WCH TIMES

Winter/Spring 2008 Volume 05

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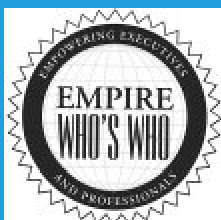

Dear Doctors and Office Managers,

Welcome to another edition of WCH TIMES !

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

Enjoy our Newsletter!

Inside this Issue

WCH Corner

Continuing Our Journey....................................2
Credentialing application program....................................3
Let's Talk More....................................3
Top 10 Ways You Can Help Us....................................3
Importance of Correct Coding on Your Superbills 4

Insurance News:

Brief Updates by Insurance 4-5
Medicare Update....................................6-7
GHI Medicare Replacement....................................7
Medicaid Update....................................7-8

Coding News:

Psychologist Billing & Coding....................................8
Understanding coding concepts....................................8-9
Incident to Service....................................9-10
How to Bill for Missed Appointments....................................10
History of Development of ICD....................................10
Criminal and Civil Liability....................................10-11

WCH Feedback Form for your comments....................................12

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

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WCH Corner

Continuing Our Journey:

As we all had transitioned into the new year, WCH achieved many successful accomplishments and future goals to report to our clients. We had ended 2007 with several completed tasks which had allowed us to continue to grow and spread our services for the upcoming year.

WCH Time Line

2007

- Registered with New Jersey State Department of Banking & Insurances as a billing service vendor
- Obtained copyrights for WCH Patient Management and Billing Operations Software
- Finalizing Development of Credentialing Application Program that will allow providers to populate multi insurance application with one click
- Modified & Tested WCH practice management software to be NPI compliant before the given dateline of May 2008
- Majority of WCH clients installed WCH Practice Management and Billing Operations Software in their office for appointment scheduling or claims view

Our expectations

2008

- In process of obtaining copyrights for Time Management Software, which allows tracking of employees work time and salary
- Implementing similar strategy as the CAQH credentialing application and initiating contracts with insurance company to use our software
- In process of becoming Certified Professional Medical Services Management (CPMSM) & Certified Provider Credentialing Specialist (CPCS) through NAMSS.
- Certify WCH Patient Management and Billing Operations Software with Certification Commission for Healthcare Information Technology
- Design Electronic Health Records Software Structure
- Begin to prepare WCH Medical Billers for testing to become certified by American Academy of Professional Coders. As a Professional Coder WCH would be able to stay on the coding edge by knowing answers to your coding questions and providing expert support through your medical career.

WCH would like to express sincere appreciation to everyone that had helped us become the company we are today.

Thank you for standing by our side as we stand by you.

Credentialing Application Program:

WCH Credentialing Program (secured) eliminates the need for the healthcare provider to complete multiple insurance applications. From our vast years of experience in the healthcare industry we know that the importance of credentialing lies in correct submission of application, necessary paperwork and tracking the application along the enrollment process at the insurance side. In itself the process of credentialing is time consuming and requires a lot of patience, specific knowledge and time which not many practitioners have always available. Our credentialing application is the most efficient and qualified to handle credentialing need of any provider. WCH credentialing application allows providers to consolidate their professional information into one unique profile that duplicates the information on the insurance applications. Let WCH application take care of your credentialing headaches!

For more information and billing plans, please contact our credentialing manager Olga Khabinskay via email olgak@wchsb.com.

Let's Talk More:

Thanks to internet and smart phones / blackberries communication is continuing to thrive. Since many of our clients contact us about patient insurance changes, their account review and another question that might arise. We have decided to implement a monthly overview of clients account in the format of a letter. Once a month our office manager will release a letter for each account pointing out good points and explaining the areas that need improvement. This type of communication will allow our clients to be familiar with their account from the billing prospective in more depth. We hope this type of communication will increase your reimbursement level and improve our daily work flow with your account.

Top 10 Ways You Can Help Us:

I. Please, provide us with all copies of the correspondence and EOB's that you receive from insurance companies, which would save a lot of time and communication flow. Do not fax, make copies and send either with a driver or by mail.

