WCH TIMES

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Dear Doctors and Office Managers,

Welcome to WCH Times Spring 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

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WCH Corner

WCH PRESENTS COOLSITE4ME

WCH presents an innovative educational www.Coolsite4me.com that creates a virtual environment that brings teachers, parents and students activities together, by allowing them to work and communicate using Coolsite4me.com tools.

Coolsite4me.com goals are:

- To create an exciting learning environment
- Promote parent-teacher communication
- Introduce educational tools that incorporate modern technology
- Create new and exciting way to encourage and track academic progress

Coolsite4me.com provides new exiting educational environment where kids can learn and play. It also makes it easy for teachers and parents to check and mark student's progress as well as create new ways to introduce educational material.

Teachers are provided with tools allowing them to create and present new lessons, tests in digital format, keep a virtual academic journal, and communicate with both parents and students regarding their educational needs.

Parents are allowed to see their children's progress, observe and participate in their learning activities and communicate with teachers via messaging system.

Children are supplied with 3D interactive lessons, games, tests and easy to use communication tools.

Coolsite4me keeps individualized records that let children, teachers, and parents keep track of student's progress in any particular area and correct their learning process as they go.

Coolsite4me.com features:

- 3D lessons and tests
- Private messaging system
- Learning basics of programming
- Customization by WCH

We are currently working on:

- Virtual cinema (downloads and viewing of educational movies in several theaters)
- E-books
- Online tutoring
- Animated helper

WCH is pleased to announce our intentions of presenting Coolsite4me.com tools to the Department of Education in hopes of introducing it to a network of public schools around the US. We will keep you updated on the progress of this exciting new venture.

EMR Update

WCH would like to remind you that CMS is working on implementing incentive for providers that are using an EMR system. This initiative will be applicable to every provider that works with **30%** or more **Medicare** patience and **20%** or more **Medicaid** recipients.

Here are advantages of working with EMR/EHR:

- Instant access to information
- Legible records
- Preventive care reminders
- After visit summaries
- Screened prescriptions

Start year	2011 payment	2012 payment	2013 payment	2014 payment	2015 payment	2016 payment	Total
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$44,000
2012		$18,000	$12,000	$8,000	$4,000	$2,000	$12,000
2013			$15,000	$12,000	$8,000	$4,000	$35,000
2014				$12,000	$8,000	$4,000	$20,0000
2015							

CMS will provide a financial incentive to implement an **EMR** system early. The table illustrates an amount a doctor could expect as reimbursement for using an EMR/EHR. Starting year 2015 there will be penalties for not incorporating an Electronic Records system.

WCH Upcoming Project

We are continuing to work on the EMR project and closely following the implementation date for the scheduled incentives time line. As the deadline set for **January 2011** is approaching to implement incentives for providers that are meaningfully using the electronic medical records in their practice, action should be taken to implement an EMR into each practice.

WCH programmers with collaboration of other physicians have been creating a unique EMR that will be offered to our clients and set for sale on the international market. Having knowledge and experience we are able to gain by providing billing, credentialing, management services, has greatly contributed in creation of a stronger EMR in contrast with any other. WCH is planning to start certification process with CCHIT and Surescripts in the Summer of 2010.

If you are interested in becoming a part of our EMR project, please contact our general manager, Olga Khabinskay for more details. Your suggestions can greatly improve overall performance and usage of the system.

Source of information obtained from: Presentation by James M. Taylor, MD. CPC Kaiser Permanente, Colorodo

WCH Credentialing Department Changes

WCH management understands the importance of having knowledgeable personal handling your credentialing process with the insurance companies. Due to recent organizational changes in the credentialing department, we are reporting that effective April 15th, 2010—credentialing department management has been transferred to Olga Khabinskay. All communications, new requests and other types of questions should be addressed to Mrs. Khabinskay and to Igor Fishman, Assistant Credentialing Specialist.

