November 2010 Volume 1, Issue 7

WCH Bulletin

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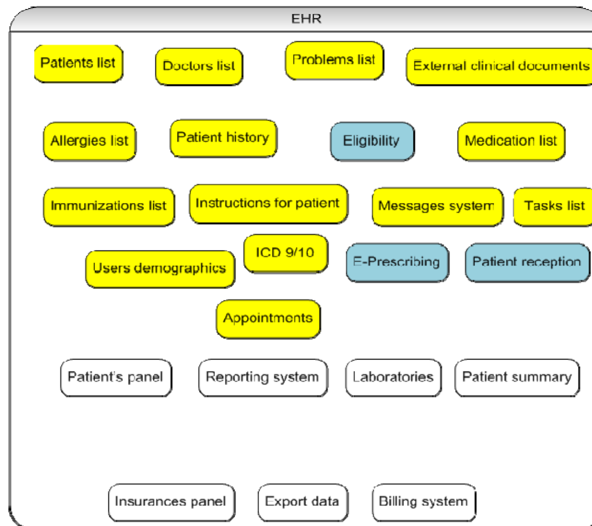
Welcome back our readers!

WCH NEWS

WCH Service Bureau, Inc. Stand Alone EMR

Paper-based records have been in existence for a very long time but now Electronic Medical Records lie at the center of any computerized health information system. Along with saved space is reduction of paper needed by medical offices, hospitals or insurance companies. Electronic Medical Records do not render paper obsolete, but they certainly do reduce needed paper significantly. Another advantage of Electronic Medical Records is the ability for all in a health care team to coordinate care. This helps to avoid duplication of testing, prescribing medicines that in combination might be dangerous and the ability for anyone on the medical team to understand the approaches taken to a condition.



Our EMR program includes a number of features, such as:

- *Recording a patient's demographic, contact and insurance information*

You can easily schedule and review appointments for your practice patients. Then selecting existing patient on the appointment sheet you can view the full image of patient's information you have on file.

- *Maintaining information on assessment and treatment plans*

Listing of all of a patient's medical problems and their treatment status leads to faster and more efficient diagnosis and treatments. The doctors can add and track all their patients' data, research and prescriptions.

- *More convenient data entry and accessibility*

Allowing paper records to easily scanned and transferred into the electronic records. Paperwork can often stay uncompleted but electronically stored is faster and easier to complete therefore it gets done effectively. When medical audits take place all information is readily available making workflow and procedures faster and smoother.

Our EMR program makes access to information very easy. The implementation of electronic medical records can save lives as quick access to our records can be lifesaving if an emergency occurs and answers to those questions are needed during the emergency decision-making process or at the very least reduce costs by minimizing repetitive tests. Since electronic records have been used in billing, the process has been streamlined to save time, money and efforts.

The chart above illustrates the progress of our EMR program. Sections in yellow are complete modules, the blue are still in process. We have finished but have not yet certified E-Prescribing. We are working on the certification for E-Prescribing and creating patient receipt, which is similar to eSuperBill. In completion of our EMR program we will also have an integrated eligibility, a patients panel, a report generation, a laboratories system (HL7), and a patient summary interface. WCH will keep you updated on our process and grow with our EMR program.

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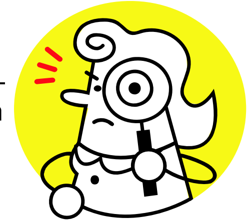
Audit Your Charts with WCH CPCs'



Ask any expert, and they will certainly tell you that the secret to full and timely reimbursements on your medical claims is proper coding. In fact, the most frequent errors in claim processing can be attributed to improper coding and/or a lack of necessary documentation. It may seem simple, but with today's ever-changing medical codes, guidelines, and regulations the task of properly putting together your medical charts requires more time and experience than ever before. With this in mind WCH is proud to present our Medical Chart Auditing services as the solution. For more information on the auditing service WCH's Certified Professional Coders can offer, please visit our website at http://www.wchsb.com/medicalchart.asp or call WCH Billing Manager, Zukhra Kasimova at (718) 934-6714 ext. 1114

Facing Technical Difficulties?