II. Provide us with copies of the front and the back of all patients' insurance cards.

III. Make sure all patients complete all demographic information, including zip code.

IV. Please review most common reasons why super bills are returned and try to avoid this in the future.

V. Sort your super bills by dates of service, and attach them to appointment sheets.

VI. Try to separate your responds to previous requests and new super bills for easier tracking.

VII. Provide us with all authorization information that you obtain for patients.

VIII. Prepare all your questions and ask them at once, or write them down and send them by fax, Allow us at least 24 hours to respond.

IX. Please familiarize yourself with Medicare web-site which can provide you with medical policies and guidelines for your specialties:

http://www.empiremedicare.com/partbny/partbny_lcd.cfm

X. Please return WCH completed surveys about our performance, we value your opinion and recommendations.

Importance of Correct Coding on Your Superbills:

ERA and EFT are not the new terms for providers since a lot of insurance companies offer these options right now. ERA stands for Electronic Remittance Advice which is an explanation of benefits in electronic format. EFT is Electronic Fund Transfer which lets providers receive payments directly to their bank accounts. It is very time consuming for WCH employees to post paper EOBs into WCH software as well as it increases the amount of human errors. Therefore in order to eliminate all these and provide accurate information we encourage all providers to sign up for EFT and ERA. Both of these options save not only time and cost, but also protect providers from losing paper EOBs and checks.

We would like to bring your attention to the most common reasons why your payments are getting delayed. One of them is missing patient information, which should always include full demographic information, copy of the insurance card (front and back). Please make sure patient puts correct DOB and full home address including zip code. **Missing DOS, proper diagnosis codes, anatomical sites, doctor's name and signature are the most frequent reasons why the superbills get returned to the office with requests for additional information**. We do try to submit the requests every week and it does happen sometimes that you may receive duplicates. However, when you are replying to our requests please read carefully what we are requesting and if it is still not clear always feel free to contact us.

When choosing proper diagnosis codes providers should follow not only medical necessity reasons, but also insurance guidelines which describe the conditions for which certain procedures are payable. If you receive a request from us for proper diagnosis it means that insurance company will not pay for the procedure with provided diagnosis. Your options are either find the one that is payable and corresponds to the patient's condition or provide us with medical documentation that could be send to the insurance career to prove medical necessity.

If it happens that you put incorrect procedures or diagnosis on the superbill please make sure you take new superbill and include correct information. The incorrect superbill should be destroyed. WCH is always providing you with correct coding information. We value our title Service Bureau granted to us by the New York State Department of Health and take responsibly for our professionalism. We work strictly with state and CMS guidelines to provide you with the most resourceful information for your practice.

Insurance News

AmeriChoice By United Healthcare:

Effective January 1, 2008 AmeriChoice became AmeriChoice by United Healthcare. The new name includes all Americhoice plans: Medicaid, Family Health Plus, Child Health Plus, and Medicare.

Here is an outline of the changes taken place after the merge of two networks:

- Americhoice provider id was replaced by United Healthcare id effective on all claims, authorizations, referrals or any other documentation on or after date of service January 1, 2008. Stop using your Americhoice provider id.
- After January 1, 2008, all Americhoice patients were issued new member id cards
- Early 2008, all United Healthcare members received new id cards
- Mental Health: The new plan is being managed by United Behavioral Health (UBH). The new member cards will reflect contact information on the back
- Prior-authorizations for mental health could be obtained through UBH web-site: https://www.ubhonline.com/login/login.jsp. UBH won't have any information on authorizations that were received in 2007.

Pharmacy benefits: The new plan pharmacy benefits are managed by Medco, except Medicaid, which is provided by the New York State.

Why did they consolidate?

Both companies wanted to deliver higher level of service to you and your patients. By combining effort it seems that this merge is beneficial for both plans and its members. We have a long way to go until we can establish a smooth process of submitting claims, timely credentialing process and ensure the highest quality of service for everyone.

