WCH TIMES

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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 Doctors and Office Managers,

Welcome to WCH Times Summer Edition!

A newsletter that is designed to inform you about our developments, insurance policies, community events, and provide ongoing support of current issues taken place in the healthcare community. Co-Editor for this edition was WCH Education supervisor Elizaveta Bannova.

Enjoy!

Our Phone Extension Changed!

Please make a note of the new extenstions on the second page!

Inside this Issue

Member of NAMSS

http://www.namss.org/

WCH NEW DIRECTORY

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WCH Corner

DME Vendor Certification

WCH has successfully completed the process of DME vendor certification and registered with National Government Services to transmit claims on behalf of NY Medicare DME providers. At the present time we are undergoing testing with other local Medicare carriers and local Medicaid programs. If your office is currently providing or planning to provide durable medical supplies to your patients, please keep in mind that WCH is able to process these claims.

Credentialing with State/Federal and Commercial Payers

Our professional credentialing team specializes in new enrollment practice update and re-credentialing process for your practice. In addition we can help you open new professional corporation and register with appropriate state agencies. In addition to providing these services for groups and individual practice we are also reminding our readers that specialize in the following:

- IDTF Enrollment
- Laboratory Enrollment
- CLIA Certification
- Civil Surgeon
- Durable Medical Supply
- Accreditation Process & Enrollment

First consultation is always free, please do not hesitate to contact WCH before signing up with another company and loosing your time and money!

Automation Package for Our Clients

WCH technical department has developed and implemented an easier way for your patients to pay their bills on our website. We are creating the following features more comfortable for you and your patients on www.wchsb.com

- Pay WCH Billing Invoices
- Purchase WCH Programs/Software
- Purchase Credentialing Packages
- Purchase any additional services/reporting

It's a secure transaction processed by Pay Pal (without the need set up of Pay Pal account), please start using this feature for your convenience.

WCH Staff Determination

We are happy to report that three members of our staff Olga Lobizova, Billing Manager, Vyacheslav Kudrov Billing Supervisor and Ilya Mirolyubov, Technical Support competed HIPAA compliance examination and received certification from Medgar Evers College. HIPAA Privacy Rule certification allows our staff protects the privacy of individually identifiable health information, to monitor and protect information about your practice, your patients and overall electronics date exchange taking place between our offices.

Future Auditing & Coding Services

By January 2010,WCH is planning to provide Auditing and Coding Services for healthcare providers. Oksana Pokoyeva, Account Representative from the billing department is preparing to take examination to become a Certified Professional Coder in early October of this year. Olga Lobizova, Billing Manager will be preparing to take examination in the upcoming year. After talking the examination, it take several weeks to receive results, meanwhile Ms. Pokoyeva will undergo necessary training in chart review and coding education. WCH will keep you updated on the progress of the CPC examination in the upcoming newsletters. We are looking forward providing you with coding services because with the upcoming EMR requirements, CMS standards and commercial payers regulations this type of service will be beneficial for your practice.

Start Using Electronic Superbill

In the previous newsletters we had informed you about testing and implementation of electronic superbill, we would like to remind our clients to start using this feature from WCH PMBOS program to eliminate paperwork hassle and establish secure transfer of information. Our electronic superbill was created with the effort to ease your internal office operations and create paperless environment. If you are interested to use electronic superbill in your practice, please contact your account representative or Olga Khabinskay, WCH General Manager for further set up process.

WCH EMR Project

As we are approaching the deadline set for January 2011 which is outlined by Medicare and Medicaid programs to implement incentives for providers that are meaningfully using the electronic medical record in their practice. Periodically, we have been informing you that WCH programmers with collaboration of other physicians are creating a unique EMR that will be offered to our clients and set for sale on the international market. We understand that currently there are over hundreds of EMR's available to healthcare providers, offering suitable solution for your office, however we strongly feel that by having knowledge's and experiences we were ale to gain by providing, billing, credentialing, management services has greatly contributed in creation of a stronger EMR in contrast with our competitors.

