June 2010 Volume 1, Issue 4

WCH Bulletin

Welcome back our readers!

WCH HAS A NEW EDGE — WE'VE UPDATED OUR WEBSITE, CHECK US OUT!

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

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

National Association of Healthcare Consultants

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

IDFT Credentialing

WCH Service Bureau, Inc is a company that specializes in Provider Credentialing. Providing credentialing services over ten years, our company knows and understands the rules and regulations of different insurance organizations and their unique credentialing requirements. We have been using our knowledge and expertise in helping IDTF's become participating providers with Health Insurance Companies.

We are aware of the high demand for them, but unfortunately the HMO plans are refusing to enroll them in their network. These Department have determined the requirements for companies who provide services as IDTF's are struggling to become credentialed with HMO's. There has been some research done by WCH, and based on the Center for Medicare and Medicaid Services (CMS) and the New York State Education Independent Diagnostic Testing Facilities (IDTF) as described by the Federal Regulations. In summary, a company that performs only the Technical Component of diagnostic service and neither does not conduct the Professional Component nor does "Practices Medicine" in the conducting of these tests require no license for this service; under Article 28 of the Public Health Law from the New York State Department of Health.

Currently, we are pursuing HMO networks in effort to open contracting opportunity for IDTF providers. We are targeting contracting and network development managers to discuss the possibility of opening IDTF panel. We are also working with our local congressman in effort to change the acceptance of IDTF into the network. In the upcoming publications we will be notifying you about our progress. If you are an IDTF facility we welcome you aboard our journey to take stand for IDTF together.

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Highmark Medicare Services Enrollment Q&A

1. When should I report a change in my enrollment information?
Change of ownership, final adverse action, and change in practice location must be reported within 30 days; all other information must be reported within 90 days.

2. How is the Medicare effective date determined?
The date of filing of a Medicare enrollment application that is able to be processed to approval. The date of filing for paper applications is the date the contractor receives a signed application. The date of filing for Internet-based PECOS applications is the date the contractor receives an electronic version of the enrollment applications and a signed certification statement.

Or

The date an enrolled physician or non-physician practitioner first started furnishing services at a new location. In addition, the previously identified physicians and non-physician practitioners who meet all program requirements may bill retrospectively.

- For services furnished up to 30 days prior to the effective date, rather than the maximum of 23 months allowed under prior regulations; and
- For services furnished up to 90 prior of the effective date if the President has declared an emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act

3. My provider number has been deactivated. What does this mean, and what do I need to do to re-enroll?
Contractors are instructed by the Centers for Medicare & Medicaid Services (CMS) to routinely search their files to identify providers that have not billed the Medicare Part B program in the prescribed time frame, and to deactivate the provider's billing status. Per Pub 100-8, chapter 10, an inactive provider is one who has not billed the Medicare program for 12 consecutive months.
Providers that have been deactivated due to inactivity should be ready to submit a valid claim when reactivating with Highmark Medicare Services. In order to reactivate billing privileges, we will require a CMS-855 application. As of January 2009, providers will receive a new PTAN when being reactivated. Providers that have been deactivated and bill electronically will also need to reactivate for electronic billing by completing the Electronic Billing Enrollment Forms. The Provider Enrollment Services Department will then notify the provider by letter once the provider is eligible to bill, and EDI Services will notify the provider by letter once the provider is eligible to begin electronic billing again. Failure to reactivate in the program will result in claim denials.

Information directly obtained from: Highmarkmedicareservices.com/faq/partb/pet provider_enrollement.html

Physical Therapy Non-Licensed Personnel

All physical therapist must be aware that non-licensed personnel titled as physical therapy aides are not recognized by the New York State Education Department, therefore are not eligible to perform activities within the scope of practice of physical therapy. In long-term care facilities a non-licensed personnel can perform activities which include: superficial hot and cold applications, assisting with both range-of-motions exercised and exercises to maintain strength and endurance in clients without related pathology, and assisting with walking within the provision of maintenance care to residents is acceptable. However, the non-licensed individual must have received certification as Nurse Aide (CAN) and other training under the directions of a physical therapist. In other settings, the aide may provide support in physical therapy services only through non-treatment related tasks, such as: maintaining treatment areas, preparing equipment, answering telephones, gathering forms for charting, and acting as a second pair of hands for the physical therapist. Unlicensed personnel may not perform physical therapy treatment. PT and PTA student may only perform treatment when on a clinical affiliation.