Empire Plan Network:

For many of you Empire Plan has been very common name in the office. But for some providers Empire Plan seems to be a new insurance plan. We would like to inform you that Empire Plan originated from United Healthcare Network. It is similar patient and provider benefits as other United Healthcare plans. If some of you are not sure if you are a participating provider with the Empire Plan, it's important for you to contact them at 877-769-7447 or reach them online at www.empireplanproviders.com . Please do not assume that if you are accepting United Healthcare you are automatically enrolled in the Empire Plan. Credentialing is necessary for enrollment into the plan.

Physical Medicine and Rehabilitation (PM&R):

- Physical Therapy is process by Managed Physical Network (MPN) and prior-authorization is required, to obtain more information you can contact them at 877-769-7447 (choose option 1-1)
- UHC/Empire plan follows reimbursement guidelines established by CMS. The most common guidelines are: 97010 (application of hot/cold packs) is not separately reimbursed; such modalities as 97012, 97016-97028 are not time based, therefore insurance will cover only one unit per day, regardless of the number of body regions treated. For more information you can contact WCH.
- Be Sure to Identify Physician Who Actually Performed Services:
- UHC requires the name of the physician who rendered the service even if that patient usually sees another provider in the group in order to process the claim in accordance with patient's benefits.
- For unmarried dependent students age 19 and older, UHC requires of full-time student status verification each semester. For the services rendered during summer/winter breaks, UHC will require information for semesters prior and after the break. Please make sure your patents submit the information on a timely manner in order to avoid the delay in claims processing.

Source of information obtained from United Healthcare Empire Plan Network Bulleting December 2007.

Empire Blue Cross Blue Shield:

As of January 1, 2008 Empire BC/BS started processing mental health claims through its own mental health department, prior to that Magellan was in charge for that. One of the advantages was elimination of the need to obtain authorization for the first 12 routine mental health and substance abuse outpatient visits each calendar year for in-network providers. A routine outpatient visit is defined as an individual, group or family therapy visit. The authorization is required prior to the 13th visit, so an Outpatient Treatment Report (OTR) should be submitted prior to the 13th visit. This policy does not apply to out-of-network providers, inpatient treatment services and psychological testing.

Credentialing is no longer required for certain specialties:

Such specialties include Acupuncturists, Dietitians, Deontologists, Speech Therapists, Radiologists, and Anesthesiologists.

You can communicate with your patients online and get compensated for it:

As of 2008 Empire HMO plan offers the opportunity to receive certain services through online web Visit powered by RelayHealth. It will let you generate additional $25 per web Visit, decrease amount of phone calls and increase patient satisfaction. Patients will be able to receive e-referrals, access e-Rx for new prescriptions and refills and schedule appointments. In order to receive more information and get started log in relayhealth.com, click on providers/online services.

Source of information obtained from Empire Blue Cross Blue Shield Newsletter, Winter 2007.

Metro Plus:

On October 15, 2007 CMS approved Metro Plus to provide managed care coverage to Medicare beneficiaries in the New York City boroughs of Manhattan, Brooklyn, Bronx and Queens. Metro Plus provides access to health care services through New York State's Medicaid Managed Care, Child Health Plus, Family Health Plus and Partnership in Care, an HIV Special Needs Program through its network of participating providers. Therefore we encourage providers to become a part of Metro Plus.

Source of information obtained from http://www.metroplus.org/providers.php

1199 NBF

As of 2008 there were two major changes in regards to 1199 patients.

As of January 1, 2008 1199NBF issued insurance card with new 10-digit numbers, instead of patient's SSN. Be sure to ask your patients for the new cards. By January 3, all claims should be sent with new IDs.

As of April 1, 2008 claims for patients with Home Care Benefit Plan will be handled by Fidelis Care. These patients are supposed to receive insurance cards with new ID from Fidelis Care. Providers should join Fidelis Care network in order to continue treating these patients. Under the Family Health Plus and Child Health Plus Program, the Outpatient Mental health and Outpatient Substance Abuse benefits are combined and include up to 60 visits per calendar year for in-network providers.

Source of information obtained from 1199 SEIU Provider Connections Fall 2007

Medicare Updates:

Medicare Premiums, Deductibles for 2008:

Here are some Medicare updates for 2008:

Medicare Part B premium is $ 96.40;

Deductible is $ 135.00;

Physical/speech therapy cap is $ 1740.00;

Occupational therapy cap is $ 1740.00.