We want to take this opportunity to invite our clients to participate in this project, let us know your ideas for the EMR interface, your suggestions can greatly improve overall performance and usage of the system for you and for other providers. If you are interested to be involved in the EMR project, please contact Olga Khabinskay, General Manager.

Referring Program

WCH invites you share benefits we offer with your colleague's!

If you are satisfied with our services and quality of work refer our services to your peers, and in return we will provide you and your colleague with the following:

Free - Time Management Program

Time cards are history! Begin using computerized program to count salary, manage office task and control overall employee's performance.

Free - Personalized Practice Website

Present your practice services, contact information and job opportunities on your personal website.

For more information about the special promotion package contact Olga Khabinskay, General Manager.

WCH Introduces Direct Medicare Information

Being a vendor has its benefits! We are able to provide more flexibility with the access of information and additional functionality that delvers quicker results and saves valuable time. WCH already provides import and export of data to and from Medicare and now we are adding: Medicare eligibility and claim status reporting for all of our current clients that use our practice management operation program. In the next month we will be sending out this information to our clients via regular program update.

If your office does not use WCH PMBOS please contact Olga Khabinskay, General Manager.

WCH Panthers -Race for Cure 2009

WCH is joining one of the biggest breast cancer charity event taken place in New York City. The Susan G. Komen New York City Race for the Cure taking place on Sunday September 13th at Central Park. We will be joined by other corporations, volunteers, survivors and people that have desire to help. We are all running to raise money, contribute to the event spirit and sense of community. Approximately a month ago WCH send out emails informing you about our participation in the race and asking you to make a donation for the cure. We set a goal to raise $1000, this money will go to research and fight against breast cancer. We would like to take this time to thank Dr. Stolina Galina, MD, Dr. Etuk Oscar, DPM and members of WCH staff for their contribution to this event. If you are interested to sponsor our team, please make the donation by following this link: http://www.komennyc.org/site/TR. In the search box enter our team name WCH Panthers and follow the link to make a donation. WCH and The Susan Komen Foundation invites you and your family to join more than 25, 000 New Yorkers in the run for cure. You are welcome to join us on this day and be part of WCH Panthers team!

For participation and for any other questions related to this event, please contact Olga Khabinskay, General Manager.

WCH Billing Department Responsibility

The billing process in itself is strenuous and requires specific knowledge in order to make a claim payable. We often see that companies, similar to ours market their services by stating that billing services is composed of billing department, follow-up department, collection department, appeal department and account representative department. At WCH we have one billing department composed of professionals that have knowledge's in all areas of billing process to make a claim paid. In our opinion it is impossible to handle the process of claim by so many departments, this creates chaos in the work process and responsibility of the account representative is diminished. WCH account representatives are able to provide full account history and if necessary detail of each claim and demographic of each individual doctor within the group. WCH feels that creation of separate billing departments only creates confusion and decreases quality of work. Of course several account representatives handle one account but they are fully able to provide billing work process from A to Z. In order to properly code, bill and collect claims payments on behalf of our clients , the designated person must know the claims processing steps beginning from the original superbill. We want to emphasize that we understand that each account requires a lot of time, work and quantified results, our account representatives achieve these results for clients.

Healthcare Industry Update

HIPAA 5010 Reminder

By January 1, 2012 CMS is requiring that all providers, clearing houses, and billing agents submit claims on their new HIPAA 5010 form. Medicare is expecting to start receiving claims on HIPAA 5010 form in 2011 in order to ensure that the billing software works appropriately before the deadline of 2012, officially replacing the 4010 form. The 5010 form will improve claims receipt, control, and balancing procedures'. The HIPPA 5010 form will increase field size for diagnostic codes; and allow ICD-9 and/or ICD-10 code values, it will not solely accept ICD-10 codes. Some system changes most likely will be needed but CMS is currently working on a 5010 web that will help with this information.