Let the knowledgeable technical team at WCH help you out! Our well rounded team of IT techs can help you figure out any problem and in fraction of the time in which you will spend trying to. The WCH technical department delivers the maximized service to all out clients. Alongside technical difficulties, WCH's technical department offers a mixture of unique services to accommodate and improve your everyday office needs. Technical services include the following but are not limited to: computer and software installation, medical software development, computer support, web & graphic design, credentialing verification/background screening, new office consulting, help in establishing relationships between healthcare related organizations. WCH provides concrete advise and effective solutions to your medical practice. WCH gives you freedom to do what you like best—care for people.

Credentialing News

Medicare/ Medicaid Applications

Medicare and Medicaid do not allow use a PO BOX as a correspondence address. If you want to receive your checks and remittance notices at PO BOX, you may use section 4 E of CMS 855 I Medicare application (Special Payment), and also Pay To Address section of Medicaid enrollment application and specify there a PO BOX address.

Medicaid:

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION

Enter the NAME of the person/department/apartment number where the mail should be sent

STREET - LINE 1

Cannot be a Post Office Box UNLESS accompanied by an actual street address

- LINE 2

CITY

Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE ( ) - EXT.

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

- LINE 2

CITY

Do NOT use abbreviations

STATE ZIP CODE - COUNTY

Medicare:

B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

"Special Payment" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payment" Address Line 2 *(Suite, Room, etc.)*

City/Town

GuildNet: 97002 Re-evaluation

Please be aware that GuildNet does not pay for physical therapy procedure codes except 97002 - re-evaluation services. Even if you a contracted provider, you can't add any other physical therapy codes to your contract, as GuildNet doesn't cover the remaining codes in general. It will be re-

called that PT should submit a re-evaluation in two circumstances: (1) when a patient exhibits a "demonstrable change" and needs his treatment goals revised or (2) when an ongoing assessment of the patient's rehabilitation requires the re-evaluation, according to CMS Pub 9 Sec. 503.

Healthcare News

The Disadvantages of Electronic Medical Records

Even though there are more advantages than disadvantages, we would like to discuss the things EMR will not do for your practice and what its disadvantages are. The main disadvantage is the financial difficulties providers and facilities will face upgrading to the EMR. Not only must you buy equipment to record and store patient charts (much more expensive than paper and file cabinets), but efforts must be taken to convert all charts to electronic form. Patients may be in the transitional state, where old records haven't yet been converted and doctors don't always know this. Further, training on electronic medical records software adds additional expense in paying people to take training, and in paying trainers to teach practitioners.

Despite the training times, nurses and doctors are most often unfamiliar with technology and significantly detract from patient time as the doctor or nurse struggle with unfamiliar equipment. Medical care in already crowded offices may be delays when technology is not reliable. It's also easy to miss recording relevant details, or to type incorrect information.
Along with reduction in doctor/patient time, some people find that electronic medical records and their accompanying systems have depersonalized doctor visits or needed calls to a doctor's office. Protocol of a system may require, for instance, any patient questions to be emailed to a doctor, even if a receptionist takes them and even if the doctor passes that receptionist multiple times a day. This can increase wait time for callbacks, or for doctor emails, especially if emails are not checked regularly.

Additionally, there is not one electronic medical records system. There are many. Streamlining patient care can only be achieved when a single system is used, since two or more systems may not work together. If the hospital uses a different EHR system than your primary care physician, health records may not be available to the hospital, or vice versa from hospital to the physician. Electronic medical records may reduce office paperwork, but they may not coordinate care between several treating physicians, pharmacies, and allied health workers as they promise to do when different systems are used by each group.

Some are also concerned about the security of their medical records, which should be completely confidential. Hackers may ultimately be able to break in EHRs despite security precautions, and they may then release confidential information to others. This has some patients worried about how safe and confidential their electronic medical records really are.

Lastly, a big disadvantage of an EMR is that it will not replace the billing department; billing and collection is still a separate process. Everyday billing and collection tasks are left to the billing department.

