WCH TIMES

FALL 2010 Issue 14

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Dear Doctors and Office Managers,

Welcome to WCH Times Fall Edition!

A newsletter that is designed to inform you about our developments, insurance policies, community events, and provide ongoing support of current issues taken place in the healthcare community.

Enjoy our Newsletter!

Inside this Issue

3047 Avenue U, Brooklyn NY 11224 / Phone: 718 934-6714 / Fax: 718 504-6072 / wch@wchsb.com /

WCH DIRECTORY

Aleksandr Romanychev
Ext—1202

Olga Khabinskay
Ext—1201

Oksana Pokoyeva
Ext—1215

Zukhra Kasimova
Ext—1114

Olga Mirolyubova
Ext –1101

Slava Kurdov
Ext-1104

Elizaveta Bannova
Ext—1103

Alena Lapshina
Ext—1209

Tatyana Zeygeril
Ext –1210

Ilana Kozak
Ext—1214

Patient Collection
Ext—1216

Technical Department
Ext—1111

Operator - Press 0

WCH Toll Free Phone:
888-WCHExperts
(924-3973)

Fax: 718-504-6072

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PAY YOUR BILLS

ONLINE @ WCHSB.COM

WCH Corner

New Billing Department Manager

In development to better our operations of the billing department, effective this month, we would like to announce that WCH appointed Zukhra Kasimova as the Billing Department Manager. She has been moved from the supervision role to support this position. Zukhra has a deep understanding of the billing operations and is more than capable to fulfill all of this position tasks.

If you have any questions of concerns in regards to our billing department you should contact Zukhra at (718) 934-6714 ext 1114 or via e-mail: ZukhraK@wchsb.com

Importance of Credentialing

Every physician practice in the country is going to be required to complete new Medicare Enrollment forms. And the rules and forms have changed – again! Don't get caught unaware.

There will be a short time limit on completing and returning these forms. Prepare now and save yourself a lot of headaches later. Physicians must be listed in Medicare's Provider Enrollment Chain Ownership System by 2011 or face unpaid claims and continued revalidation. It only takes one mistake on your enrollment form to stop the entire approval process and that can cost you thousands of dollars.

WCH is your number one guide to successfully re-enroll – the first time!

Legal Counselor Corner

Article prepared by: WCH Attorney, Alyona Mirsagatova, Esq.

WCH would like to announce that our Newsletter will contain a new section, *Legal Counselor Corner*. It is designed to address all legal issues that you might be faced with, and to provide efficient and effective legal, administrative and management support. The WCH *Legal Counselor Corner* is maintained through the assistance of Arthur Shtaynberg, Esq., President and CEO of LicensePro LLC. For more detailed information, please visit http://www.balanceprousa.com. Arthur Shtaynberg, Esq., is very familiar with legal issues surrounding medical management, credentialing, marketing, accounting, cost reporting and quality assurance services in the healthcare industry.

Also, LicensePro has extensive experience in all legal aspects of opening new clinics, and offers legal guidelines on:

- Articles of Incorporation
- OSHA compliance
- HIPAA compliance
- Development of Policy & Procedure Manuals
- The legal impact of recent cases or new regulations

The following is a list of services rendered by Balance Pro:

1. Home Health Agency (HHA)
- A. State Licensed Medical Model
- B. Medicare Certified Model
- C. Non Medical Model
- D. Home Infusion
- E. Certificate of Need
- F. Accreditation with JHACO, CHAP, ACHC
- G. Requests for Proposals and Grants writing (RFP's)
- H. Policies and Procedures Manuals Drafting and compliance updating
- I. Recruitment and Staffing

2. Durable Medical and Surgical Equipment and Supplies (DME POS)
- A. Prosthetics and Orthotics
- B. Respiratory Supplies
- C. Accreditation with JHACO, CHAP, ACHC

3. Independent Diagnostic Testing Facility (IDTF)
- A. Fixed Location (ex: Sleep Lab, MRI, CT Scan)
- B. Mobile/ Portable Model (ex: Ultrasound, Echocardiogram, Vestibular Balance Test, X-ray)
- C. Combined Fixed/ Portable Model

4. Adult Day Health Center (ADHC)
- A. Medical Model:
  - Generic,
  - Alzheimer's,
  - Parkinson's,
  - Developmentally Disabled,
  - Mentally Retarded
- B. Social Model
- C. Partial Daycare/ Psychiatric Model

5. Hospice
- A. Certificate of Need Model

6. Assisted Living Facility
- A. Subsidized
- B. Private Pay model

7. Dialysis/ End Stage Renal Disease (ESRD) Center

8. Mobile Dentistry
9. Mobile Health Clinic
10. Pharmacy
- A. Infusion Pharmacy
- B. Closed Pharmacy

11. Optical Store
12. Comprehensive Outpatient Rehabilitation Facility (CORF)
- **A.** Cardio Rehab Model
- B. Pulmonary Rehab Model

13. Substance Abuse Programs (OASAS)
- A. Outpatient Counseling
- B. Inpatient Detox

14. Nursing Home/ Residential Facility
15. Adult Home/ Residential Facility
16. Half Way House/ Correctional Facility Rehabilitation Model
17. Private Prison/ Incarceration Model
18. Educational Programs
- A. Long Term Comprehensive Curriculum
- B. Degree Granting Model
- C. Voucher Program

19. Meals on Wheels
- A. Food Assistance Program

20. Ambulatory Surgery Centers
21. Early Intervention Program
- A. Center Based
- B. Home Based

22. Pre-K Program
23. Blood Lab
24. Office of Mental Health (OMH)
- **A.** Residential Psychiatric Rehab
- B. Inpatient Psychiatric Rehab

25. Staffing/ Recruitment Office
- **A.** Professional Placement(Physicians, Registered Nurses, Therapists: PT, OT, ST, RT)
- B. Paraprofessional Placement (HHA, PCA, etc)
- **C.** Contracting term employments

26. Auction House
- A. On-Site
- **B.** On-line

27. Medical Marijuana Dispensary

Also, please be advised that Mr. Shtaynberg currently has two medical spaces up for rent. The first location is in the borough of Brooklyn, with 10,000 square feet and situated at Ocean Parkway and Church Avenue. The second location has 18, 000 square feet and is located in the Mt. Vernon/Yonkers area of Westchester. Mr. Shtaynberg is open to all offers. If you are interested, please contact him via email at artesq@gmail.com. Spaces are available with certain licensed businesses at NO PURCHASE COST.

Questions from Clients

Q: Will the therapy cap in Medicare be established again in 2011?

A: APTA and AOTA are working with Congress to achieve a longer-term solution to the cap and extend unfettered access to outpatient Part B physical and occupational therapy for Medicare beneficiaries beyond January 1, 2011 as Congressional action needed to prolong PT CAP extension.

