December 2010 Volume 1, Issue 8

WCH Bulletin

Welcome back our readers!

WCH NEWS

WCH Service Bureau, Inc. would like to take this time to wish you and your family a happy holiday season! The year-end brings no greater pleasure then the opportunity to express to you our season's greetings and good wishes. May your holidays and New Year be filled with JOY. All of us at WCH join in saying Thank You and wishing you a happy holiday and a prosperous new year.

As 2010 comes to an end, we'd like to share with you just a few of the accomplishments WCH Service Bureau, Inc. has achieved:

- **WCH received Better Business Bureau (BBB) accreditation**
- **Compliance program established according to the Medicaid OMIG regulations**
- **WCH staff became Medicare Fraud and Abuse compliance certified**
- **Certified Professional Medical Auditor (CPMA) certification obtained**
- **More employees obtained Certified Professional Coding Certification**
- **Time Management Program installed in client's offices**
- **Real Time Eligibility created**
- **WCH's team of programmers successfully created several projects customized by medical offices**
- **Publication of monthly bulletin**
- **Developed an educational website (CoolSite4me.com); submitted proposal to City BID to be used in public school education**

Marcia B. Smith, Esq. Has helped many WCH clients with reinstatement of their provider IDs in NY State, assisted DMEs to add shoes category to their Medicaid file, and other healthcare related legal issues. If you need assistance in any of the above, you may contact her at 518-462-3000; msmith@icrh.com;
you can also visit her blog at:
www.healthcareintegrationadvisors.com/

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

ACCREDITED BUSINESS

American Academy of Professional Coders

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

National Association of Healthcare Consultants

Member of AMBA American Medical Billing Association

EMPIRE WHO'S WHO

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

Inside this issue:

CPMA on Staff at WCH Service Bureau!

WCH is committed in providing our clients with professional and reliable services. Our staff is working hard to accomplish these results. WCH Service Bureau, Inc. congratulates Oksana Pokoyeva, CPC with advancing her career by passing the Certified Professional Medical Auditor, CPMA certification examination.

Certified Professional Medical Auditing performs based on the knowledge of:

- Compliance and Regulatory Guideline Knowledge
- Coding Concepts
- Scope and Statistical Sampling Methodologies
- Medical Record Auditing Skills and Abstraction Ability
- Quality Assurance and Risk Analysis
- Communication of Results and Finding
- The Medical Record

WCH Services and How They Can Benefit You

Medical Billing: process of submitting and following up on claims to insurance companies and other payers in order to receive payment for services rendered by a healthcare provider.

Benefits of trusting WCH with your Medical Bill

- 10 years of experience
- Certified professional coders on staff
- Maximize your cash flow
- Receive 98% -100% reimbursement rate
- Every eligible covered insurance claim will be paid: That's a guarantee!
- Rigorous collection process
- Free software allows full control from the client

Credentialing: process of establishing the qualifications of licensed professionals, organizational members or organizations, and assessing their background and legitimacy

Benefits of credentialing with WCH:

- 10 years of experience
- Enrollment complete in shortest amount of time
- Estimated relationship with insurance reps
- Eliminating client of hassling paperwork and follow-up calls
- Through monitoring until provider becomes panel member

- Tri-weekly reports of ongoing status

We specialize in: Independent Diagnostic Testing Facility (IDTF); Durable Medical Supply (DME); Pharmacies; Multi-Specialty Groups; Laboratories; Solo Groups and Physician Groups; Civil Surgeons; Individual contracts (all specialties); Transportation Companies; Early Intervention Agency (EIA); Home Health Agency(HHA) Already credentialed? – WCH can also help you with re-credentialing, adding/removing you tax ID, location update, and many other application related things

IT Support: With today's fast paste technological society, it is important to be up to date and enhance your everyday work with technology. WCH offers many different technical support options for providers. We offer our own ready-made software to decrease your daily task efforts, as well as creating custom business software which will meet your work and life-style.

Benefits of getting technical support from WCH:

- Long time experience
- Programmers with Master Degrees
- Fast and reliable service, with references
- Well-minded professionals which can help minimize your workload with technology!
- A relentless commitment to quality, service, and customer satisfaction, and excel in the innovation, ease of use, and utility of our products and services

Chart Auditing: 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.