CMS posted education training and materials on www.cms.hhs.gov

CMS – WEB BASED TRAINING

CMS has made available a revised June 2009 Web-Based Training for The Certificate of Medical Necessity (CMN) for physicians, health care professionals, and medical administrative staff in the completion, submission and maintenance of the documentation required verifying the CMN.

It can be accessed by going to http://www.cms.hhs.gov/MLNGenInfo . Scroll to the "Related Links Inside CMS" section at the bottom of the page, and select Web Based Training (WBT) Modules. You will find the "Certificate of Medical Necessity WBT " from the list provided.

CMS posted education training and materials on www.cms.hhs.gov

Stop Medicare and Medicaid Fraud

Many health care providers work hard everyday to ensure that civilians are getting the care they need. However due to the illegal actions of health care fraud perpetrators, billions of dollars are stolen from taxpayers each year, and they have no intention of stopping. Even more so, getting bolder and more sophisticated, embezzling billions of dollars in false billing and fraud schemes, robbing Medicare and Medicaid.

This affects every American, because they obtain critical resources from our health care system. This causes an increase of health care costs and potential harm in the short-term and long-term financial obligations of CMS.

Eliminating fraud will cut costs for families, businesses and the federal budget and increase the quality of services for those who need care.

The U.S. Department of Health and Human Services (HHS) and U.S. Department of Justice (DOJ) are working together to help eliminate fraud and investigate fraudulent Medicare and Medicaid operators who are cheating the system.

Source of information obtained from : http://www.hhs.gov/stopmedicarefraud/

MEDICARE

Comprehensive Error Rate Testing (CERT) Program

CMS has established what they call the Comprehensive Error Rate Testing (CERT) Program, which inspects claims monthly to determine if they are processed correctly. This will help protect Medicare's trust fund and determine any errors. CMS and Highmark Medicare Services will use this CERT error finding to determine underlying reasons for claim errors and develop appropriate action plans to improve compliance in payment, claims processing, and physician/provider billing practices. AdvancedMed will alert you that one of your claims has been selected for the monthly random sampling. Your office will then receive a letter requesting information and you would have to comply in a timely manner. If no response is given or only one part of the requested information is provided, will result in a CERT denial and a refund of monies previously paid.

Source of information obtained from http://highmarkmedicareservices.com/partb/em/index.html

PART B BILLING FOR ULTRASOUND

In 2007 Medicare Part B covered about 17 million ultrasound services in ambulatory settings at a cost of over $2 billion. OIG used 2007 Medicare Part B claims data to identify 20 counties that were in the top 1 percent of counties for both average allowed charges for ultrasound per Medicare beneficiary and percentage of beneficiaries who received ultrasound services. The Medicare data was used to determine the high use county reporting ultrasound services also claims were examined for the presence of a limited set of page, and select Web Based Training (WBT) Modules. You will find the "Certificate of Medical Necessity WBT " from the list provided. By learning this course you'll be available to identify the healthcare staff responsibilities, completely report he items required for CMN, find the list of common errors etc.

Source of information CMS Learn Resource: 200906-26

Ordering/Referring Providers Verification

Centers for Medicare & Medicaid Services (CMS) under CR 6417 is expanding claim editing to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer Medicare services. Beginning effective October 5, 2009 CMS is expanding claim editing to meet Social Security Act requirements. This does not alter any existing regulatory restrictions such as, the physicians and non-physicians practitioners who meet the definitions at section 1861(r) and 1842(b)(18)(c) of the Social Security Act are eligible to order or refer services for Medicare beneficiaries.

According to CR 6417 only the following providers can order or refer beneficiary services:

Doctor of Medicine or Osteopathy, Dental Medicine, Dental Surgery, Podiatric Medicine, Optometrist, Chiropractic Medicine, Physician Assistant, Certified Clinical Nurse Specialist, Nurse Practitioner, Clinical Psychologist, Certified Nurse Midwife, and Clinical Social Worker.