Q – Does New York Medicaid pick up commercial insurance co-pay?

A- When a provider **contracts** with a commercial insurance payer, the Medicaid Program pays the difference between the commercial insurance payment amount and the commercial insurance patient coverage amount. Essentially, Medicaid pays the commercial insurance co-payment, deductible and/or co-insurance.

When a provider **does not contract** with a commercial insurance payer, Medicaid pays the patient responsibility. In this case, this is the difference between the commercial insurance payment amount and the provider's usual and customary charge, up to the Medicaid rate.

Note: If the Medicaid payment is lower than the commercial insurance payment, Medicaid pays nothing. This policy is unchanged.

Q: Can an occupational therapist hire a physical therapist to work in the PC, which is owned by the OT.

A: A PC may only provide services in its field. For example, a hypothetical PC named "Occupational Therapists For Everyone, PC" may only provide occupational therapy services. It cannot offer physical therapy services, speech services or any other professional services. Also, because it is allowed only to provide professional services, it can only manage the services that it provides.

Source: Michele, Professional Corporations

Q: Does the national drug code that we submit from our pharmacy chargemaster have to be exactly what was administered to the patient?

A: Bill the NDC for the actual drug that is administered. The code submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered. Providers should not bill for one manufacturer's product and dispense another. Billing an NDC from a reference file (e.g., the Redbook) when it is not the actual drug administered is considered fraudulent billing.

Source of information: http://www.medlearn.com/questions/pharmacy.html

Q: What do the "improper" payments that RACs discover consist of?

A: The following are examples of improper payments: incorrect payment amounts; incorrectly coded services, which includes Medicare severity diagnosis-related group (MS-DRG) miscoding; non-covered services (including services that are not reasonable and necessary); and duplicate services.

Source of information: http://www.medlearn.com/questions/general.html

Healthcare News

Developing Outpatient Therapy Payment Alternatives Research Project

CMS and its data collection contractor, RTI International, have conducted a conference to explain the research project known as DOTPA "Developing Outpatient Therapy Payment Alternatives. After participating, WCH would like to share the information with you.

The research is intended for all institutional and non-institutional providers of outpatient physical therapy, occupational therapy, and speech language pathology who are reimbursed under Medicare Part B, day rehabilitation programs, Part B therapy in nursing facilities, hospital outpatient therapy departments, CORFs/ORFs; as well as physicians who refer beneficiaries for outpatient therapy.

Three main components of the study:

1. Develop a patient assessment tool for measuring severity and outcomes of Medicare therapy patients covered by Part B
2. Collect patient assessment data from a provider sample representing the range of settings and patients providing services under Part B
3. Use the sample data, along with administrative data, to develop alternative payment models of outpatient therapy

General Principles

- Collect data to measure case mix and outcomes (and feasibility of using in a payment system)
- Focus of applying case mix adjustors and outcomes measures to models based on the MFS
- Assessment items – and therefore case mix and outcomes – should be appropriate to the ambulatory patient populations

CMS encourages interested facilities, practices, and individual provider to consider enrolling. By participating, providers gain an opportunity to contribute to ground-breaking research in case mix measurement and payment methodology for therapy services paid under Part B.

For more information please visit: optherapy.rti.org

Source of information obtained from: DOTPA Data Collection Special Open Door Forum

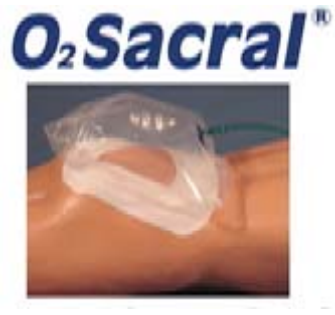
TO2 – Topical Oxygen Therapy

Topical Oxygen Therapy is a treatment used to help heal open wounds by providing pure oxygen directly to the wound site. When oxygen is delivered directly to the surface of the wound it is *Topical* Oxygen. Topical Oxygen Therapy provides a natural, safe and non invasive alternative for wound healing that can be administered in any setting.

Wounds cannot heal without oxygen. Topical Oxygen Therapy delivers oxygen directly to the surface of the wound. Treatments last for 90 minutes a day, and is repeated for four consecutive days each week. Three days of rest follow, and then the cycle is repeated, the typical regimen lasts twelve to sixteen weeks.

New York Medicaid Approved Indications:

- Neuropathic/Diabetic Ulcers
- Stage IV Pressure Ulcers
- Venous Insufficiency Ulcers
- Non-Healing Surgical Wounds
- Trauma Wounds
- Chronic Ulcers of Mixed Etiology

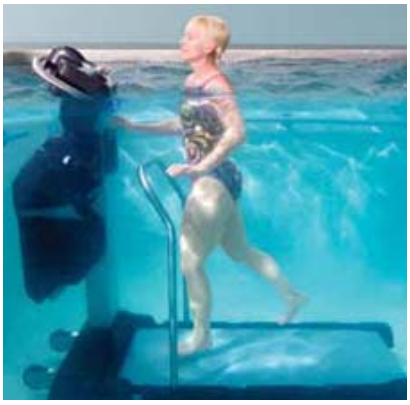


Contact Erik Langer, sales representative at (646) 220-1381 for more information!

Transform Your Rehabilitation with these Modern Therapy Machines

Introducing the new HydroWorx X80 Underwater Treadmill with integrated resistance jet technology. It turns a static pool into a highly functional rehab and fitness experience that empowers your outcomes and profit potential by providing:

- Gait training, balance enhancement, confidence building
- Low-impact cardio and deep tissue massage
- Unique fold up design and portability to fit any pool area
  No installation required



Gravity free. Impact free. Barrier free.

Information obtained directly from: http://hydroworx.com/x80/

For your post-operative and post-injury patients, AlterG's unique unweighting treadmill provides the opportunity to include closed kinetic chain functional rehabilitation earlier than ever before. AlterG is FDA cleared to safely provide a functional rehabilitation tool for any of your lower extremity patients who are:

- Approved by their treating physician for at least 25% partial weight bearing
- Allowed to flex and extend their hip, knee, and ankle through a limited range of motion

This revolutionary rehabilitation equipment also provides "prehab" conditioning with significantly reduced pain. Patients who try the AlterG treadmill overwhelmingly prefer it and 100% of those surveyed say they like it.

Information obtained directly from: http://www.alter-g.com/functional-rehabilitation

Innovation of Footwear

The Vibram Five fingers is the shoe where is feels as if you're walking barefoot. Wear it for: jogging, running, walking, yoga/Pilates, fitness, trekking, swimming/water sports, climbing/bouldering, Indoor CrossFit, Travel, & After Sport.