EMR and ICD-10 Collectively

The nation's mass conversion to electronic health records isn't the only seismic shift on the horizon in health IT. Even before the economic stimulus legislation passed earlier this year, healthcare organizations already had been busy planning for the transition to ICD-10 coding by October 2013, and the related switch to ANSI X12 5010 standards for HIPAA transactions by January 2012. And unlike the Medicare and Medicaid EHR program that will pay bonuses for adopting technology--and eventually impose penalties for not using EHRs--the 5010 and ICD-10 codes will be mandatory if you want your Medicare claims paid.

Medicare News

Therapy CAP for 2011

Section 1833(g)(5) of the Social Security Act (as amended by section 3103 of the Affordable Care Act) extended the exceptions process for therapy caps through Dec. 31, 2010. Since the MEI for 2011 is 0.4 percent, **the therapy cap amount for 2011 is $1870.**
The Medicare agency's authority to provide for exceptions to therapy caps (independent of the outpatient hospital exception) will expire on Dec. 31, 2010, unless the Congress acts to extend it.

Source of information obtained from: http://www.cms.gov/TherapyServices/

2011 First Quarter Interest Rate Released

Medicare contractors will charge/pay a slightly lower interest rate for claims underpayments/overpayments this period than in the last. Effective Oct. 22, the private consumer interest rate is 10.75 percent—compared to 11 percent for the previous quarter. Medicare Regulation 42 CFR §405.378 provides for the interest assessment at the higher of the current value of funds rate (1 percent for 2010), or the private consumer rate as fixed by the Treasury Department. Interest accrues from the date of the final determination. See regulation 42 CFR §405.378 for final determination definitions, as well as when exceptions and waivers to this regulation may apply.

Source of information obtained from: http://news.aapc.com/index.php/2010/10/2011-first-quarter-interest-rate-released/

Acceptable Electronic Signatures

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable.

Listed below are examples of acceptable electronic signature:
Chart "Accepted by" with provider's name

- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed before import by" with provider's name
- Digitalized signature: handwritten and scanned into the computer
- "This is an electronically verified report by John Smith, M.D."
- "Authenticated by John Smith, M.D."
- "Authorized by: John Smith, M.D."
- "Digital Signature: John Smith, M.D."
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically approved by" with provider's name

When you submit medical records to the CERT contactor with an electronic signature, you must also include a copy of the electronic signature protocol/procedure. The protocol/procedure should describe the requirements that the physician uses his own ID and password to enter the system to sign the medical records. The CERT contractor will keep a copy of the protocol/procedure on file for each provider for future documentation request, so only one copy will need to be submitted.

Source of information obtained from: MMR201010 (Medicare Monthly Review) | October 2010

New Waived Tests

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW, defined as CLIA waived test, to be recognized as a waived test. However, the test with CPT code 82962 does not require a QW modifier to be recognized as a waived test.

CPT Code	Effective Date	Description
G0430QW	January 1, 2010	Noble medical Inc. Split-Specimen Cup
82274QW, G0328QW	March 1, 2010	Inverness Medical Clearview iFOBT Complete Fecal Occult Blood Test
82010QW, 82962 (no QW modifier needed)	March 2, 2010	Nova Biomedical Nova Max Plus Glucose and B-Ketone Monitoring System
83986QW	April 15, 2010	Common Sense Ltd. VS-Sense Test{qualitative}
85610QW	April 15, 2010	CoaguSense Self-Test Prothrombin Time/INR Monitoring System (Prescription Home Use)
G0430QW	April 21, 2010	Redwood Toxicology Laboratory, Inc Reditest Freedom Cup
G0430QW	April 21, 2010	Noble Medical Inc. NOBLE 1 Step Cup {OTC}
G0430QW	April 30, 2010	Express Diagnostics, DrugCheck Waive Cup
G0430QW	April 30, 2010	Express Diagnostics International Inc. DrugCheck Waive Multiple Drug Screen Cups
81003QW	June 3, 2010	Cole-Talyor Marketing Inc. CTI-120 Urine Strip Analyzer

The official instruction, CR 7084, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2038CP.pdf on the CMS Web site.

