WCH TIMES

WINTER 2010 Volume 11

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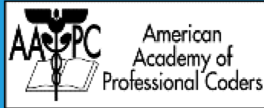

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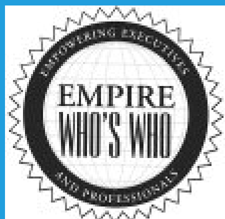

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Welcome to the Winter Edition of WCH Times!

I hope that everyone had enjoyed the Holiday Season and looking forward to working with changes set for the New Year. The insurance industry is taking the healthcare community by storm with more rigid compliance programs, new billing guidelines and unreasonable payment regulations. Lets get started!

WCH Corner

Certified Professional Coder on Staff

We are committed in providing our clients with professional and reliable services. WCH staff is working hard to accomplish these results. We are proud to announce that Oksana Pokoyeva from the billing department has passed Certified Professional Coder exam administered by American Academy of Professional Coders. Several members from the billing department are now in process of preparing to take the CPC examination in mid February of 2010.

WCH is looking forward to providing coding services and sharing with you important information about insurances requirements and document compliance that will safeguard your practice record keeping process. Knowing coding is a big deal in the reimbursement process. This knowledge can be used in billing process, denial issues, and challenge rules and regulations of insurance carriers.

Most physicians hate coding, frankly we don't blame them. Each of us is a professional in its own field: doctors treat patients, billers bill and coders code. This year, WCH is planning to complete training in chart auditing and become AAPC Certified Professional Medical Auditor.

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WCH Received BBB Accreditation

WCH is proud to announce that we are a “BBB Accredited Business in good standing”! As a BBB accredited business we built trust, advertise honestly, tell the truth, are transparent, honor promises, are responsive, safeguard privacy, and embody integrity!

Being a part of BBB WCH becomes a business that the marketplace can trust. We have met all of standards and we understand how important TRUST is in today’s marketplace. We support the everyday efforts of BBB and practice the codes of good business.

We will keep you updated with more information about the services will WCH will soon be offering!

Notary Public on Staff

We are always looking for ways to safe your time and provided a better convenience during your document signing for billing or credentialing processes. We are proud to announce that on staff we now have New York State license notary public to handle all your document needs.

Compliance Program in Effect

Medicaid Inspector General posted a mandated compliance program that must be completed by Medicaid providers, suppliers, billing or claiming $500,000 or more from Medicaid program in the a 12 month period. The deadline was set for January 1, 2010. WCH Service Bureau, Inc was directly impacted by the mandatory program because we submit claims for clients that receive the $500,000 or more. WCH has developed a compliance program and has submitted the certification form to be listed as a complainant provider of service.

Credentialing News

Update Your Practice Locations

According to Transmittal 907, effective January 25, 2010 CMS will urge providers to delete old practice locations from their enrollment by using the CMS-8551 application. This step can be prevented by closing out the provider enrollment at the old practices in previous states before moving. Contact WCH Credentialing Manager for more information about the process. You can read the full transmittal @ www.cms.hhs.gov/transmittals/downloads/R307PI.pdf

Healthcare Industry Update

How You Can Receive the H1N1 Influenza Vaccine

Register @ https://hcsteamwork1.health.state.ny.us/pub

This registration is for providers who are interested in the vaccine; however, it not does obligate you to receive or administer it; the registration does not guarantee you will receive the vaccine, because supplies are limited.

Requirements *You* must sign the federally mandated Provider Agreement agreeing to appropriately store and handle the vaccine, to administer vaccines only to CDC targeted groups, and to report vaccine usage.

Once the registration is received and the provider agreement has been signed, providers will be able to order vaccine by calling (800) KID-SHOT.

Source: Medicaid update: October 2009, Special Edition

With a New Year, Comes a New Deductible

To prevent any loss on deductible payments, follow the three simple steps:

1. Confirm the deductible amount with the patient's insurance

2. Contact your patient before the appointment; confirm that the patient is aware of their deductible and has financial ability to pay.

3. If the patient does not have the ability to pay you have two options: A) If it is not an emergency, reschedule for a time the patient has the ability to pay. B) See the patient and hope to be paid some other time.

Source obtained from: The Coding Institute 2009, Vol. 9, No.12

RAC Recovering Overpaid Money?