Benefits of auditing your charts with WCH:

- Ensure that your charts are error free
- Prevent losing money
- Stay focused on your patients health, while we take care of their charts
- AAPC: Certified Professional Coders, and Certified Professional Medical Auditors on staff

NEW: Transcription Services: Are you looking for more time at the end of the day? If so, stop wasting time writing medical notes, and rely of WCH to transcribe your voice recording of medical notes into writing and in digital format.

Benefits of providing transcription with WCH:

- Fast and efficient service
- Accurate transcription from your recordings
- References available

You may visit us on the web for more detailed information on the services we offer, or contact us at (718) 934-6714

WCH Account Representatives are Compliance Certified

In an effort to fight fraud, waste and abuse (FWA), the Centers for Medicare & Medicaid Services (CMS) require providers who treat Medicare Advantage members to complete annual fraud, waste and abuse compliance training. Here at WCH we took the liberty to undergo the compliance training. The training course was followed with a completion of an online exam. We are proud to announce that the following account representative have obtained their compliance certification:

- Ilana Kozak
- Victoria Uzakova
- Oksana Pokoyeva, CPC, CPMA
- Olya Sin
- Svetlana Skosirsky
- Nataliya Leontyeva
- Ekaterina Sobakina
- Olga Mirolyubova, CPC
- Elizaveta Bannova
- Nadya Khryukina
- Mariya Lihina
- Maria Radzivlyuk
- Adelya Salikhova

The compliance training indicates that WCH account representatives:

- Recognize laws and concepts affecting compliance and fraud, waste, and abuse (FWA)
- Increase awareness of FWA
- Use identification techniques in the work environment

WCH's EHR Software

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 Health Records do not render paper obsolete, but they certainly do reduce needed paper significantly. Another advantages of Electronic Health Records are the ability for different health care providers to coordinate care, to improve quality of care and patient safety; huge potential for cost savings and decreasing workplace inefficiencies and many more. 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. The implementation of electronic medical records can save lives as quick access to patients records can be lifesaving if an emergency occurs and answers to those questions are needed during the emergency decision-making process. Since electronic records have been used in billing, the process has been streamlined to save time, money and efforts.

WCH's EHR program makes access to information very easy. We invite you to participate in creating an interface as user friendly as possible. We appreciate all of your suggestions.

<u>Modules our EHR program includes:</u>

- Medical Records: Drug List, Allergies, Immunizations, Medical History, Problems, Instructions
- Demographic information
- Progress notes
- E-Prescribing
- Eligibility
- Laboratories
- Reporting System
- Patient Panel
- Messages System
- Appointments System

<u>Other options in WCH's EHR:</u>

- Drug List contains list of drugs that was assigned to patient and tools for adding, removing and deleting.
- Medical History contains list of diagnosis that was assigned to patient and tools for adding, removing and deleting.
- List of critical information (for example diagnosis like diabetes) about patient and tools for adding, removing and editing.
- Information about patient's allergies and tools for manage its. In Rx. System shows alerts about drug allergies.
- List of patient's immunization and tools for manage its.
- List of Instruction given by doctor to patient.
- Patient's information with editing function.
- Progress notes consist of two parts: list of entered documents and form for filling data during patient's visit.
- This module allows you to create electronic prescriptions and send them through the SureScripts
- Using this module you can manage list of appointments
- Functionality for managing tasks. It allows to follow status of task, assigns it, controls due dates.

Claim Editing for Ordering/Referring Providers Delayed Until Further Notice

Breaking News! On November 24, 2010, the Centers for Medicare & Medicaid Services (CMS) announced that the automated edits will not be turned on to deny claims effective January 3, 2011. CMS had previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid (Phase 2 implementation of the new edits). They are working diligently to resolve enrollment backlogs and other system issues and will provide ample advanced notice to the provider and beneficiary communities before they begin any automatic nonpayment actions. At this time, there is no target date for Phase 2 implementation of the new ordering/referring edits. Contractors have been instructed to continue to process claims according to Phase 1 guidelines, where if a claim fails the edits, a warning message will appear on the rendering provider's remittance advice.