"The typical human foot is an anatomical marvel of evolution with 26 bones, 33 joints, 20 muscles, and hundreds of sensory receptors, tendons and ligaments. Like the rest of the body, to keep our feet healthy, they need to be stimulated and exercised.

That's why we recommend wearing FiveFingers for exercise, play, and for fun. Stimulating the muscles in your feet and lower legs will not only make you stronger and healthier, it improves your balance, agility and proprioception."

Prices range from: $85-$100, depending on the style.

Information obtained directly from: http://www.vibramfivefingers.com/index.cfm

OIG 2011 Work Plan: Old and New Targets

The Office of Inspector General (OIG) released on Oct. 1, its annual work plan for the coming year. Not surprisingly, the federal agency said it will review many Medicare Part B issues which have been under the looking glass in years past. With everything that's been going on this past year with health reform, however, the OIG has plenty of new projects to address as well.

The work plan is all encompassing, but specific to Medicare Part B, the OIG says it will continue to review the following programs and activities:

- Place of service errors
- Ambulatory surgical center (ASC) payment system methodology
- Coding and payment of evaluation and management (E/M) services
- Billing of portable X-ray suppliers
- Billing for Medicare outpatient therapy services
- Sleep testing payments
- Services and billing patterns in areas highly concentrated with independent diagnostic testing facilities (IDTFs), as well as IDTF compliance
- Comprehensive outpatient rehabilitation facilities
- Improper payments for claims not reasonable or necessary
- Services billed with dates of service after beneficiaries' date of death

New activities the OIG says it will take on in 2011 include:

- Medicare payments for Part B imaging services
- Services performed by clinical social workers
- Partial hospitalization program services
- Polysomnography payments
- Outpatient physical therapy provided by independent physical therapists
- Diagnostic testing payments
- Laboratory test unbundling by clinical labs
- Glycated hemoglobin A1C test payments
- Trends in laboratory use
- Lab test payment comparison with other public payers
- Provider assignment rules compliance
- Medicare billings with modifier GY
- Payments for services ordered or referred by excluded providers
- End-stage renal disease (ESRD) payments
- Error-prone providers
- Comprehensive Error Rate Testing (CERT) program

There also are several new and continuing projects planned for durable medical equipment (DME) services and supplies.

Source of information obtained from: http://news.aapc.com/index.php/2010/10/oig-2011-work-plan-old-and-new-targets/

Utilization of Services of Scribes

Physicians may on occasion utilize the services of scribes to assist with documentation during a clinical encounter between the physician and patient. The scribe is present during the encounter and records in real time the actions and words of the physician as they occur. Scribes may not interject their own observations or impressions into the medical record.

The physician is ultimately responsible for all documentation and must verify that the scribe's note accurately reflect the service provided.

The scribe's note should also include their name and legible signature, the name of the physician providing the service, the date, and name of the patient for whom the service was provided.
The physician's note should indicate affirmation of the physician's presence during the time encounter was recorded, verification that the information was reviewed by themselves, and that everything is accurate.

Source of information: http://www.cms.gov/manuals/downloads/pim83c03.pdf | NGS E-mail Update

Mandatory Influenza Vaccine

In a new policy, the American Academy of Pediatrics (AAP), states that "despite the efforts of many organizations to improve influenza immunization rates with the use of voluntary campaigns, influenza coverage among health care personnel remains unacceptably low" and recommends that all health care personnel should be required to receive an annual vaccine.

The Society for Healthcare Epidemiology of America (SHEA) and the Infectious Disease Society of America (IDSA) have already endorsed mandatory vaccination policies for all health care workers to reduce risk of infection among patients and employees.

The Advisory Committee on Immunization Practices began recommending influenza immunization for health care workers in the early 1980s; however, according to a Rand Corp. survey last year, 39 percent of health care professionals said they would not get a flu vaccine, even with the threat of pandemic flu. With that threat over, that rate will likely be even lower this year.

Vaccine shortages put the policy on hold, but the State of New York Department of Health is writing a permanent regulation to make influenza vaccination a condition of employment for health care personnel, according to *Infectious Disease News*.

State Sen. Tom Duane, who chairs the health committee, said he is reintroducing a flu shot bill, according to *The Epoch Times*. "People don't like being told what to do, but frankly, if you work in a hospital setting, flu vaccination should be mandatory," Duane told the *New York Daily News*. "There will be people mad about it, but I do believe it's necessary."

Source of information obtained from: http://news.aapc.com/index.php/2010/10/mandatory-flu-shot-bill-is-reintroduced/

Risk Management Policies Should Include:

- HIPPA privacy and security rules (www.hhs.gov)
- OSHA (www.osha.gov)
- Labor Law- US Department of Labor e-laws (www.dol.gov/elaws)

Audiology TC/PC Divided Codes

The instruction further states that if a service such as comprehensive auditory evoked potentials– has both a technical component (TC) and a professional components (PC), then the TC may be preformed by a technician who is appropriately trained, following a protocol, and supervised by the physician . The supervisor is providing the PC for the service.
In the explanation of PC/TC divided codes, CMS states that "a physician may not bill for a PC service furnished by an audiologist" An audiologist employed by or in a contractual relationship with a physician or physician group must be an enrolled supplier of Medicare services. Audiologists who render services in office or clinic settings should bill for the PC services (or any covered audiological service) using their own NPI as the rendering provider on the claim. However, if an audiologist is employed by a physician or physician group, payments may be "reassigned" to the employer. Audiologists may complete a Reassignment of Benefits form for each employer so that the payment for service rendered by the audiologist can be directed to the physician or group that employs the audiologist

Source of information from: The ASHA Leader | August 3, 2010 Pg. 4

Check Out Cpt 2011 Codes For Cardiology

CPT 2011 has more new cardiology codes than you can imagine. Whether it's revascularization, heart catheterization, observation services, and more, all have new looks for the coming year. Read on and get an overview of what you can expect in the next round of CPT codes.

37220-37235: Endovascular revascularization, open or percutaneous

The CPT codes in this category are distinguished by the vessels involved: iliac, femoral/popliteal, and tibial/peroneal. Other distinguishing features include whether the physician carries out angioplasty, stent placement, and/or atherectomy. For instance, the definition of 37231 will be "Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when carried out."

93451-93464, 93563-93568: Cardiac catheterization & coronary angiography
If you like code range shake ups, you will like this. These 20 just-in codes cover options for reporting combinations of services, covering right and left heart caths, cath placement for coronary angiography, and injection procedures.

As a consequence of these additions, you will have to say good bye to some of your old favorites. The deleted codes are inclusive of 93501, 93508-93529, and 93539-93556.

99224-99226: New codes for subsequent observation care
Subsequent day observation care will also get new codes, which are reportable each day. You will need to give more attention to these just-in codes as they'll change the way you code an observation stay longer than 48 hours.