"Unlicensed personnel may not perform physical therapy treatment. "

Source of information obtained from: Empire State Physical Therapy | May/June 2010, pg 13

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Attention Diagnostic Imagining Providers!

Effective July 1, 2010 Medicare contractors are scheduled to reduce the payment under the Medicare physician fee schedule for the **technical component of certain multiple diagnostic imaging procedures done is a single imaging session from 75% to 50%.**

Source of information obtained from: NGSmedicare.com/content.aspx?CatID=2&DOCID=22230

Important Facts from CMS to Help Protect Your Practice

If you are closing, relocating, change status, or change members of a group, you are required to contact the Medicare contractor to update your records within 30 days of the change. You can find information of the enrollment process, Internet-based Provider Enrollment, Chain and Ownership system, adding/deleting group members, or change to address on: www.cms.hhs.gov/MedicareProviderSupEnroll. Individual provider should also notify Medicare as soon as reassignment agreements are terminated, since failure to do so allows the previous entity to continue billing Medicare. To terminate a reassignment agreement a completion and submission of the CMS-855R is required.

Source of information obtain from: "Protecting Your Practice" Brochure by CMS

Pre-Audit Check List

1. Pull all encounters that have been selected for audit with all of the accompanying documentation.
2. I you believe there may be a problem with your claims or how they were billed, contact an attorney to help you through the audit process. If not, move to step 4.
3. Perform an internal audit of the claims and if necessary, hire an external auditor to also review the claims.
4. If there is a problem, do not alter documentation, alter billing records, destroy records, or in any other way compromise the information.

Source of information obtained from: Part B Insider | Vol. 11, no. 15, pg 115

Insurers Required to Stop Using Ingenix Databases to Price Out-of-Network Claims

The American Medical Association (AMA) and several other state medical societies have filed suits against insurers that used databases from Ingenix Inc. to set a price on out-of-network claims. Insurers including UnitedHealth Group, Aetna, Cinga, and Wellpoint have suits filled against them. **It is conspired that these insurers have underpaid physicians for out-of-network claims for over 15 years**. There are now at least 10 national or regional insurers that have agreed with New York Attorney General, Andrew Cuomo, to quit using Ingenix databases and contribute a total of nearly $100 million to fund the creation of an independent national database to process out-of-network claims. AMA has set up a website to help physicians file claims against insurer, UnitedHealth Group. The deadline to file a claims to share in the UHG fund it Oct. 5.

Source of information obtained from: Health Data Management | June 2010, pg 8

NY MEDICAID UPDATES

DURABLE MEDICAL EQUIPMENT

NY Medicaid policy requires that each newly enrolled DME provider be a fully operational walk-in business that is open to the public and staffed with trained personnel capable of providing the proper fitting, demonstration, and services of the supplies available to Medicaid beneficiaries. The DME provider must conduct business before being enrolled in Medicaid, have a storefront with an indication that the business is open, operate during normal business hours, clearly display items provided, and allow handicapped access to the store. Also, effective January 1, 2011 enrolled DME providers that relocate their service address must ensure that the new address is fully operational walk-in store with all the criteria mentioned above, if it does not, it will be considered non-compliant and will be terminated from NY Medicaid.

AUTOMATIC REFILLS UPDATE

Automatic refill programs offered by pharmacies are NOT an option for Medicaid beneficiaries. Automatic refilling of prescriptions/orders for prescription drugs, over the counter products, medical surgical supplies, and internal products are NOT allowed under New York State Medicaid. A request for a refill and provider inquiry, in which the provider initiates contact with a Medicaid beneficiary to determine if a refill is necessary is allowed.

NEW EDIT CODE IMPLEMENTED

Effective May 27, 2010, Medicaid implemented edit 000528 "Missing or invalid quantity dispensed". This edit will ensure that prescription drugs are reimbursed according to appropriate packaging and unit of use quantities. This edit will deny claims when the dispensed quantity submitted does not correspond with drug package size, or unit of decimal quantity.

WCH is now offering chart coding and auditing services.
Let our Certified Professional Coders do you chart coding and auditing at an affordable $27 per hour. Please contact WCH management for more information.

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

WCH Service Bureau, Inc

Medicare Time Filling Period.

***Claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service**

***Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010**

WCH Service Bureau,
3047 Avenue U
Brooklyn, NY 11229
Phone: (718) 934-6714
Fax: (718) 504-6072
E-mail: wch@wchsb.com

Visit us on the web:
WWW.WCHSB.COM