Evaluation & Management Guidelines:

Findings from the Comprehensive Error Rate Testing (CERT) program continue to show that Evaluation & Management (E&M) services make up the most significant portion of errors. The documentation of the visit in the medical record, when reviewed, does not support the code billed; providers are incorrectly coding and billing E&M services.

Medicare offers Comparative Distributions Reports (CDRs) that would show how a provider uses certain E/M codes compared to the doctors with the same specialty within the same group. The report can be requested online:

http://www.empiremedicare.com/partbny/lpet/cdrform.htm

Moreover Medicare is currently offering teleconferences on Evaluation and Management Documentation guidelines. In order to register for the conference call please fill out the request form:

http://www.empiremedicare.com/seminar/partbny/evalandmanage_ny.htm

TeleHealth Services:

Please be informed that CMS determined that the use of certain telecommunications system may substitute for a face-to-face encounter for such procedures as consultation, office visits, individual psychotherapy, pharmacology management, psychiatric diagnostic interview examination and neurobehavioral status exam. However, in order to be eligible for reimbursement originating sites must be located in either a non- Metropolitan Statistical Area (non-MSA) county or rural Health Professional Shortage Area (HPSA)

Medicare Physician Fee Schedule update is effective as of July 1, 2008:

Medicare Physician Fee Schedule is based on certain criteria, such as: relative value units (RVUs, which include level of time and work performed by a physician, practice and malpractice expenses), conversion factor (CF, which is determined by a geographic area), and geographic practice code indices (GPCI). As of July 1, 2008 CF will be changed from $38.0870 to $34.0682, which will be followed by the decrease in the Medicare physician fee schedule by 10.6% below current levels. Moreover, as of January 1, 2009 CMS estimates the decline by 15.4% below current level. However, don't be frightened because Congress is currently on a Medicare package that would block the cuts. Medicare is pursuing the goal to become an active purchaser of high-quality care instead of being passive payer. Some tools that Medicare uses for that are Physician Quality Reporting Initiative (PQRI) and implementation of "structural measures" for electronic health record systems.

Do not report SSN on NPI registry website in "Other Provider Identification Numbers":

CMS mentioned that some providers report their SSN's as provider IDs on the NPI registry website. As far as that information is publicly available, please make sure you do not report your SSN.

Electronic Health Records (EHR) Demonstration:

In order to foster implementation and adoption of EHR CMS is launching EHR Demonstration, which will last 5 years. CMS will recruit up to 1,200 primary care practices in 12 communities/states/geographical areas in 2008 and 2009. Incentive payment will be provided to participating practices. However, as far as CMS is already conducts some other projects in the state of NY, NY providers are excluded from HER Demonstration.

For more information go to: http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/2008_Electronic_Health_Records_Demonstration.pdf

Medicare claim review programs:

Please be aware that currently Medicare has five claim review programs in order to prevent and recoup improper payments and make sure that claims do comply with Medicare coverage, coding, billing and payment guidelines. Some reviews are done automatically by the system analyzing proper units billed, proper anatomical sites and bundling rules. Some reviews are performed on a manual basis, which more often might be followed by the request for medical records. As far as Medicare costs for processing claims increase every year Medicare now pays a close attention to resubmitted and duplicate claims.

Preventive Services:

Once again we would like to remind you about Medicare Preventive Services, which would help providers not only prevent or detect the early disease stage, but also increase practice's earnings. Because coverage of preventive care services with private payers is so varied, many providers perform the services by avoid billing them as not sure if they get paid. However, Medicare generously covers preventive care services. More information on covered services, rules and guidelines is available on the CMS website: http://www.cms.hhs.gov/home/medicare.asp as well as brochures are available by mail.

Please be advised that Medicare covers diabetic screening tests twice a year, not less then 6 months apart for beneficiaries that are at high risk for diabetes. Diabetic Screening tests include: blood glucose test (except reagent strip); glucose, post-glucose dose; and glucose tolerance test. Medicare also covers such diabetic supplies as blood glucose self-testing equipment, therapeutic shoes and inserts and insulin pumps. However a provider should be an authorized supplier by Medicare in order to get paid for it.