Source of information obtained from: Andrea G. Freibauer, Consultant at Medicare Provider Outreach & Education, Medicare Part B, NGS

Timely Claims Filing Requirement Reminder

As a result of the Patient Protection and Affordable Care Act (PPACA, effective immediately, all Medicare Fee-For-Service physicians, providers, and suppliers submitting claims to Medicare for payment be aware that all claims for services furnished on or after Jan 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service or Medicare will deny those claims. If you have Medicare Fee-For-Service claims with service dates from January 1, 2009 through December 31, 2009, those claims MUST be filed by December 31, 2010, or Medicare will deny those claims.

Source of information obtained from: http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf

Billing of New Q Codes for 2010-2011 Seasonal Influenza Vaccines for Medicare Fee for Service Providers

The Centers for Medicare and Medicaid Services (CMS) has created specific HCPCS codes and payment rates for Medicare billing purposes for the 2010-2011 influenza season.

Effective for claims with dates of service on or after January 1, 2011, CPT code 90658 will no longer be payable by Medicare. Effective for dates of service on or after October 1, 2010, the following new influenza Q codes will be payable by Medicare: Q2035 (Afluria), Q2036 (Flulaval), Q2037 (Fluvirin), Q2038 (Fluzone), and Q2039 (Not Otherwise Specified flu vaccine).

Physicians, other practitioners, and suppliers may submit their claims with the new influenza Q codes on an individual basis or via the roster billing process. CMS has instructed Medicare contractors to hold all claims containing the influenza Q codes with dates of service on or after October 1, 2010, until their systems are able to accept them for processing. The Medicare contractors' systems will be ready to process claims containing the Q codes no later than February 7, 2011. Physicians, other practitioners, and suppliers also have the option to hold their claims containing the new influenza Q codes until February 7, 2011. For further information, please see Transmittal 815, Change Request 7234, issued on November 19, 2010.

Source of information obtained from: http://www.cms.gov/MLNMattersArticles/downloads/MM7234.pdf

The "Physician Payment and Therapy Relief Act of 2010" Extends 2.2 Percent Medicare Physician Fee Schedule Update

On Tuesday, November 30, 2010, President Obama signed into law, "The Physician Payment and Therapy Relief Act of 2010." This law extends through Friday, December 31, 2010, the 2.2 percent update to the Medicare Physician Fee Schedule (MPFS) that has been in effect for MPFS claims with dates of service of Tuesday, June 1, 2010, through Tuesday, November 30, 2010. Payments for 2010 services under the MPFS will continue without delay. Please watch your listservs and your contractor's website for more information, should Congressional action prevent the 2011 negative update from going into effect on Saturday, January 1, 2011.

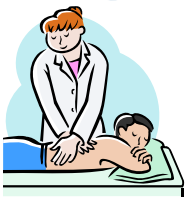
Source of information obtained from: https://www.highmarkmedicareservices.com/mailinglists.html

2011 Payment Policies and Rates

Barring Congressional intervention, the final rule reduces payment rates for physicians' services under the Sustainable Growth Rate (SGR) formula. These payment rates are currently scheduled to be reduced under the SGR system on Dec. 1, 2010, and then again on Jan. 1, 2011. The total reduction in MPFS rates between November 2010 and January 2011 under the SGR system is 24.9 percent. "While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical," CMS states in the final rule. "We are committed to permanently reforming the Medicare payment formula." Meanwhile, for 2011, the MPFS conversion factor is $25.5217; and the national average anesthesia conversion factor is $15.8085. CMS also is rebasing and revising the Medicare Economic Index (MEI) to use a 2006 base year in place

of a 2000 base year. Specifically, CMS is not making an adjustment directly to the work relative value units (RVUs), but is instead increasing the PE RVUs by an adjustment factor of 1.181 and the malpractice RVUs by an adjustment factor of 1.358.
Source of information obtained from: http://www.ngsmedicare.com/wps/portal/ngsmedicare

Therapy Caps



We've mentioned it in our previous bulletin, but just as a reminder, we wanted to share this information with you again: 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.ngsmedicare.com/wps/portal/ngsmedicare

