews are directed to ensure provider compliance with laws, regulations, policies and rules of the Medicaid program. The office is expanding to accommodate the need to increase auditing and investigating activities across New York State .

Chapter 442 of the Laws of 2006 created a new Social Services Law § 363-d which requires that Medicaid providers develop and implement compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program. To review basic guidelines of such a compliance program go to:

http://www.omig.state.ny.us/data/content/view/81/65/

Especially we would like to bring your attention to preparing and maintaining of medical records that should be kept at least for a period of six years. It is considered an unacceptable practice for a provider to fail to provide documentation requested by investigators for services that were billed and paid by Medicaid.

Source of information obtained from www.omig.state.ny.us

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

WCH Feedback Form

Please use this form for your suggestions and comments.

Your Name

Email Address