If your MAC has overpaid you and the recovery audit contractor (RAC) is now requesting the overpaid money back, according to CMS Transmittal 162, effective December 15 you could have 12 months to repay! The RAC can give you an extended repayment plan.

To read the full transmittal visit: www.cms.hhs.gov/transmittals/downloads/R162FM.pdf

Non-Par Providers: Your Fee is Your Fee!

As a Non-Par provider have you ever wondered when you should collect your entire fee from the patient: At each visit? Or should you wait until you receive the EOB and bill the patient?

Well, the answer is "Your fee is your fee." You are not contracted with the insurance, so their allowance does not matter. You should collect your full fee from the patient the day of the visit. After

submitting the claim to the insurance, the insurance will pay the patient their allowable amount.

Source obtained from: The Coding Institute 2009, Vol. 9, No.12

New Technology

The Fisher Wallace FW-100 Cranial Stimulator

New break-through technology machine is designed to provide symptomatic relief to patients suffering from depression, anxiety, and insomnia.

This portable, hand-held device used micro-electrical currents at patented frequencies to stimulate the brain's production of serotonin, dopamine, and beta-endorphin, GABA and DHEA while lowering levels of stress hormone cortisol. For more information visit: www.fisherwallace.vom or call 212.688.8100

Three Simple Steps: Entering E-Prescribing Era

Step 1: Decide which system to use: a stand-alone system? Or one that is part of an HER (electronic health records)?

Step 2: Bill a denominator code: E/M service codes 99201-99205 and 99211-99215; Outpatient consultation codes 99241-99245; or G codes G0108 or G0109.

Step 3: Report G8443-G8446 as the Numerator

Source of information obtained from The Coding Institute Vol. 10, No. 42

Non-Physician Practitioners Responsibility

CMS reports that as a duty all non-physician practitioners are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This is important to keep sure that claims are processed correctly. Here are reportable events that may affect claims processing, a payment amount, or a non-physician practitioner's eligibility to participate in the Medicare Program:

- Change in practice location
- Change in final adverse action
- Change of business structure
- Change in organization legal business name/tax identification number
- Change in practice status
- Change in reassignment of benefits
- Change in banking arrangements or any payment information

Something to Look Forward to

1.10% Medicare pay bonus for primary care.

2. Creation of the CMS "innovation center."

3. A slew of measures to boost the primary care work-force.

4. Permanent elimination of the sustainable growth rate (SGR).

5. Weakening the proposed Independent Medicare Advisory Counsel (IMAC).

Obtained from Part B News, November 2, 2009| Vol. 23, Issue 42

Word of Advice

In the 2010 CPT guidelines, blood flow becomes an add-on code, which creates a massive decrease in the reimbursement. Dr. Martin suggests, if you have patients for whom a cardiac MRI to measure blood flow would be beneficial and medically necessary, bill the four blood-flow codes. He says that the worst-case scenario is payment only for the non-blood flow portion, at the same rate you're being paid now for cardiac MRIs.

Source of information obtained from Part B News, November 2, 2009| Vol. 23, Issue 42

National Government Service VS Highmark

Carrier	Provider Inquiries	Provider Outreach & Educa-	Claims Process-ing	Appeals	Provider Enroll-ment	Medical Review	Overall Average
NGS	4.1	4.3	4.4	4.0	4.1	4.3	4.21
Highmark	4.7	4.7	4.9	4.7	4.4	4.6	4.66

Source: Part B News November 2, 2009 | Vol. 23, Issue 42

2010 is The Year of the Lung

"*The Year of the Lung* goals are to raise awareness about lung health among the public, initiate action in communities worldwide, and advocate for resources to combat lung disease including resources for research and research training programs worldwide. A key objective is to begin to build a social movement for greater public awareness and policy action."

Read more about 2010 The Year of the Lung @ http://www.2010yearofthelung.org/

Claims Reforms that Benefit the Providers

We had reported in the previous edition that New York managed care reform legislation will take place in January 2010. Under the new law healthcare providers will be paid in 30 days instead a 45 days waiting period on all electronically submitted claims. In addition providers have 120 days to submit claims after DOS to most insurance carriers compare to the 60-90 day rule implemented before by majority of payers. WCH billing department is taking advantage of the new rule in the fight for your claims collection.