Stay tuned: These new CPT codes are just the beginning. There will also be new Category III atherectomy and iliac repair codes with effect from January 1. Many existing codes will see revisions, including iliac repair, angioplasty, non-coronary stent placement, wearable ECG recording, and non-invasive physiologic studies.

Source: http://www.articlesnatch.com/Article/Check-Out-Cpt-2011-Codes-For-Cardiology-/1695658

Optimize Nuclear Medicine Coding

1. Select the appropriate HCPCS code for the radiopharmaceutical agent used for stress test.

Separate payment for radiopharmaceuticals can be made when this supply is billed in connection with certain procedures [diagnostic radiologic procedures [including diagnostic nuclear medicine] requiring pharmaceutical or radiopharmaceutical contrast medical and/or pharmacological stressing agent).

Utilize this HCPCS code to indicate the use of the thallium: A9505 (supply of radio-pharmaceutical diagnostic imaging agent, thallous chloride TI-201, per mCi). This radiopharmaceutical code is for each mCi. So use it as many times as necessary to account for the entire dose. For example, if three mCis were used, bill the code three times. (Check with your local carrier for their specific requirements.)

Note: You may see an imaging stress test called treadmill-MIBI that uses another radiopharmaceutical, called sestamibi, instead of thallium. It is coded the same way as a thallium stress test, except the HCPCS code is A9500 (supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m sestamibi, per dose). This HCPCS code is per dose; therefore use it only once per injection, no matter how many MCIs of Tc99m are used, explains McKusick. But if there are two

injections, for rest and stress, then use the code twice.

2. Code for the pharmacological agent, if appropriate.

Sometimes, because of an illness, injury or chronic condition, patients cannot exercise and myocardial stress is induced through an intravenous injection of pharmacological agents such as dipyridamole (Persantine), adenosine (Adenocard), or dobutamine (Dobutrex).
If the non-exercise stress test is performed at a site where the physician does not own the equipment, then the drug is considered a hospital supply and as such cannot be billed separately by the cardiologist. But you may be entitled to bill for the drugif your practice owns the equipment. For Medicare and other payers that accept HCPCS codes, use the following:

J1245 - injection, dipyridamole, per 10 mg
J1250 - injection, dobutamine HCI, per 250 mg
J0152 - injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270)

Note that many payers have strict requirements when billing for the pharmacologic agent in stress testing. Some require a copy of the pharmaceutical invoice to support the claim, notes the American College of Cardiology. Other payers cover pharmacologic stress testing only when exercise testing is documented as not possible, notes the American College of Radiology. Such payers may require that the need for pharmacologic testing be documented in the patients medical record as well as on the claim form with the appropriate ICD-9 code. And be sure to check with your payers to find out their specific requirements.

Note: Do not bill for actual intravenous administration of the drug because that is considered part of the test and therefore, should not be coded separately.

2011 New, Revised, Deleted Podiatry Diagnosis Codes

There are no "significant" changes for 2011 that effect the Podiatric practice
V13.63 Personal history of (corrected) congenital malformations of nervous system
V13.68 Personal history of (corrected) congenital malformations of integument, limbs, & musculoskeletal systems

V15.53 Personal history of retained foreign body fully removed

DELETED CPT CODES
11040 Deleted effective January 1, 2011
11041 Deleted effective January 1, 2011

NEW CPT CODES
11045 NEW 2011 DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
11046 NEW 2011 DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
11047 NEW 2011 DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64566 NEW 2011 POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE TREATMENT, INCLUDES PROGRAMMING

Also several SUBSEQUENT OBSERVATION CARE codes will be added effective January 1, 2011.

Healthcare News of Physical Therapy

Physical Therapy 2020 According to APTA

APTA Vision Sentence for Physical Therapy 2020

By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and perfection of impairments, functional limitations, and disabilities, related to movement, function, and health.

APTA Vision Statement for Physical Therapy 2020

Physical Therapy, by 2020 will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Physical therapists will be practitioners of choice in patient health networks and will hold all privileges of autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist directed and supervised components of interventions.

Source of information obtained from: Empire State Physical Therapy | September/October 2010, pg. 17

Direct Access: Physical Therapy Treatment without a Referral

On November 20, 2006 the "Direct Access" law went into effect in NY allowing physical therapists with three years of practical experience to treat patients without a referral. Many practitioners have yet to embrace direct access in their respective physical therapy setting. The defined required experience is three years on practical experience which is defined as 4,329 hours, or 30 hours per week for 48 weeks per year, and must be accomplished over a 36 month period. Once the physical therapist has completed the evaluation and discussed the plan of care with the patient, a physical therapist assistant or student may provide care. Care may also be provided by a physical therapist that does not have direct access privilege; however, only the physical therapist with direct access privilege may alter the plan of care. The length of treatment without referral is limited to 10 visits or 30 days regardless of who is providing the care.

The 10 visits begin when the first treatment is provided and ends when a patient is discharged from care after a maximum of 10 visits or 30 days. An important point to be aware is that the initial evaluation is not included in the 10 visits unless treatment begins on the same day.