Firstly, if the claim does not pass the edits described above, Medicare will continue to process the claim and will include a remark message (M68 – missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification) on the Remittance Advice.

Secondly, if the billed service requires an ordering/referring provider and none is present, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify the ordering/referring provider's NPI and name reported on the claim against Medicare's provider enrollment records to ensure the ordering/referring provider is enrolled in Medicare and is a specialty eligible to order or refer.

Source of information obtained from: http://news.aapc.com/index.php/2009/07/cms-releases-medicare-partb-proposed-rule/#more727

Anti Mark up Rule

An "Anti-markup Rule" went in effect on January 1, 2009 for all diagnostic test (other than clinical laboratory tests) billed under Medicare Part B regulations. Over time Centers for Medicare and Medicaid Services (CMS) will change all references to "purchased diagnostic tests" in Medicare manuals to "anti-markup test (s)". Any "purchased diagnostic test" should be consider a reference to an anti-mark up test. CR 6371 discusses some specific criteria that should be used to determine when the anti-markup payment limitation applies and when it does not apply. This does not apply to independent laboratories. The 'Anti-markup Rule" will prevent ordering physicians and other ordering providers, ex: nurse practitioners, from charging Medicare full fee for diagnostic tests performed on Medicare patients if the test is not performed or supervised by the ordering physician or other physician with whom the ordering physician "shares a practice" with. However, this does not apply to all practices. Physicians who are supervising the Technical Component (TC) or Professional Component (PC) or both are allowed to bill for the full Medicare fee. These physicians are considered to share a practice with a physician group for which he or she provides at least 75% if his or her professional services, even if the physician works for one or more billing physician groups or other health care entities. Claims must be submitted with the proper coding in the Purchased Service segments of the ANSI X12 837P electronic claim format. When billing using the Form CMS-1500, each component of the test must be submitted on a separate claim form.

Source of information obtained from MLN Matters number # MM6371

In Brief CMS Anticipated Changes for 2010

Medicaid Physician Fee Schedule (MPFS) proposed a new rule that addresses Part B payment policies. Under this proposed rule, physicians and non-physicians (NPPs) paid under (MPFS) are anticipating a 21.5% payment cut unless a new legislation is passed to offset it. Centers for Medicare & Medicaid Services (CMS) are intending to increase payment rates for primary care services and Part B payment changes such as; Update the practice expense component of physician fees, Remove physician administered drugs from the definition of "physician services", Stop making payment for consultation codes. Physicians would use evaluation and management (E/M) codes, and CMS would increase payment rates for these codes, Increase the payment rate for the Initial Preventative Physical Exam (IPPE), or "Welcome to Medicare" visit, and Refine how Medicare recognizes the cost of professional liability insurance in its payment system. In addition any participating physicians who successfully report Electronic Prescribing Incentive and Physician Quality Reporting Initiative (PQRI) program measures would qualify for incentive payments in 2010 of up to 2.0 percent of their total estimated allowed charges for each program. This proposed rule will also employ provisions in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that added new Medicare benefit categories for cardiac and pulmonary rehabilitative services and for chronic kidney disease education which will go in effect January 1, 2010. CMS would also like to propose reduced payment for imaging services beginning January 1, 2012. This would apply to mobile units, physicians' offices and independent diagnostic facilities that conduct imaging but would not apply to physicians who interpret the images.

Medicaid

Payment for Office Based Surgery

Effective July 14, 2009, New York State law (Chapter 365 of the Laws of 2007) requires accreditation of physician offices where surgical or other invasive procedures are performed under moderate sedation, deep sedation or general anesthesia. Beginning with the date of service of July 14, 2009, Medicaid will no longer pay for office based surgery or other invasive procedures performed under moderate sedation, deep sedation or general anesthesia unless the office location has been accredited by one of the designated

accrediting agencies. Please note that the law and the Medicaid policy does not apply to dentists or podiatrists. The following web page provides additional details related to the Office Based Surgery (OBS) Law and associated requirements:http://www.health.state.ny.us/professionals/office-based_surgery/