OIG Work Plan for 2010

OIG released work plan for fiscal year 2010. Complete outline of work plan can be found at oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf .

Here are some areas OIG will look into this year:

- Part B Imaging Service Payments
- Evaluation and Management services during global surgery periods
- Outpatient physical therapy services provided by independent therapists
- Polysomnography payments

Insurance News

MEDICARE

2010 Deductible

The standard deductible for 2010 for all Medicare Part B beneficiaries will be $155

2010 Therapy Cap

The therapy cap amount for 2010 will be $1,860 for occupational therapy and $1,860 for physical therapy and speech-language pathology services combined.
→ Beware that in 2006 Congress passed legislation implementing the therapy caps but authorized exceptions for patients which permit the medically necessary qualifications. The exceptional modifiers which showed medical necessary were extended to end of 2006, 2007, and again for 2008, however Congress only authorized until December 31, 2009! For now it is not clear if the exception process will or will not be in place for 2010. We will keep you updated on this matter.

Source: NGS Online

Payment & Policy Changes for 2010

Each year we anticipate the decision for the Medicare Physician fee Schedule Final Rule to find out what to expect for the upcoming year. Proposed Physician Fee Schedule payment cuts in average of 15%-26% has shocked health care community. Since Senate and House of Representatives has not reached a decision on Health Care Bill in 2009 President Obama has signed Department of Defense Appropriations Act of 2010 which provides a two-month zero-percent (0%) update to the 2010 Medicare physician fee schedule (MPFS), effective only for dates of service January 1, 2010 through February 28, 2010. This Act allow more time for Congress to reach a decision on Health Care Reform. We are hoping final decision will be a reasonable and will not impact the quality of care your are providing.

CMS is also finalizing its proposal to stop making payments for consultation codes; other than the G codes which are used to bill telehealth consultations. CMS is looking to redistribute the resulting savings toward increasing payments for the existing evaluation and management (E/M) services. In addition, CMS will adjust payment for the surgical globe period to reflect on a higher value of office visits furnished during the globe period.

To view a copy of the final rule with comment period, please see:www.federalregister.gov/inspection.aspx#specialSource: CMS E-mail update

Automatic Medicare Claim Crossover to Medicaid

On December 3, 2009 New York Medicaid will begin receiving Medicare crossover claims directly from Medicare's Coordination of Benefits Contractor (COBC). GHI in its role as the COBC will forward claims to Medicaid, no matter what the claim's date of service. Once WCH bills your claims to Medicare, and Medicare reimburses its portion, and the Medicare remittance will indicate that the claim has been crossed over to Medicaid. Although, Medicare will only first sent the data to GHI, who will then sent it to Medicaid. Medicaid will pay for the remaining patient responsibility; if there will be no patient responsibility the claim will simply be denied.

WCH will only submit the claim to Medicaid, if the Medicare remittance will not indicate that the claim had been crossed over to Medicaid. WCH will strongly review all your Medicare remittances to be certain that your claim reached Medicaid.

Source: Medicaid Update October 2009 | Volume 25, Number 12

HighMark Medicare: Faxing Medical Documentation

If your electronically submitted claim requires medical documentation, you are now able to fax this information to Highmark Medicare Service any time before the claim submission. To retrieve the required fax cover sheet please log onto: https://www.highmarkmedicareservices.com/edi/guide/chapter11.html

Source: Medicare Part B EDI E-mail update | November 2, 2009

Your Payments May Be Impacted!

Because you are already aware of Medicare's implantation of the new system which will reject any claim with an ordering/referring provider that is not enrolled with Medicare, we would just like to remind you once again of the fast growing changes. We are already in the first phase out of two phases in the implantation. For those providers who are still submitting claims with non-enrolled Medicare ordering/referring providers are receiving payments, but with an indication that the ordering/referring provider is not participating. This is the warning phase.
Effective January 4, 2010, the second phase will take place, if the service or item you bill requires an ordering/referring provider and is does not show a participating ordering/referring provider on the claim, the claim will NOT BE PAID!

If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.

WCH strongly recommends you to provide us with the ordering/referring provider's name and NPI in order to prevent any payment impacts. Our billing department will not be able to appeal these claims and unfortunately provider/suppliers can loose money.

Providers who order or refer should verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do.