***Billing prolong services to Medicare*:**

Prolonged Services may only be reported with the highest code level in a code family for counseling and/or coordination based on time. It should exceed at 30 minute beyond the time for the highest level. However, that excludes time spent by office staff with the patient, or time the patient remains unaccompanied by the physician, such as the patient remains in the office for later observation or for infusion therapy. Though additional time spent does not have to be continuous, and can represent the sum of incremental periods in a given day. Keep in mind that clinical notes must reflect the exact time spent personally by the physician and the reason for the extra time must be stated or easily inferred.

GHI Medicare Replacement:

On Mach 18, 2008 National Government Services has combined Jurisdiction 13 (Queens County) as part of NGS servicing area for claim processing and provider enrollment. The cut off date for GHI Medicare claims and enrollment application is set for July 18 2008. After this date NGS will replace GHI Medicare. For all future provider questions and claims processing please contact NGS Provider Call Center 866-837-0241.

Medicaid

Medicaid informs all providers that it is their responsibility to inform Medicaid on any changes, such as ownership, tax identification number, contact information, addresses, NPI. Provider maintenance forms could be found on Medicaid website.

As per the publication of Medicaid compliance news CMS will be hiring more Medicaid integrity program contractors in order to conduct provider audits in 2008. MIP contractors go through the special learning of regulations and rules

in order to avoid incorrect findings and fighting. Once auditors identify overpayment the state notifies providers and has 60 days to collect the overpayment. Therefore it is in the best interests of the providers to keep health records in order and proper track. Most states advise providers to submit requested documentation within 90 days. If it is not received on a timely manner a provider can face liability and penalties from their states.

National Drug Code (NDC) Requirement on Medicaid Claims:

Effective January 1, 2008 Medicaid requires 11-digit NDC, dispensing quality and unit of measure to be submitted for physician-administered drugs. National Drug Code is number maintained by the Food and Drug Administration which identifies the drug labeler/vendor, product and product package size. It is a provider's responsibility to give this information for each drug that they want to be reimbursed for. Otherwise drug is not going to be paid by Medicaid.

Regarding Written Prescriptions:

As of April 1, 2008 Medicaid requires all prescriptions to be written on tamper-resistant paper. CMS has outlined the three baseline characteristics as those that: (1) prevent unauthorized copying of a completed or blank prescription form; (2) prevent the erasure or modification of information written on the prescription; or (3) prevent the use of bogus prescription forms. Please note that electronic prescriptions, faxed prescriptions and prescriptions sent over the telephone are exempt from this requirement.

Source of information obtained from Medicaid Update 2007.

Coding News

Clinical Psychologists Billing & Coding

One of the first steps for carriers to recognize psychologists as health care providers was implementation of six codes for health and behavior assessment and intervention services in 2002. The main difference of these codes from the regular psychotherapy is that these services focus on patients whose primary diagnosis is physical in nature. Therefore as long as patients have medical and not a psychiatric diagnosis these codes will be reimbursed at 80% rate by Medicare. Here are the providers who can bill these codes: psychologists, nurses, licensed clinical social workers, and other healthcare clinicians whose scope of practice permits. However, physicians should report Evaluation and Management codes for such services. For private insurance it should be checked with the carrier to determine its policy.

Here are the codes and Medicare rates for New York State:

CPT Code	Service	Medicare Rate	
		(15 min – 1 unit)	(1 hour - 4 units)
96150	Assessment – initial	25.04	100.16
96151	Re-assessment	24.24	96.96
96152	Intervention – individual	23.35	93.4
96153	Intervention – group (per person)	5.64	22.56
96154	Intervention – family w/ patient	22.95	91.8

Source of information obtained from http://www.apa.org/practice/cpt_2002.html

Understanding coding concepts

Communicating with insurance companies and billers is very important for understanding coding issues. Private payers try to follow Medicare guidelines, but often they develop their own rules and regulations. Therefore it is really important to keep track of new updates and changes. Reviewing EOBs and understanding adjustment and rejection codes will help you a lot to develop patterns of how careers process certain procedures, reimbursement rates and covered benefits. That should substantially help you to decrease your practice write-offs.