Source of information www.emedny.org

HR 646, The Federal Acupuncture Coverage Act

What does it mean? HR 646, also known as "The Federal Acupuncture Coverage Act of 2009," amends title XVIII of the Social Security Act to provide for coverage of qualified acupuncturist services under part B of the Medicare Program, and to amend title 5, United States Code, to provide for coverage of such services under the Federal Employees Health Benefits Program. **Importance?** The passing of this bill the Acupuncturist and Oriental medicine Doctors with be able to bill from Medicare Part B for service rendered as well as Federal Employees Health Benefits Program. If you need any other assistance in this matter please contact your member of congress for support in HR 646.

Source of information http://www.rallycongress.com/aaaom/1944/please-support-hr-646-federal-acupuncture-coverage-act/

OIG—Reviewed POS Coding for services rendered in 2005-2006

OIG presented the final report for incorrectly coded claims for 2005 and 2006 by physicians. Investigation detected that not all the physicians are correctly coding Place of Service for the submitted claims; the services which were actually performed in outpatient hospital settings and ambulatory surgical centers (ASCs) were coded as performed in office settings. OIG detected that $20.2 million were overpaid to providers during 2005 and 2006 and gave instructions to Part B carriers to: Work with physicians who provided incorrectly billed service in order to recover overpayment instruct and educate physicians and theirs billing agencies about importance of correct POS coding fiscal intermediaries and program safeguard contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments. Source of information http://www.oig.hhs.gov/

Red Flag Rule

In November 2007, the Federal Trade Commission (FTC) issued a set of regulations, known as the "Red Flags Rule," requiring that certain entities develop and implement written identity theft prevention and detection programs to protect consumers from identity theft.

The implementation date for this rule is August 1 2009, the AMA issued policy template in order to identify, detect theft and that providers have to do in order to report theft. For policy sample please refer to http://www.ama-assn.org/ama1/pub/upload/mm/368/red-flags-rule-policy.pdf

The purpose of the RED FLAG RULE is to identify theft form entity site who is performing illegal activities (using other's entity information such as Social Security number, Credit Card, Name, Insurance information etc) All healthcare professionals has to comply with RED FLAG RULE law and must have the adequate policy and procedures in place by August 1 2009, or they may face a penalty of up to $2,500 per "knowing violation."

How does the Rule differ from HIPAA privacy and security rules?

HIPAA is intended to protect personal health information (PHI) for security and privacy purposes. PHI as defined by HIPAA is covered by the Red Flags Rule, but the Rule extends to other sensitive information:

- Credit card information
- Tax identification numbers: Social Security numbers, business identification numbers and employer identification numbers
- Insurance claim information
- Background checks for employees and service providers

What is a "red flag?"

A Red Flag is a pattern, practice, or specific account activity that indicates the possibility of identity theft. The FTC identifies the following as red flags:

- Alerts, notifications or warnings from a consumer reporting agency
- Suspicious documents and/or personal identifying information, such as an inconsistent address or nonexistent Social Security number
- Unusual use of, or suspicious activity relating to, a patient account

Notices of possible identity theft from patients, victims of identity theft or law enforcement authorities.

For more information theft detection and other procedures please refer to:http://www.ama-assn.org/ama1/pub/upload/

PT&OT Services—Payment Review.

OIG announces that in 2009 in theirs work plan they are going to pay close attention to outpatient physical therapy services performed by independent therapists. For reimbursement, the OIG says all outpatient physical therapy services must be "reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member" A recommended reference for therapy services documentation requirements is Medicare Benefit Policy Manual, 100-2, chapter 15, sections 220 and 230. To be considered reasonable and necessary, the services must meet Medicare guidelines. National Government Services Inc, in its turn prepares a specific prepayment review for Physical and Occupational therapy services performed by specialties other than Specialty 65 (Physical Therapist billing independent) and 67 (Occupational Therapist billing independent), as previous review detected providers who bills incorrectly such services.