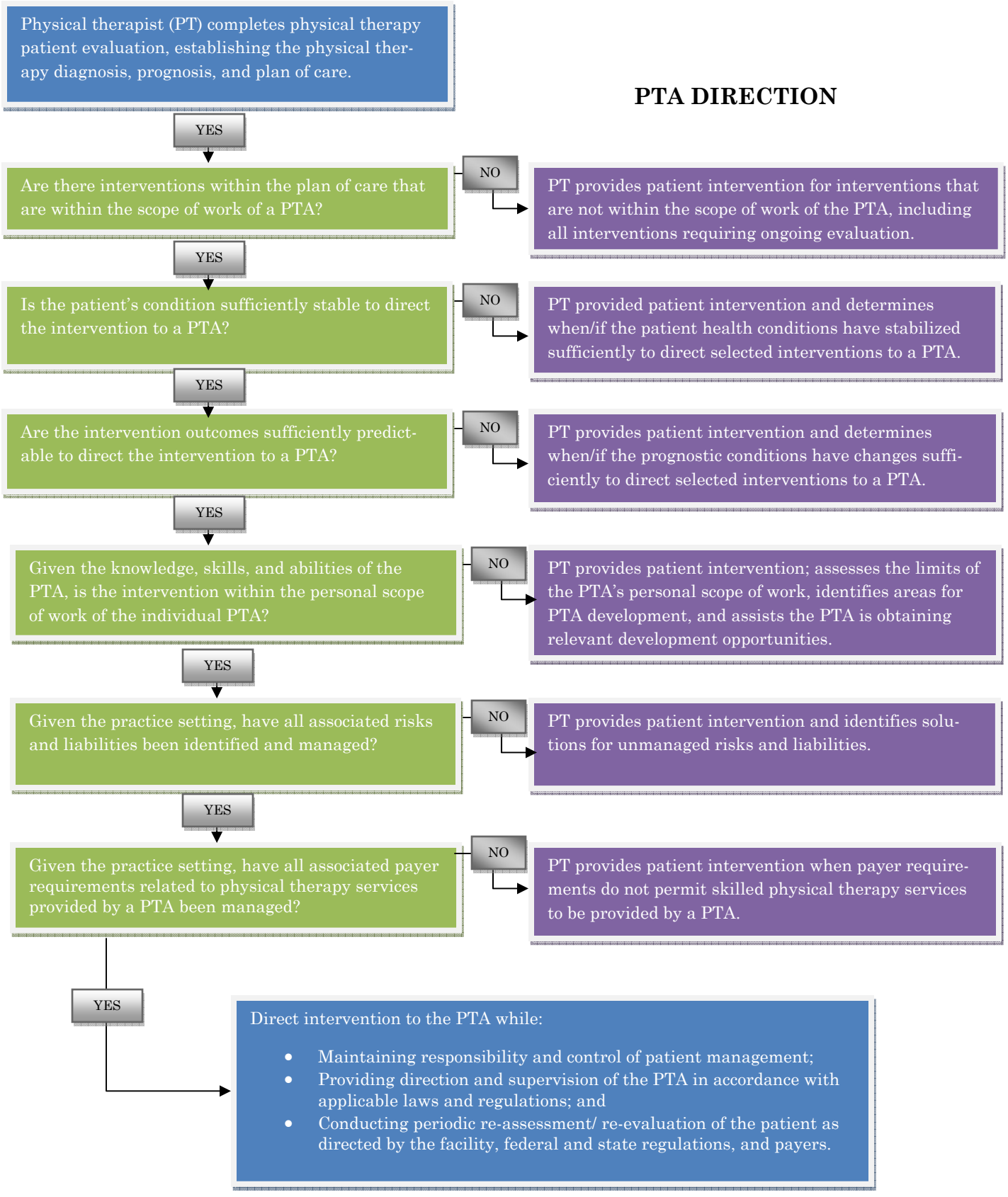
The law does not restrict the populations that can be served or the facilities where treatment takes place. There are no restrictions specific to age or site. However, insurance reimbursement, specific work-place policies or NYS regulations (e.g. SNF, home health, schools, etc.) may restrict treatment being provided under direct access. Therefore, it is the responsibility of the physical therapist to be aware of the insurance requirements, specific work site policies or any NYS regulations prior to providing physical therapy services under the direct access law.

Source of information obtained from: Empire State Physical Therapy | By Jennifer Bunao, OT, DPT, NYPTA Practice Committee | September/October 2010, Pg. 11

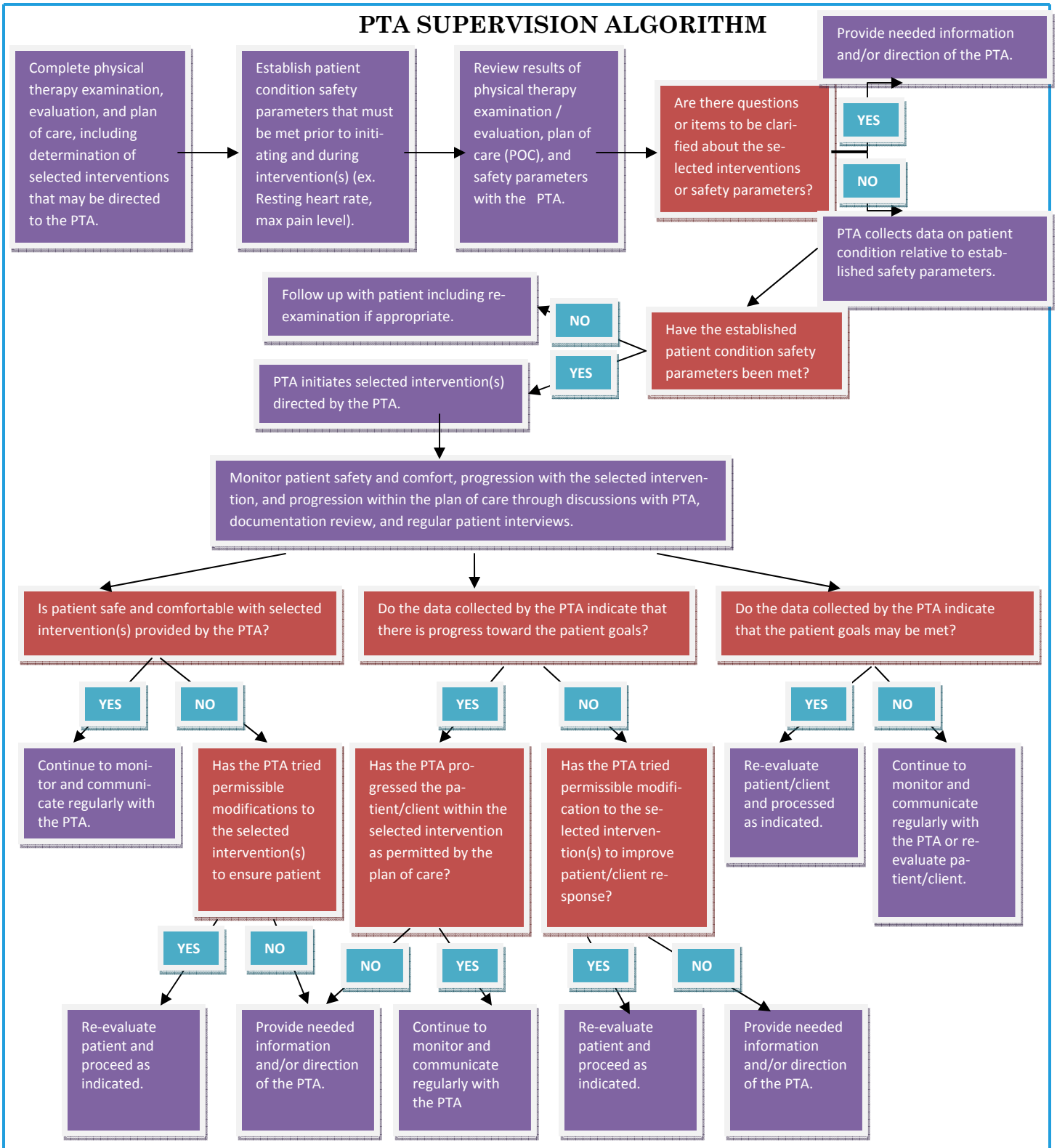
Legislative Update

A10137-S7121 – Extends the provisions of Chapter 534 of the Laws of 1993 relating to PTAs to provide services in home care settings for an additional four years. These services are allowed when the supervising physical therapist establishes a program of care for a patient, has an initial joint visit with the patient and the PTA, periodically evaluates and treats such patient and provides a final evaluation to determine if the treatment plan should be terminated. – Signed into Law July 30; chap. 258