Medical Necessity:

Medical necessity is the key component of patient care and reimbursement. Medicare develops national and local coverage determinations for diagnostic and therapeutic procedures that could be found on either Medicare or CMS web sites. These policies provide not only covered diagnosis codes, but also frequency and referral requirements,

place of services where certain procedures could be performed and medical documentation requirements. Here are some additional ways to protect yourself from denials:

- Make sure you have physician order for the service ordered in the chart;
- Documentation should state tests ordered and rational for ordering
- Make sure patients sign Advanced Beneficiary Notice (ABN) is case if test is denied for not being medically necessary and you can bill patients.

Private payers typically give guidelines as well. The highest level of specification of patient's condition will always help you to identify medical necessity.

Bundling Rule:

Another import issue to keep in mind is bundling rule. It is usually applied to the procedure from the same coding family or to the procedures that were performed on the same anatomical site. Insurance companies either apply some kind of reduction on bundled codes or pay just for the major one. In order to be fully reimbursed for all procedures your medical documentation should clearly indicate that these were completely distinctive procedures and there was medical necessity to perform both of them it case we will want to appeal the denial.

Repeated and discontinued procedures:

It does happen sometimes that a patient comes back to the office for the same procedure that was done couple days ago in case something did not go well first time you need to indicate that on the superbill which you submit to WCH company, in order for it to be coded properly. The same issue is with the procedures that were discontinued, not fully performed, please bring it our attention.

***Defining separately identifiable evaluation and management*:**

It is a common scenario when a patient comes to the office for evaluation and management he/she also receive other services on the same date. In order to be reimbursed for both E&M and other procedures the medical documentation should confirm that E&M was separately identifiable procedure, in other words it should show that E&M service was above and beyond the usual preoperative and postoperative care associated with the procedure. For example, if a patient comes for a surgery or some diagnostic test and a doctor or office staff perform quick evaluation and preparation for the surgery or test the reimbursement for this service is included into the surgery or test payment and E&M is not considered separately identifiable. However, if a patient comes for an office visit and a doctor makes a decision to perform a necessary surgery or test on the same day then E&M could be billed. The similar issue arises when a patient comes for follow-up visit during the post-op care, which is 10 days for minor surgeries. If a patient comes back to the office within 10 days with complains related to prior surgery, E&M is not going to be paid, because post-op care is included to the payment of the surgery. However, if he/she comes back with new complains E&M is reimbursable, but diagnosis codes should clearly show unrelated condition.

Source of information obtained from American academy of professional codes, December 2007

Incident to Service

Incident to billing can bring increased revenues to your practice, however you should be aware about compliance concerns that exist for this type of billing. Incident to the physician's care includes services provider by non-physicians and billed under physician provider ID. Here are some indications that you should be alert about when billing incident to:

- direct physician supervision at every visits means that billing physician should be physically present in the office;
- proof of physician involvement on ac active level, not only establishing the plan of care, but actively managing it;
- incident to services can be provided by "auxiliary personal", such as employees, leased employees, independent contractors that have required training and qualifications to perform specific services;
- the non-physician practitioner can not see new patients or evaluate new problems;
- you should never bill one physician as incident to another physician's services, due to not being credentialed;

For more details you can refer to federal regulations at 42 CFR §410.26(b). Please keep in mind that when patients receive EOB from their insurance careers they only able to see billing provider name and it might look suspicious for them that they actually never saw the doctor who billed for the services that day. So, your defense will be once again appropriate documentation.