Source of information obtained from: MMR201010 (Medicare Monthly Review) | October 2010

Centers of Medicare and Medicaid

Impact of the ACA Provisions

The impact of the ACA provisions, wage index and market basket updates, and case-mix coding adjustments are expected to decrease home health agency (HHA) payments by approximately $960 million, or 4.89 percent, in 2011.
Under the new health reform law, the existing HHA outlier cap becomes permanent and HH PPS rates are reduced by 2.5 percent. The law also requires CMS to apply a 1 percentage point reduction to the 2011 HH market basket amount for a 1.1 percent market basket update.

Source of information obtained from: http://news.aapc.com/index.php/2010/11/cms-updates-home-health-payments-for-2011/

Medicaid

Mandatory Compliance Program Certification Required by 12/31/10

Social Services Law (SSL) §363-d and Part 521, of Title 18 of the New York State Codes, Rules, and Regulations, both entitled Provider Compliance Programs, is being actively enforced by the Office of the Medicaid Inspector General (OMIG) in 2010. This regulation requires that all Medicaid providers who fall under the following categories, certify that they have adopted and implemented an effective compliance program by December 31, 2010:

- persons subject to the provisions of Articles 28 or 36 of the New York State Public Health Law;
- persons subject to the provisions of Articles 16 or 31 of the New York State Mental Hygiene Law; or
- other persons, providers, or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

Under 18 NYCRR §521.2(b), "substantial portion" of business operations is defined as any of the following:

- when a person, provider, or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from the medical assistance program;
- when a person, provider, or affiliate receives or has received, or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from the medical assistance program; or
- when a person, provider, or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on

behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.
Each compliance program must contain the eight elements required under SSL §363-d and 18 NYCRR §521.3(c). When applying for enrollment in the medical assistance program, and during the month of December each year thereafter, 18 NYCRR §521.3(b) requires that providers certify to the Department of Health and OMIG that a compliance program meeting the requirements of the regulation is in place. The annual deadline each year for providers to certify that they have an effective compliance program is December 31.
The regulation, certification form, and FAQ's are available on the OMIG Website at:
http://www.omig.ny.gov. Under the "Compliance" tab on OMIG's home page click on "Provider Compliance" to access this information. Questions? Please contact the Bureau of Compliance at (518) 402-1116.

Source of information obtained from: October 2010 Medicaid Update

Medicaid Fee-For-Service Coverage of Seasonal Flu and Pneumococcal Immunizations

New York Medicaid will reimburse enrolled office-based practitioners, pharmacies, and Article 28 clinic providers for the cost of the seasonal flu and pneumococcal vaccines and for the administration of these vaccines. The fee-for-service coverage policies and billing rules for seasonal flu and pneumococcal vaccines have been specifically designed to facilitate improved access to these vaccines and are outlined as follows:

- Medicaid will cover the cost of seasonal flu and pneumococcal vaccines and the administration of these vaccines.
- Medicaid continues to reimburse clinics, physicians and pharmacies $13.23 for vaccine administration. Nurse practitioners and licensed midwifes continue to be reimbursed $11.25 for vaccine administration.
- Administration of seasonal flu and pneumococcal vaccines may be provided in Article 28 clinic settings; in a practitioner's office by a physician, physician's assistant, nurse practitioner, licensed midwife, registered nurse or licensed practical nurse; or, for ages 18 and older, in a pharmacy by certified pharmacists (within their respective scopes of practice under the State Education Law).

Medicaid Office-Based Practitioner FFS Billing Chart

Immunization Type	Code For Vaccine	Code for Administration	Medicaid Reimbursement for Vaccine	Medicaid Reimbursement for Administration *(Amount varies based on billing provider)*	Vaccine for Children Program (VFC)
			Age 19 and older		*Up to Age 19*
Seasonal Flu	90655 90656 90657 90658 90660	G0008 for intramuscular administration 90473 for intranasal or oral administration	Actual Acquisition Cost	**$13.23** - physician **$11.25** - nurse practitioner or licensed midwife **$8.57** - physician **$7.28** - nurse practitioner or licensed midwife	**Enhanced administration fee of $17.85** Bill vaccine procedure code and append with "SL" modifier *(do not bill an administration code)*
Pneumococcal	90669 90732	G0009 for intramuscular administration	Same as Above	**$13.23** - physician **$11.25** - nurse practitioner or licensed midwife	Same as Above

Billing questions? Please call (800) 343-9000. For policy questions, please call (518) 473-2160.