Source if information AAPC Coding Edge/ www.ngsmedicare.com

US Healthcare Reform

Why are Americans are at risk?

The Obama-Biden plan is oriented for improve healthcare quality, increase coverage costs, coverage will able to be maintained. If you don't have health insurance, you will have a choice of new, affordable health insurance options.

Barak Obama and Joe Biden believe that health system should be redesigned in order to reduce waste and inefficiency and to improve healthcare quality, and it would reduce costs for millions Americans.

This plan is directed to reduce costs, guarantee choice and ensure quality care for all.

INVEST IN ELECTRONIC HEALTH INFORMATION TECHNOLOGY SYSTEMS

As most of medical record are still kept in paper format and it cost twice more to process it then in electronic format. 10$ billions will be invested each year for the next 5 years, to move the U.S. health care system to broad Adoption standards-based electronic health information systems, including electronic health records. A study by the Rand Corporation identified that if most of healthcare providers offices and hospital will be adopted the electronic health records systems it will save up to 77$ billions a year.

IMPROVE ACCESS TO PREVENTION AND PROVEN DISEASE MANAGEMENT PROGRAMS.

Health plan will be required to participate in the new public plan, Medicare or the Federal Employee Health Benefits Program (FEHBP) utilize proven disease management programs. This will improve quality of care and lower costs, as well. Health plans will be required to disclose the percentage of premiums that actually goes to paying for patient care as opposed to administrative costs. Barack Obama and Joe Biden will support providers to put in place care management programs and encourage team care through implementation of medical home type models that will improve coordination and integration of care of those with chronic conditions.

ENSURE PROVIDERS DELIVER QUALITY CARE

Providers will be required to report preventable medical errors, and support hospital and physician practice improvement to prevent future errors. An independent institute will be established to guide reviews and research on comparative effectiveness, so that Americans and their doctors will have accurate and objective information to make the best decisions for their health and well-being. Increasing medical malpractice insurance rates are making it harder for doctors to practice medicine and raising the costs of health care for everyone. Antitrust laws will be strengthen to prevent insurers from overcharging physicians for their malpractice insurance. Due to constantly increasing costs for health care coverage millions of Americans are at risk to loose it. By razing costs many of employers are affected and they unable purchase health coverage for theirs employees. The Obama-Biden plan provides new affordable health insurance options by:

1) guaranteeing eligibility for all health insurance plans – will require all insurance to cover pre-existing condition, regardless prior history and get comprehensive benefits

2) creating a National Health Insurance Exchange to help Americans and businesses purchase private health insurance – through Exchange, all American can purchase new plan or change the existing one. The Insurer will have to issue policy to every applicant with fair and stable premiums not depend on health status.

3) providing new tax credits to families who can't afford health insurance and to small businesses with a new Small Business Health Tax Credit- as not all families are qualified for public health programs such entities will get a tax credit from Barack-Biden plan for premiums. To be eligible for the credit, small businesses will have to offer a quality health plan to all of their employees and cover a meaningful share of the cost of employee health premiums.

4) requiring all large employers to contribute towards health coverage for their employees or towards the cost of the public plan - Large employers that do not offer meaningful coverage or make a meaningful contribution to the cost of quality health coverage for their employees will be required to contribute a percentage of payroll toward the costs of the national plan. Small businesses will be exempt from this requirement

5) requiring all children have health care coverage - will expand the number of options for young adults to get coverage by allowing young people up to age 25 to continue coverage through their parents' plans.

6) expanding eligibility for the Medicaid and SCHIP programs

7) allowing flexibility for state health reform plans. Due to federal inaction, some states have taken the lead in health care reform. Under the Obama-Biden plan, states can continue to experiment, provided they meet the minimum standards of the national plan.

Source of information www.barackobama.com

WCH Feedback Form

Please use this form for your suggestions and comments.

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Your Name

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Email Address

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Take a look at www.wchsb.com

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