Incentive Payment Program for Primary Care Services, Section 5501(a) of The Affordable Care Act

A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, who provides CPT codes 99201 through 99215 for new and established patient office or other outpatient Evaluation and Management (E/M) visits for primary care services furnished on or after January 1, 2011 and before January 1, 2016, will receive a 10 percent incentive payment for services provided to primary care practitioners, identified as:

1. In the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or

2. In the case of non-physician practitioners, enrolled in Medicare with a primary care specialty designation of 50-Nurse
CMS will provide Medicare contractors with a list of the National Provider Identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments. Practitioner, 89-certified Clinical Nurse Specialist, or 97-Physician Assistant; and

3. For whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the PFS for such practitioner during the time period that has been specified by the Secretary.
Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP.
Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data 2 years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.
Source of information obtained from: MM7060 – Incentive Payment Program for Primary Care Services, Section 5501(a) of The Affordable Care Act

Home Health Face-to-Face Encounter; A New Home Health Certification Requirement

A new Medicare home health law goes into effect on January 1st that affirms the role of the physician as the person who orders home health care based on personal examination of the patient. Effective in January, a physician who certifies a patient as eligible for Medicare home health services must see the patient. The law also allows the requirement to be satisfied if a non-physician practitioner (NPP) sees the patient, when the NPP is working for or in collaboration with the physician.

As part of the certification form itself, or as an addendum to it, the physician must document that the physician or NPP saw the patient, and document how the patient's clinical condition supports a homebound status and need for skilled services. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care. While the long-standing requirement for physicians to order and certify the need for home health remains unchanged, this new requirement assures that the physician's order is based on current knowledge of the patient's condition.
Source of information obtained from: http://www.cms.gov/center/hha.asp

Americhoice by UnitedHealthcare: Changing Their Name

Effective January 1, 2011 Americhoice is changing their name to UnitedHealthcare Community Plan. However, all coverage information plans and reimbursement will remain the same. After January 1, your patients will begin receiving new ID cards, please be aware even though the patients

have received new cards, it is still very important to check eligibility and obtain authorization if needed.

ValueOptions: Provider Connect and ValueOptions.com Helpful Hints

You can find many helpful tools on the Provider section on the www.valueoptions.com website. You will find things like: provider handbooks, provider forms, provider newsletter and news, network specific information, and ProviderConnect helpful resources.

You can register and log into the interactive provider portal, ProviderConnect. On ProviderConnect providers can: view member information, authorizations and claim information, enter authorizations, view recent provider summary vouchers, update "My Practice Information" by sending a ProviderConnect inquiry, and contact ValueOptions with any questions/concerns via s ProviderConnect Inquiry.

For specific instructions on how to register for ProviderConnect or to do any of the above ProviderConnect functions please access the ProviderConnect user guide for instructions for future use on www.valueoptions.com
Source of information obtained from: ValueOptions November Monthly eNewsletter

Technology Smartphone as a Medical Tool

Along with the traditional white coat, the stethoscope has long been a symbol of the medical profession. That diagnostic tool may be disappearing from the doctor's pocket, however, as more doctors use their smartphones instead. At the root of this shift is an application, invented by a researcher in the United Kingdom, that turns the Apple iPhone into a stethoscope. Already more that 3 million people have downloaded the free app. The stethoscope app in the "medical" section of the Apple App Store for the iPhone. Not all of these apps belong there, but some can be very useful to doctors on a day-to-day basis. Included in a "Top 10" list are apps like Epocrates, which puts a massive amount of drug information into the doctor's hands, including warnings on interactions, a pill identifier, and a medical calculators. Another app that made the list is MedPage Today Mobile, which provides up-to-the-minute medical news and even allows doctors to get CME credits.