Fee-For-Service Billing Instructions for Office-Based Practitioners
When provided in a practitioner's office as a standalone service or as part of an evaluation and management visit, vaccine administration charges and vaccine charges, if applicable, must be billed using the Medicaid fee schedule. Seasonal flu and pneumococcal vaccines are billable to Medicaid at their actual acquisition costs for persons aged 19 and older. If these services can be covered by Medicare or another third party insurance coverage, such benefits must be exhausted prior to billing Medicaid. These vaccines are not billable to Medicaid for those under age 19 as they are provided free of charge through the Vaccines for Children Program. Fees for administration of the seasonal flu and pneumococcal vaccines for those 19 and older and those under age 19 are provided in the chart below. The chart also outlines vaccine procedure codes, vaccine specific administration codes, and Medicaid reimbursement for the vaccines and their administration.

Source of information obtained from: October 2010 Medicaid Update

Mandatory Medicaid Managed Care Expanding To Additional Counties

Effective October 1, 2010, managed care enrollment will be required for most Medicaid beneficiaries residing in Cayuga, Essex, Hamilton, Madison, Schoharie, Tompkins, and Wayne Counties. Once a mandatory managed care program is implemented in a county, it is expected that the enrollment of all eligible Medicaid beneficiaries will take up to 18 months to complete. Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly en-

couraged to check eligibility *at each visit* as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Managed Care Coordinator" or "Eligible PCP" (depending on the device used). MEVS will identify the scope of benefits a Medicaid beneficiary's Medicaid managed care organization provides through specific coverage codes. When using a touch-tone telephone you will hear the "Description" of each covered service. When using either the Point of Service (POS) or ePACES the "coverage codes" will be displayed. If the message "All" appears, all services will be covered. *Medicaid will not reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.* Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries may contact their local department of social services to learn more about managed care.

Questions? Please contact the Division of Managed Care, Bureau of Program Planning & Implementation at (518) 473-1134.

Source of information obtained from: October 2010 Medicaid Update

Payment Error Rate Measurement Program Request for Medicaid Provider Documentation

The Centers for Medicare & Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in New York Medicaid and the Children's Health Insurance Program (CHIP). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). CMS uses a national contracting strategy, consisting of contractors, to perform various steps in the process, including a medical review of selected Medicaid fee-for-service claims throughout Fiscal Year (FY) 2011. This will be New York State's second time participating in the PERM program. The State also participated in the PERM program in Federal FY 2008. For more information on the PERM project, please visit: http://www.cms.gov/PERM/.

Under PERM, reviews will be conducted in three areas:

1. Fee-for-service claim payments,
2. Managed Care payments, and
3. Beneficiary eligibility for both the Medicaid Program and CHIP.

Impact on New York State:

New York State is one of 17 states included in the Federal Fiscal Year 2011 review of payments made from October 1, 2010, through September 30, 2011. New York State has assigned PERM project oversight for Medicaid fee-for-service payments and managed care capitation payments to the Office of the Medicaid Inspector General (OMIG). PERM project oversight of eligibility for both the Medicaid and CHIP programs is assigned to the Office of Health Insurance Programs (OHIP).

The Process: CMS has contracted with A+ Government Solutions, Inc., to serve as their documentation/database contractor. A+ Government Solutions, Inc., will request documentation from a sample of providers to substantiate claims paid in FFY 2011. They will also operate as the review contractor. The OMIG requests that providers also send a copy of the documentation to their attention in order to confirm documentation is complete. In New York State's 2008 PERM project this step eliminated a major problem that other States had with incomplete documentation. By mirroring the federal review, New York State was able to contact the provider to secure missing documentation before an error was assigned. It also enabled New York State to appeal claims that were erroneously disallowed and have the disallowances overturned.

The first requests for documentation by the federal contractor should be mailed to the providers in February 2011. If you are contacted, we ask for your cooperation and a timely response. Receipt of the documentation is essential to the success of the PERM program. Requests and subsequent receipt/non-receipt of documentation will be tracked. Your timely response will facilitate the PERM process and minimize the need for further follow-up action by the OMIG.