Source of information obtained from: Empire Physical Therapy | September/October 2010


PTA DIRECTION
Physical therapist (PT) completes physical therapy patient evaluation, establishing the physical therapy diagnosis, prognosis, and plan of care.
YES
Are there interventions within the plan of care that are within the scope of work of a PTA?
NO
PT provides patient intervention for interventions that are not within the scope of work of the PTA, including all interventions requiring ongoing evaluation.
YES
Is the patient's condition sufficiently stable to direct the intervention to a PTA?
NO
PT provided patient intervention and determines when/if the patient health conditions have stabilized sufficiently to direct selected interventions to a PTA.
YES
Are the intervention outcomes sufficiently predictable to direct the intervention to a PTA?
NO
PT provides patient intervention and determines when/if the prognostic conditions have changes sufficiently to direct selected interventions to a PTA.
YES
Given the knowledge, skills, and abilities of the PTA, is the intervention within the personal scope of work of the individual PTA?
NO
PT provides patient intervention; assesses the limits of the PTA's personal scope of work, identifies areas for PTA development, and assists the PTA is obtaining relevant development opportunities.
YES
Given the practice setting, have all associated risks and liabilities been identified and managed?
NO
PT provides patient intervention and identifies solutions for unmanaged risks and liabilities.
YES
Given the practice setting, have all associated payer requirements related to physical therapy services provided by a PTA been managed?
NO
PT provides patient intervention when payer requirements do not permit skilled physical therapy services to be provided by a PTA.
YES
Direct intervention to the PTA while:
• Maintaining responsibility and control of patient management;
• Providing direction and supervision of the PTA in accordance with applicable laws and regulations; and
• Conducting periodic re-assessment/ re-evaluation of the patient as directed by the facility, federal and state regulations, and payers.

PTA SUPERVISION ALGORITHM



Insurance News

Centers of Medicare and Medicaid

Comparative Billing Reports

The Centers of Medicare and Medicaid Services (CMS) is always looking for new ways to educate providers, one of the approaches used is Comparative Billing Reports (CBRs). CBRs are based on selected study topics to look at utilization patterns and communicate this information to providers. CBRs provide comparative data on how an individual health care provider varies from other providers. Providers have found these reports very helpful and encouraged CMS to produce more CBRs and make them available to providers; therefore, CMS is reaching out by contracting with two new contractors to produce and disseminate these CBRs.

If you have any questions regarding the CBR, please contact the CBR Producer:

SGS SBR Services Helpdesk (530) 896-7080 or visit www.cbrservices.com
To update your contact information or change your preferred method of receipt of CBRs, please contact:

Livanta LLC (888) 313-9666 or visit www.cbrcontactupdate.com

Source of information obtained from: Provider CBR cover letter

CMS Targets Services for Review:

A recent OIG report found nearly $45 million in improper Medicare payments in 2007 for transformational epidural injection services and $23 million in improper facility fee payments associated with those professional services. CMS will be increasing its oversight of these claims, especially for injections performed in the office setting. A review of place-of-service coding of physician services processed by Medicare that same year revealed place-of-service overpayments of $13.8 million. Services have a higher payment rate when performed in non-facility locations where the physician incurs the overhead expense. In the audit sample, only 10 of 100 coded services qualified for the higher non-facility practice expense payment. CMS will review questionable claims from the period and will develop a data match to identify physician services at high risk for place-of-service miscoding. An OIG study of chiropractic claims from 2009 found a 31.7% error rate with $174.1 million in projected improper payments. CMS will perform a focused review of whether chiropractic services were medically necessary acute chiropractic treatment and deny claims determined to be maintenance therapy. Physicians contacted by Medicare for review should call Kern Augustine at 800-445-0954 for assistance.

Source of information obtained from: NY SL September 2010 Health Law Update

Medicare

Providers Ordering Service

Do you order laboratory tests, radiology services, other types of diagnostic tests, diabetes self management training, medical nutrition therapy or durable medical equipment or supplies? If the answer is yes, your National Provider Identifier (NPI) is entered on claims sent to Medicare as an ordering/referring physician. **Beginning January 3, 2011, when those claims reach your Medicare contractor and the NPI entered as the ordering/referring is not in the Provider Enrollment, Chain and Ownership System (PECOS) those claims will reject and not be paid.**

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), contact WCH today and let us get the application completed for you.

Source: http://www.ngsmedicare.com/Content.aspx?DOCID=23906&CatID=2

Therapy Services Primary Diagnosis Need to Indicate Reason of Encounter

Effective November 1, 2010, when coding for therapy services, the primary diagnosis codes should indicate the reason for the encounter, and the specific condition for which therapy services are provided MUST also be included as secondary and subsequent diagnoses. Claims without secondary diagnoses may be denied.

Primary Diagnoses:

- V57.1 CARE INVOLVING OTHER PHYSICAL THERAPY
- V57.21 CARE INVOLVING OCCUPATIONAL THERAPY
- V57.3 CARE INVOLVING SPEECH-LANGUAGE THERAPY
- V57.81 CARE INVOLVING ORTHOTIC TRAINING
- V57.89 CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE

Q: How will this affect you?

A: PT providers will need to place – V57.1 – as a primary diagnosis and OT providers will need to place- V57.21 as a primary.

Source: NGS Medicare Future LCD for Outpatient Physical and Occupational Therapy Services (L26884)

Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities No Documentation or Insufficient Documentation Submitted

WCH would like to inform you of the recent news from Medicare Learning Network. Please review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

RAC demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration:

• Provider non-compliance with timely submission of requested medical documentation; and

• Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

CMS reminds providers that medical documentation must be submitted within 45 days of the date of the Additional Documentation Request (ADR) letter. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim. Also there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

• RACs must clearly indicate deadlines for submission of medical records in ADR letters;

• RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation;

• RACs must accept and review extensions requests if providers are unable to submit documentation timely;

• RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim;

• RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records;

• RACs must implement the RAC look back date of 3 years with a maximum look back date of October 1, 2007;

• RACs must limit the number of medical records requests every 45 days;

• RACs must indicate the status of a provider's additional documentation requests on their claim status websites;

• RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and

• RACs must post all approved issues under review on their websites.

CMS recommends providers implement a plan of action for responding to RAC ADR letters (tracking audit and appeal findings, identifying patterns of error, implementing corrective actions). Providers should also consider monitoring their RAC websites for updates. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

The following list identifies information unique to each of the four RACs, the States they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

RAC Region A- Diversified Collection Services (DCS), Inc. of Livermore, California:

States in Region: Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).