Source of information obtained from: Green Branch Magazine | Pg. 128

Billing Expert: CoPays With No Billable Service

Question: Can we collect a copay from a patient on a postoperative follow-up visit which is not billed to the insurance?
Answer: No. You cannot collect a copay for a follow-up visit that you are not billing to the insurance company. You aren't billing the service to the payer because it is included in the postoperative care for the procedure. That means you should not be charging the patient for the visit either. Routine follow-up care is included in the surgical fee and there are no charges (including copays) to the patient for routine postoperative care during the global period.
Source of information obtained from: The Coding Institute | Oct. 2010, Pg. 78

Red Flag Program Clarification Act of 2010

The U.S. House of Representatives passed without objection, Dec. 7, the Red Flag Program Clarification Act of 2010 (S.3987). This legislation limits the type of creditors that must comply with the often-delayed Red Flags Rule. The Senate unanimously passed the bill on Nov. 30. Under the bill, physicians are no longer considered creditors and are exempt from the Red Flags Rule requirements. "We're pleased Congress clarified its law, which was clearly overbroad," Federal Trade Commission (FTC) Chairman Jon Leibowitz said in a Dec. 8 statement.
The Red Flags Rule, scheduled to take effect Jan. 1, 2011, requires many businesses and organizations to implement a written Identity Theft Prevention Program designed to detect the warning signs — or "red flags" — of identity theft in their day-to-day operations. The way the rule was written, physicians who did not require payment in full at the time of service would be considered creditors and would have to comply with the rule.

This inclusion in the rule did not bode well with the health care industry. The American Medical Association (AMA) and other physician groups filed a lawsuit to get the FTC to permanently remove physicians from the scope of the Red Flags Rule.
At the request of several members of Congress, the FTC further delayed enforcement of the Red Flags Rule through Dec. 31, while Congress considered legislation that would affect the scope of entities covered by the rule.

The Red Flag Program Clarification Act of 2010 amends the Fair Credit Reporting Act to exclude from the definition of creditor "any creditor that advances funds on behalf of a person for expenses incidental to a service the creditor provides to that person."
President Obama is expected to sign the bill before the Jan. 1, 2011 deadline.
Source of information obtained from: http://news.aapc.com/index.php/2010/12/physicians-are-not-creditors-congress-says/

President Obama Signs the Medicare and Medicaid Extenders Act of 2010

New Law Includes SGR Fix through December 2011

On December 15, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. CMS is pleased that this law has addressed key issues for beneficiaries and providers and we are actively engaged in implementing these changes.

Below are technical summaries of key provisions of the MMEA along with some information about how these changes may affect providers and provider billing.

Physician Payment Update: Prevents a payment cut for physicians that would have taken effect on 01/01/11. While the physician fee schedule update will be zero percent, other changes to the relative value units (RVUs) used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2011. CMS is currently developing the 2011 Medicare physician fee schedule (MPFS) to implement the zero percent update, and we expect all 2011 claims to be processed timely, in compliance with the new legislation.

Extension of Medicare Physician Work Geographic Adjustment Floor: Current law requires payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 103 of the MMEA extends the existing 1.0 floor on the "physician work" geographic practice cost index, through December 31, 2011. As with the physician payment update, this change will be accomplished through a revised 2011 MPFS.

Extension of Physician Fee Schedule Mental Health Add-On Payments: For calendar year 2010, certain mental health services' payment rates continued to be increased by five percent. Section 107 of the MMEA extends the five percent increase in payments for these mental health services, through December 31, 2011. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2011 MPFS.

Extension of Exceptions Process for Medicare Therapy Caps: Section 104 of the MMEA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011. The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Extension of Moratorium On Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients: Independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Repeal of the Delay of RUG-IV: Section 202 of the MMEA repeals the delay of the Skilled Nursing Facility (SNF) PPS RUG-IV classification system. Therefore, RUG- IV will continue to remain in effect from October 1, 2010, as previously implemented by the final SNF payment regulation for FY 2011. All claims processing activities shall proceed in accordance with the existing instructions.

Please be on the alert for more information pertaining to the MMEA of 2010. Finally, as a reminder, beginning on January 3, 2011, eligible professionals, eligible hospitals, and critical access hospitals can register for the Medicare and Medicaid Electronic Health Records Incentive Programs. For more information, please visit the website at www.cms.gov/EHRIncentivePrograms.

Source of information obtained from: www.cms.gov

Our upcoming WCH Times publication will include a detailed journey throughout our last decade, as we celebrate WCH Service Bureau. Inc's ten year anniversary. We look forward to sharing our exciting journey with you!

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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