<u>Credentialing Contacts:</u>

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Olga Khabinskay—Ext 1201 Email: OlgaK@wchsb.com

Healthcare News

Basics of ICD-10

ICD-10 implementation is due to be used as of October 1, 2013; ICD-9 codes will not be accepted on or after October 1, 2013, there will be no grace period. It is important to understand this implantation and know the difference between ICD -9 and ICD-10 codes.

ICD-10-CM – The diagnosis classification which was developed by the Centers for Disease Control and Prevention for the use in all of U.S medical care treatment facilities. Contains 68,000 diagnosis codes, while ICD-9-CM contains on 13,500. Structure of ICD-10-CM is 3-7 characters, examples: P09, S32.010A, 09A.211, M1A.0111. Codes longer than 3 characters always have a decimal point after the 3 characters. The first character is always alpha, while 2nd-7th alphanumeric, 7th character used in certain chapters (obstetrics, musculoskeletal, injuries, and external causes of injury)

ICD-10-PCS – The procedure classification which was developed by CMS, this system uses 7 alpha or numeric digits while the ICD-9 coding system uses 3 or 4 numeric digits. Structure of ICD-9-PCS is 3-5 characters, examples: 496, 414.00, V55.3. Codes longer than 3 characters always have decimal point after first 3 characters. The 1st character is alpha or numeric, while the 2nd – 5th characters are numeric.

The graph illustrates an example of an ICD-9-CM to ICD-10-CM break transition.

ICD-9-CM Mechanical complication of other vascular device, implant and graft	**ICD-10-CM Mechanical complication of other vascular grafts:**
996.1 - Mechanical complication of other vascular device, implant, and graft	T82.310- Breakdown (mechanical) of aortic (bifurcation) graft (replacement)
	T82.311- Breakdown (mechanical) of carotid arterial graft (bypass)
	T82.312- Breakdown (mechanical) of femoral arterial graft (bypass)
	T82.318- Breakdown (mechanical) of other vascular grafts
	T82.319- Breakdown (mechanical) of unspecified vascular grafts
	T82.320- Displacement of aortic (bifurcation) graft (replacement)

Benefits of ICD-10-CM
Up-to-date classification systems will provide much better data for:

- Measuring the quality, safety, and efficacy of care
- Designing payment systems and processing claims for reimbursement
- Conducting research, epidemiological studies, and clinical trials
- Setting health policy
- Operational and strategic planning and designing healthcare delivery systems
- Monitoring resource utilization
- Improving clinical, financial, and administrative performance
- Preventing and detecting healthcare fraud and abuse
- Tracking public health and risks

Some similarities between ICD-10-CM and ICD-9-CM include:

- Format
- Divided into Alphabetic Index and Tabular List
- Tabular List is a chronological list of codes divided into chapters based on body system or condition
- Tabular List is presented in code number order
- Same hierarchical structure
- Codes are invalid if they are missing an applicable character
- Codes are looked up the same way
- Many conventions have same meaning
- Nonspecific codes ("unspecified" or "not otherwise specified") are available to use when detailed documentation to support more specific code is not available

Some differences between ICD-10 and ICD-9 include:

- All codes are alphanumeric
- Codes can be up to 7 characters in length
- Codes are more specific
- Code titles are more complete (no need to refer back to a category, subcategory, or subclassification level to determine complete meaning of code)
- Laterality (side of the body affected) has been added to relevant codes
- Expanded use of combination codes
- Injuries grouped by anatomical site rather than type of injury
- Codes reflect modern medicine and updated medical terminology
- Addition of the 7th character

Source of information obtained from: Centers for Medicare and Medicaid; The Coding Edge July 2008

DEATH & IN DEBT

Do you have large outstanding balances for patients who are deceased? If yes, you must act fast to have these bills paid because, your practice most likely cannot afford to let them go. While you do not want to be insensitive, you deserve to be reimbursed for the services you have provided. Find out about the patient's estate. In many states when a person dies, anyone who is owed anything by the deceased can file a claim against the estate within a certain time limit. You cannot file a claim once the time limit was exceeded. You must write off the bad debt; therefore you must work fast. You can bill your patient's family, if there is no estate; if they will not pay you will have to write off the bad debt. Contact a trust and estates attorney in your area to find out the law for your state.