Subcontractors: PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies

Email: Info@dcsrac.com Website: http://www.dcsrac.com/portal.html

Revisions and Reissuance of Audiology Policies: The Key Points

- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician.
  - **CARC 170:** (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
  - **RARC N290:** (Missing/incomplete/invalid rendering provider primary identifier.)
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills.
- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician.
  - **CARC 185:** The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; and
  - **RARC M136:** Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service.
- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services are not "always" therapy services and the audiologist is qualified to perform the service.
- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.

- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
- The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

Don't forget you have only until December 31 to submit

Medicare claims with dates of service from

October 1, 2008 through December 31, 2009!

Prepayment Audit for CPT 98941 for Part B Jurisdiction 13 (NY and CT Only)

National Government Services Medical Review Department for the Jurisdiction 13 Part B Medicare Administrative Contractor (MAC) is performing a service-specific prepayment audit of CPT code 98942 (Chiropractic manipulative treatment (CMT); spinal, 5 regions). To date, the audit findings are:

- Only 11% of all the claims reviewed were allowed for payment
- Of the 11% allowed for payment, over half of the claims were reduced to 98940 (Chiropractic manipulative treatment [CMT]; spinal, 1-2 regions level due to the documentation not supporting the level billed)

In addition, separate post payment audits were conducted in 2009 for CPT code 98941 (Chiropractic manipulative treatment [CMT]; spinal, 3-4 regions) in which NGS reviewed approximately 1320 claims that resulted in an 80 percent error rate.

A recent Office of Inspector General (OIG) audit found that significant vulnerabilities exist in connection with chiropractic claims, particularly concerning Medicare payments for maintenance therapy. The 2009 Medicare fee-for-service (FFS) error rate for chiropractic services was 31.7 percent with $174.1 million in projected improper payments. Maintenance therapy and missing plans of care were the primary cause of errors.

Based on these results, NGS will be implementing a service-specific prepayment audit for CPT code 98941 (Chiropractic manipulative treatment [CMT]; spinal, 3-4 regions) for the Connecticut and New York regions.

This audit will be validating that the documentation supports the level of service billed and Medicare coverage criteria is met for medical necessity. Providers are encouraged to review the Local Coverage Determination (LCD) for Chiropractic Services (L27350).

Source of information obtained from: http://www.ngsmedicare.com/content.aspx?CatID=2&DOCID=23923

Medicare Physician Fee Schedule Update for 2011

We once again are at the time of year where we await on Congress for the Medicare fee schedule for the following year to be released. Congress has kept quiet and will stay quiet until after the November 2 midterm elections, although there was a bit of scurrying before the Oct. 8 adjournment.

On June 25, President Barack Obama signed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 to forestall a 21 percent pay cut and provide physicians with a 2.2 percent positive update to Medicare payments. Unfortunately, that increase has an expiration date. Physicians are now looking at a 23 percent cut in their Medicare payments beginning Dec. 1 and another 6.5 percent pay cut Jan. 1, 2011.

The U.S. Senate is considering proposals for another temporary pay patch, according to the American Medical Association (AMA). One of the proposals being considered would extend the current 2.2 percent payment update for the remainder of 2010 and give physicians an additional 1 percent increase in 2011. However, barring further Congressional intervention, the sustainable growth rate (SGR) formula would go into effect in 2012 and payments would be cut by an estimated 33 percent.

Other legislation would do away with the SGR formula entirely. Sen. Blanche Lincoln introduced a bill Oct. 4 that would repeal the current Medicare physician SGR payment system and provide physicians with annual updates.

As Congress is adjourned until Nov. 15 and a holiday recess follows soon after, it is unlikely this bill will be considered before next year. With such a small window of opportunity, it's more likely physicians can expect a repeat performance of last June

Source of information obtained from: http://news.aapc.com/index.php/2010/10/medicare-physician-pay-cut-looms-again/

How Medicare's practitioners used office visits E/M coded in 2008

Code	Allowed Services	Allowed Charges
99201	330,246	$10,993,149
99202	2,380,961	$141,111,643
99203	5,301,932	$468,388,530
99204	3,312,271	$449,870,244
99205	1,025,974	$175.958,255
99211	8,949,081	$171,164,076
99212	20,237,336	$260,482,185
99213	102,020,752	$5,942,894,563
99214	69,042,867	$6,069,446,356
99215	8,526,696	$1,023,502,977

In all, Medicare paid practitioners for 221,128,116 million office visits in 2008. Nationally, 99203 and 99213 were the codes all specialties billed most frequently for new and established patient visits, respectively.

Source of information obtained from: The Coding Institute | July 2010

Highmark Medicare

Highmark Medicare has initiated a prepayment review for all claims with 99204 and 99205

For any claims sent in, requests will be sent to the provider requesting copies of the medical record before any payment is made. They are looking for supporting content to justify these levels of services and signature legibility and meeting the "incident to" guidelines, among other things mentioned.

This is across the board - all specialties, affecting providers from these states: Delaware (DE), District of Columbia Metropolitan Area (DCMA), Maryland (MD), New Jersey (NJ), and Pennsylvania (PA)

Source of information: https://www.highmarkmedicareservices.com/bulletins/partb/news09202010.html

Medicaid

Budget Cuts Cause a 1.1% Reduction in Reimbursement

The final 2010-11 State Budget (Chapter 313 of the Laws of 2010) requires across the board reductions to most undisbursed general fund and state special revenue aid to localities appropriations (including Medicaid, school aid, social services, etc) commencing on September 16, 2010. These provisions were enacted to address financial plan deficiencies related to reductions to the enhanced Federal Medical Assistance Percentage (FMAP) authorized by Congress. Based on this recently enacted statute, the State is implementing a 1.1% across the board reduction to all Medicaid payments that

are processed on or after September 16, 2010. The reduction will remain in effect through March 31, 2011.

Paper remittances will display the actual reduction amount as a recoupment identified by Financial Reason Code 'FCF' and the corresponding description of 'FMAP CONTINGENCY FUND'. Similarly, the 835 electronic remittances will carry the reduction amount in the PLB segment with the qualifier J1. If you see that actual check amount less than total amount paid to the provider, you need to check at the glossary, if the reason of reduce is J1

Source of information: http://www.nyhealth.gov/health_care/state/fmap_contingency_plan/ ;

http://www.emedny.org/Medicaid_Payment_Reductions_2010-09-29.pdf

Elderplan

Terminating Classic I Plan for all Members

Elderplan will be terminating their Classic I plan for all members as of 2011. However, Elderplan has created a new plan to transfer these patients to, Medicare Advantage plus Managed Long Term Care (MAP). Any patient currently enrolled into the Elderplan's Classic I program, and qualifies for full Medicaid, can switch to the new plan. Your patients would not have to give up their membership in Elderplan, they can switch now, and neither you nor those patients will experience any disruption in coverage.
The new plan offers many great added benefits for your patients such as: personal care assistants, transportation, and expanded dental, vision and hearing coverage.
Elderplan patients can switch to MAP now, and do not have to wait to 2011 to enjoy these added benefits.