Questions? Please contact the Payment Error Rate Measurement project staff via e-mail at: PERMNY@omig.state.ny.us or by phone at (518) 408-0485 or (518) 486-7153.

Healthfirst

Source of information obtained from: September 2010 Medicaid Update

Changes to Behavioral Health Authorization Requirements

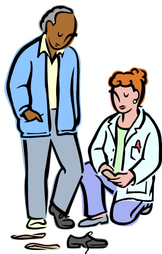
Effective January 1, 2011, the authorization requirement for traditional outpatient mental health services is being removed. This change is being made to reflect requirements under the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) that says plans may not apply more restrictive financial requirements or treatment limitations to Behavioral Health than those applied to medical/surgical services. A recent ruling extended the reach of the MHPAEA to Managed Medicaid plans.

By removing the authorization requirement for traditional outpatient Behavioral Health services effective Jan 1, 2011, Healthfirst is leading the way in eliminating existing barriers to care and reducing the administrative burden that the current outpatient utilization review processes place on those who provide behavioral health services.

Source of information obtained from: Health First web-site

Questions You've Asked

Medicaid & Podiatry Service:



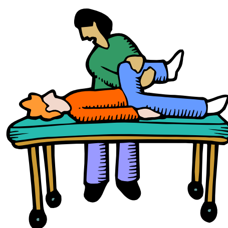
Q: Can we bill podiatry services to Medicaid?
A: Podiatry is not a covered service under NYS Medicaid. It was eliminated from the Medicaid Program by a change in statute in 1992. Pursuant to that statute, Medicaid can only reimburse a podiatrist for: care provided to children under 21 years of age (with a referral from a physician), and, a portion of the Medicare Part B coinsurance for dually eligible Medicare/Medicaid recipients. Payment can be made to the group practice.

Q: Can services rendered by a hired podiatrist, be billed under the medical director who hired the podiatrist?
A: A physician cannot bill Medicaid for services provided by their salaried podiatrist. A physician can only bill Medicaid for services that he/she personally provides to the patient.

Medicare PTA Employment:
Q: Can PMR employ PTA (physical therapy assistant) and bill for his services?
A: No: **Medicare policy L26884** "Physical and occupational therapy services may be provided by physicians, non-physician practitioners (NPPs), or incident-to the services of physicians/NPPs when provided by physical or occupational therapists, in the office or home. All therapy medical necessity, certification, documentation, and coding guidelines of this LCD apply with one exception. When therapy services are performed incident-to a physician's/NPP's service, the *therapist* does not need a license to practice therapy, unless it is required by state law. All other physical or occupational therapist qualifications (education and training) must be met. Therapy services must be directly supervised. *The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section 230.4 for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4."*

Non Certified OTA Services:
Q: Is a non certified Occupational Therapy Assistant able to treat patients under licensed Occupational Therapist supervision in the office setting?
A: A New York State Certified OTA may only perform such duties as approved by their supervising NY State licensed OT. A person who is NOT certified as an OTA by the OT Board of the NY State Education Department may NOT practice OT under any circumstance until such time as that certification is granted. To hire a person who is NOT certified or licensed by the OT Board would be considered an illegal practice subject to review by our Office of Professional Discipline. If you are inquiring about a licensee or certificate holder becoming "certified" as a membership of either the state or national OT organizations, those are NOT necessary to become licensed or certified.

PTA "Incident To" Billing:
Q: Can services of a physical therapy assistant be billed "incident to" a doctor's services?



A: No. The services provided by Physical Therapist Assistants (PTAs) cannot be billed incident to a physician/NonPhysician Practitioner's (NPP), because they do not meet the qualifications of a therapist. Only the services of a licensed/registered physical therapist can be billed "incident to" a physician service. PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. PTAs act at the direction and under the supervision of the treating physical therapist and in accordance with state laws. The services of the PTA are only billable when provided under the direct supervision of the physical therapist and under their National Provider Identifier (NPI) number. *Source:* http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

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

WCH Service Bureau, Inc

Our Services

- Medical Billing
- Credentialing
- Software & Website Development
- Chart Auditing
- Real Time Eligibility
- Transcription
- Remote Receptionist

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