Source of information obtained from American academy of professional codes, January 2008

How to Bill for Missed Appointments:

One of the facts that influence office insufficiency is missed appointments which causes interruption in the scheduling process. Some studies indicate that it might reach up to 12% of total visit per year. Some of the recommendations that could prevent missed appointments are reminding of upcoming appointments by calling or mailing a letter. Also if you noticed that there is a high rate of no-show ups try to schedule two patients at the same time that you know won't take much time. If the patient constantly misses the appointments it might be more beneficial for you to terminate him/her from your practice. And finally, you can establish a policy to bill patients for missed appointments which could be a good incentive for patients to show up. Back in June 2007, CMS published guidance on billing Medicare patients for no-show ups. The general rules are:

- Office should have a written policy on missed appointments and inform all patients about it (obtain patients' signatures for confirmation);
- It should be applied to all patients equally;
- Charges for missed appointments should reflect missed business opportunity, not the cost of service.

Most common range that providers used to charge is $35 to $50. The policy should also include guidelines for proper cancellation of the appointment. However, keep in mind that this policy can not be applied to Medicaid patients.

Source of information obtained from American academy of professional codes, November 2007

History on Development of the ICD (International Classification of Diseases):

The first attempt to classify diseases was perform by Australian statistician Sir George Knibbs in 18th century. In 1785 William Cullen, of Edinburgh, published more general classification under the title *Synopsis nosologiae methodicae*. However, the best arrangement and principles of classifying diseases by anatomical site were proposed by William Farr (1807-1883) from England which still survived as the basis of the International List of Causes of Death. For the purposes of discussion and approval of any changes of disease classification International Statistical Conferences took place in different countries periodically. In 1893, a French physician, Jacques Bertillon, introduced the Bertillon Classification of Causes of Death at the International Statistical Institute in Chicago. In 1944 the manual for coding causes of illness was published in the United States. International Classification of Diseases, Injuries, and Causes of Death took revision several revisions already. In 1948, the World Health Organization (WHO) assumed responsibility for preparing and publishing the revisions to the ICD every ten years. The tenth revision (ICD-10) and so far the last one was developed in 1992 and published by the World Health Organization. **ICD-11 is planned for 2011year.**

Criminal and Civil Liability:

Did you know that originally HIPAA originally started not as a privacy statute, but rather statute of a health care fraud and accountability? Numerous health care sanctions were established that make it easier for the government to prove civil fraud and obtain higher penalties. Civil monetary charges might reach up to $ 10,000 per false claim. Definition of "knowing" false claim includes intentional ignorance and reckless disregard of the truth. Failure to repay overpayment which you are aware of could be construed as criminal intent to defraud. Nowadays the burden of proof in most cases is mere reckless disregard, which could be proved easily considering all billing and coding information that is available in billing and coding manuals, insurance bulletins, on internet and through the phone lines. Such liability could be applied not only to providers, but to billers and coders as well. Therefore, we are trying to be very cautious and conscious on information received from providers' office, saving all documentation and strongly advise you to do the same.

What you need to do in case if federal or state agency investigators show up at your office without prior notification:

It is essential for your practice to develop policies and procedures for responding to government investigators. Federal investigators are individuals from the Department of Health and Human Services (HHS), Office of Inspector General (OIG), the Unites States department of Justice (DOJ) or Federal bureau of Investigation (FBI). Here are some key steps that should be taken before you disclose any information to investigators:

- Ask for photo identification and verify their credentials;
- Contact your legal counsel as soon as possible and verify if investigators can wait till your counsel arrives;
- Ask for a search warrant, which specifies locations and documents that they have the right to enter and seize;
- Send staff members, that are not involved in the search, home and cancel any appointments for the day;
- Instruct your staff members to cooperate with investigators, but not disclose voluntarily any additional information that was not requested;
- Any interviews should be taken with legal counsel present;
- When investigators leave, evaluate the factors that lead to the investigation;
- Never change, move or destroy any documents subject to investigation;
- Make sure you have copies of all papers that you provided to investigators and received from them, keep in mind that even if investigators showed up in your office it does not mean that a crime occurred.

Source of information obtained from American academy of professional coder, April 2008

NPI Arrived

May 23, 2008

(Medicaid has extended NPI exception till September 2008)

HAVE A GREAT SUMMER

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

You can send your requests by email to

OLGAK@WCHSB.COM

WCH Feedback Form

Please use this form for your suggestions and comments.

Your Name

Email Address