Source of information obtained from: Elderplan Letter of Inform

Worker's Compensation

The Worker's Compensation Alter to Many Positive Changes

Worker's Compensation Board proposed a new fee schedule that includes an across-the-board 30% increase to the Evaluation and Management service codes, effective December 1, 2010. The board will also conduct reviews and revisions of the physician and health care provider fee schedule over the next 12 months.

The Worker's Compensation Board is preparing to implement a major change in the manner medical care that is provided to injured workers. The NYS Workers' Compensation Medical Treatment Guidelines will become the mandatory standard of care for the mid and low back, neck, shoulder, and knee, effective for dates of service on or after December 1, 2010. These for body parts were chosen because they represent the most frequent claims and the highest medical costs.

The medical treatment guidelines will: establish a standard of medical care for injured workers; expedite quality care for injured workers; improve the medical outcomes for injures workers; speed return to work by injured workers whenever possible; reduce disputes between payers and medical providers over treatment issues; increase timely payment to medical provider; and reduce overall system costs.

Source of information obtained from: Worker's Compensation Information Letter

Filing of Worker's Compensation Claims

In this article we will discuss the keys to minimizing delays and better ensuring success when treating Worker's Compensation (WC) patients. WC claims are mostly filed through the employer, using a specific form such as an accident report or first report of injury. To be certain that a WC claim can be filed and is approved you must answer to the following question: "Is this a work related condition?" If yes, verity with patient that they have filed the appropriate paperwork and the claim has been approved. Ask for an identification number. If the patient has yet to file a claim, they must do it promptly. Most states have a time limit to file claims which usually varies from a few months to a year. Once the claim has been filed, a claim manager will review the information to determine whether to approve or deny. Acute situation injuries are typically approved faster than those for occupational disease.

You should understand if the correct entity is being billed. Ask the patient is he or she know who is responsible for paying WC bills. If the patient does not know, you should contact the employer's human resource office. The following parties may be responsible for paying workers' compensation bills:

- Self-insured companies that administer their own workers compensation claims;
- A third-party administrator (TPA) under contract to manage a self-insured company's claims
- A private workers' compensation carrier
- A state-funded insurance company
- A provider network under contract with the above parties
- The federal government for some federal programs

You can visit: www. Apta.org and click on "areas on interest", "reimbursement", "then "workers compensation" to determine who to bill when you know what state law permits in terms of insurance carriers and networks.

Source of information obtained from: Compliance Matters | By: Karen Jost, PT, MS | September 2010, pg 40

Atlantis Health Plan

Shut Down of Health Plan or Reorganization Plan

The New York State Department of Insurance will require that Atlantis Health Plan Inc. take steps to begin disenrollment of all members by November 1 and may initiate a process to liquidate Atlantis on or after that date unless their currents reorganization/recapitalization plan is successful. Atlantis has presented their plan to the New York Department of Insurance.

Options available for Atlantis Health Plan Inc.:

- Shut down of the health plan: will result in the disruption of care to health plan members and drastically reduce payments if any to providers.
- Reorganization Plan: Atlantis has experienced capital partner willing to infuse the required capital which will allow Atlantis to emerge as a fully financially stable and compliant health plan starting November 1, 2010.

This statement is written on all Atlantis Health Plan checks sent to you. By cashing that check you agree that under no circumstance will you Balance Bill either Atlantis or any member for any monetary amount above and beyond the agreed amount except for any applicable co-payments, deductibles, or coinsurance.

Source of information obtained from: Client's check from Atlantis Health Plan, Inc

EMPIRE | BlueCross BlueShield

Child Health Plus Aligns with Medicaid's Fee Schedule

Effective January 15, 2011, Empire will update its Child Health Plus (CHP) physician and practitioner fee schedule to more closely align with Medicaid which is consistent with other government program reimbursement rates in the industry. As NYS continues to focus on healthcare costs to address budget deficits, the 2010-2011 New York State budget included a substantial reduction to monthly premiums payable to participating CHP plans including Empire. To ensure that these reduced premiums are adequate to cover medical expenses for the population, it has become necessary for Empire to more closely align their reimbursement with Medicaid.

Accordingly, the CHP fee schedule will be reimbursed at 100% of New York State Medicaid for dates of service on and after January 15, 2011.

EMPIRES CURRENT HMO, PPO, INDEMNITY, MEDICARE, AND HEALTHY NY RATES WILL **NOT** CHANGE.

Source of information obtained from: EMPIRE BULLETIN

Entertainment

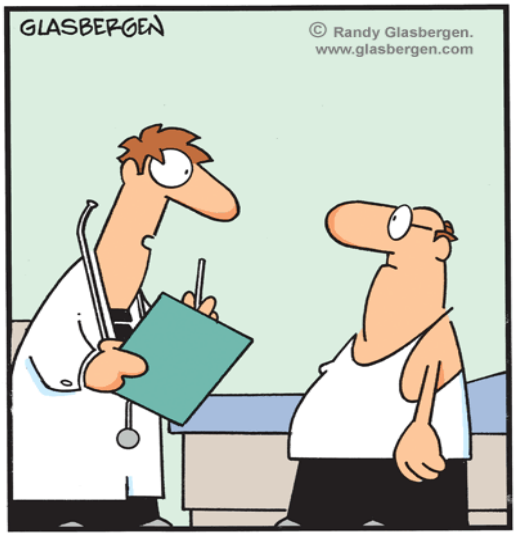
Interesting facts about October 2010:

This OCT. has:
5 Fridays;
5 Saturdays; and
5 Sundays, all in 1 month!

"You Must Be Joking!" - Layman's Dictionary of Medical Terms

Artery : study of paintings
Bandages : The Rolling Stones
Bacteria : back door to a cafeteria
Caesarean Section : a district in Rome
Cardiology : advanced study of card games
ICU : Caught you
Labor Pain : hurt at work
Medical Staff : a doctor's cane
Minor Operation: coal digging
Node: was aware of *(knew)*
Outpatient: a person who has fainted
Pathological: a reasonable way to go *(logical path)*
Recovery: Room place to upholster furniture
Tumor: an extra pair *(two more)*
Varicose : nearby *(very close)*
Urine : opposite of "You're Out"!

Source of information obtained from: http://www.ambanet.net/amba_news0910.htm



"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

WCH Feedback Form

Please use this form for your suggestions and comments.

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Your Name

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Email Address