Message from Medicare bulletin on this issue: Medicare implementation of system edits to assure that provider/suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries.

Please make sure that your records are on file in the PECOS system! Take note that just because a physician has an NPI does not necessarily mean that it is in the PECOS system. Beginning April 5 your claims will be denied if services referred or ordered by doctors that are not part of PECOS or the MAC's claim system.
Source of information obtained from MLN Matters # MM6421 and The Coding Institute Vol.10, No. 42

Red Flag Rules Implementation Nov. 1, 2009

Implementation of the Red Flag Rules is set for November 1, 2009 without further delay. The Federal Trade Commission (FTC) had delayed the rules for a year to supply more education to the businesses affected. However, your practice might be exempted due to the bill which passed. If your business has 20 or fewer employees, your business will be exempt from the rules.

The Red Flag Rule apply to: Financial institutions and creditors with covered accounts. To learn more about the Red Flag Rule, please visit: http://www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm

Source: Part B News November 2, 2009 | Vol. 23, Issue 42

Multi-Carrier System Integration

The Multi-Carrier System (MCS) claims of Connecticut, Upstate New York, Queens County, and Downstate New York Medicare segments will merge into one system. **Effective December 15, 2009** one IVR system will replace the four current systems; all Connecticut and New York Part B providers will call NGS IVR at **877-869-6504.**

In order to carry out the MSC consolidation, NGS will have "dark days" on Monday, December 14, 2009 and Tuesday December 15, 2009. During these days Medicare online systems will not be available for either internal or external use. System dark days will impact the availability of claims processing and payments, EDI transactions, the Provider Contact Center, and the IVR system.

WCH is working with Medicare to avoid potential delay in payments associated with this transition. Your claims submitted on 12/10/09 and 12/11/09 will be processed within 1 day, therefore you may experience more than usual payments within these weeks. No payments will be made on 12/14/09 and 12/15/09; once the system merge is complete the payment cycles will fall back into place.

Source: http://www.ngsmedicare.com/content.aspx?CatID=2&DOCID=21012

http://www.ngsmedicare.com/content.aspx?CatID=2&DOCID=21011

Outpatient Mental Health Treatment Limitation

Centers for Medicare & Medicaid Services is carrying out the outpatient mental health treatment limitation over a five-year period, from 2010-2014. Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services (80% of the physician fee schedule).

Medicare is now paying only 50% of the approved amount under the physician fee schedule for outpatient mental health treatment rather than 80% that is paid for most other services.

Section 102 of MIPPA requires that the current 62.5% outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

Five Year Period	Limitation Percentage	Of which Medicare Pays	Patient Pays
January 1, 2010 – December 31, 2011	**68.75%**	**55%**	**45%**
January 1, 2012 – December 31, 2012	**75%**	**60%**	**40%**
January 1, 2013 – December 31, 2013	**81.25%**	**65%**	**35%**
January 1, 2014 – onward	**100%**	**80%**	**20%**

Enrollment Deadline Extended

Usually, the annual participation enrollment process would end on December 31, 2009, but this year the enrollment deadline has been extended until March 17, 2010.

MEDICAID

Documentation is now Required for Ordering NYC Transportation Services

When a Medicaid enrollee is traveling to medical appointments, the patient must use the same mode of transportation they use to carry out every day duties. Although most NYC residents use mass transit, there are certain condition necessitates that require other forms of transit. In these certain conditions an ambulatte is a way of transportation for the Medicaid enrollee. Medicaid will pay only pay for the most "medically appropriate" level of transportation to and from services covered by the Medicaid Program.

When non-emergency transportation is ordered by a practitioner, the practitioner must use the **MAP-2015 form** to record the patient's file of the ordering of ambullete or nonemergency services.

The MAP-2015 should only be used "when the patient has a condition that necessitates a mode of transportation other than mass transit, but that necessity cannot be readily discerned from the patient's medical record".

The MAP-2015 is not necessary when "a patient can use mass transit or it is clear from the patient's record that mass transit would be difficult to navigate and upon discharge from a hospital, the Discharge Plan clearly indicates the presence of a condition necessitation livery, ambulette or non ambulance transportation".

The MAP-2015 form can be requested from Medicaid. WCH also has a copy of this form for records.

Source: Medicaid Update | April 2007, page 6

New Threshold Application Form

Make sure to request the threshold applications from Medicaid. With the new applications you will save yourself a lot of time because, there is no limit to the amount of visits you are requesting authorization for. Please visit: http://www.emedny.org/new/index.html for more information.

Coverage and Reimbursement for Seasonal Flu, H1N1, and Pneumococcal Vaccines

Medicaid will reimburse enrolled office-based practitioners, pharmacies, and Article 28 clinic providers for the administration of the H1N1 vaccine, for the cost of the seasonal flu and pneumococcal vaccines, and for the administration of these vaccines. Because the H1N1 vaccine supplies are provided by the Federal Centers for Disease Control (CDC) at no cost, Medicaid will not cover the cost of H1N1 vaccine and supplies, but will cover the cost of administration. Medicaid will cover the cost of seasonal flu and pneumococcal vaccines and the administration of the vaccines. The fees have increased $2.00; $13.23 will now be reimbursed.

Source: OCT09 Special Edition Medicaid Newsletter

PHI Privacy

If you need to submit protected health information (PHI) to eMedNY make sure PHI that is being faxed or e-mailed is going to the correct receiver, and that you include a confidentiality statement on your cover letter. Also make sure not to send PHI through e-mail unless it is in a password protected attachment.

VALUE OPTIONS

ValueOptions is going Green!

Effective **November 1, 2009** ValueOptions will discontinue the mailing of Provider Summary Vouchers (PSVs). If you have not already signed up for electronic funds payment to receive electronic notices and payments, we urge you sign up immediately at www.paypanhealth.com and/or www.valueoptions.com/pclogin begin receiving your notices and payments electronically.

PaySpan Health is an electronic solution which delivers EFTs, ERAs, Provider Summary Vouchers and much more. This solution is free to all providers, it eliminates waiting for paper checks or vouchers to be printed and delivered, it improves cash flow through automated payments, and providers have online access to view remittance records at their convenience.

Source: ValueOptions, Update E-mail

EMBLEM HEALTH (GHI-HIP)

GHI HMO

As a result of GHI and HIP joining together under EmblemHealth; on November 1, 2009 GHI HMO Select, Inc. does not participate in the Medicaid Managed Care, Family Health Plus, or Child Health Plus programs. This has affected the Westchester County and the five boroughs of NYC.

Medicaid enrollment is mandatory in Westchester and in the five boroughs of NYC. Therefore, all GHI HMO Medicaid Managed Care or Family Health Plus members must choose a new health plan by October 16, 2009, Child Health Plus members, by October 20, 2009!

You may continue providing covered care to your GHI HMO patients if you are not in the new health plan's network, under the following circumstances:

- Patient has a serious conditions and is receiving ongoing associated care. Only for 60 days from 11/01/09.
- Patient is three or more months pregnant as of 11/01/09. Only for 60 days after delivery.
- Must obtain prior authorization from the new health plan to treat members during the transitional period.
- Even though you still might be working under the old health plan's network, providers must agree to follow the new health plan's policies and accept the new health plan's reimbursement rates.

Source: EmblemHealth Update letter | August 21, 2009

HealthFirst

2010 Healthfirst Medicare Plan Updates

Transportation: Livery (Medicare) and ambulette (Medicaid) service are available based on medical necessity. •LIP – 16 round trips per year •65+ – round trips per year •Jade, CBP & MPP – 8 round trips per year •MAX- unlimited •IBP – 20 round trips per year

Pre-Authorization Guidelines: EMG/Nerve Conduction Studies require prior authorization

Jade Benefits Plan: This new plan focuses on the Asian market. It will be available to members residing in Manhattan, Brooklyn, and Queens only, but members who enroll will have access to the entire Healthfirst Medicare Network. **The Jade Benefit Plan will be the only Healthfirst Medicare plan in New York to offer an acupuncture benefit.** The benefit will be limited to two visits to a network-contracted acupuncturist per quarter at$5 copay per visit. Some other highlights: •Inpatient: $125 per day for 3-10 days per admission •PCP: $0 copay per visit •Specialist: $10 copay per visit •Transportation: $0 copay for up to 8 round trips per year (2 per quarter) •Acupuncture: $5 copay for up to 8 visits per year (2 per quarter)

Source: Healthfirst Update, November 15, 2009

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NEW LOCATION

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www.wchsb.com