Source of information obtained from: The Coding Institute | February 2010, Vol. 10, No. 2 pg 9-13.

An EHR on Occupational Therapist

Speech pathologists and physical therapists had the choice of using an electronic medical record and documentation program for a while now. The programs are designed for their use and provided by their national associations. Now, occupational therapists have the choice of using a special electronic health record (EHR) due to a new partnership. The American Occupational Therapy Association (AOTA) has a licensing agreement with Cedaron Medical Inc. to develop an electronic patient record and documentation system for occupational therapy professionals. The software can be customized by OTs, and document all components of patient care, include tools for scheduling patients and communicating directly with billing systems.

Source of information obtained from: Part B Insider | Vol. 11, No. 8, pg 61

HANYS and HCA Charge OMIG

The New York Office of the Medicaid Inspector General (OMIG) has been charged with "abusing its power and authority during provider audits" by the Healthcare Association of New York State (HANYS) and the Home Care Association of New York (HCA). The HANYS and HCA claim that the OMIG has been engaging in wrong principle of behaviors; quality

of care in pursing recoupment efforts was not taken into consideration and accusing practices of abusive billing and coding practices where it did not exist. It has been announced "that the Feds will continue to vigorously investigate and prosecute fraud."

Source of information obtained from: Stat Law 2010 Update | Kern Augustine Conroy & Schoppmann, P.C.

How Long Do You Retain Your Patient's Medical Records?

New York State requires that medical records be **retained for six years**. Physicians must have written documentation if needed to defend against potential audit, malpractice actions, and other professional practice investigations. Although the law is set for six years, keep in mind that under the federal False Claims Act, allows the federal government to look back up to ten years to investigate a suspected violation. Therefore, you are recommended to keep records of **patients who are covered under Medicare or Medicaid for ten years**. Physicians are also encouraged to prepare a written medical record retention policy and train their staff to ensure compliance with the law.

Source of information obtained from: Stat Law 2010 Update | Kern Augustine Conroy & Schoppmann, P.C.

New Law - End-Of Life Decision

On March 16, 2010, Governor Paterson signed into law the Family Health Care Decisions Act (FHCDA), which allows family members to make health care decisions on behalf of patients who lose their ability to make such decisions, and have not prepared advance directives regarding their wishes. Until now, those kinds of decisions could only be carried out if someone has signed paperwork detailing their wishes or legally designating someone to act on their behalf. The problem was that only 20 percent of patients have signed medical orders or proxies, which over the years has created difficult situations. The FHCDA brings a solution to that problem. Family members will now be able to make decisions based on the patient's best interests, even if that patient never filled out a proxy form.

The FHCDA does not apply to individuals without decision-making capacity who have developmental disabilities or who reside in mental health facilities, if health care decisions for these individuals can be made under other laws or regulations. The FHCDA requires establishment of a special advisory committee to guide the Task Force in careful consideration of whether decision-making for these individuals should be incorporated into the FHCDA.

Under reform in New York:

- 2.7 million residents who do not currently have insurance and 734,000 residents who have nongroup insurance could get affordable coverage through the health insurance exchange.
- 1.6 million residents could qualify for premium tax credits to help them purchase health coverage.
- 2.9 million seniors would receive free preventive services.
- 511,000 seniors would have their brand-name drug costs in the Medicare Part D "doughnut hole" halved.
- 249,000 small businesses could be helped by a small business tax credit to make premiums more affordable.

Source of information obtained from: www.state.ny.us/governor

The Health Insurance Reform

In 2019, 30% of people would be uninsured in 29 states and 10% in all other states, if nothing had been done. Less people would have coverage through an employer and more people would be in struggle with high health care costs and health insurance premiums. With the new law, millions of Americans are expected to have coverage, reduced premiums,

and out-of-pocket costs.

How the health insurance reform will affect:

Families**:**

- Ensures consumer protections in the insurance market.
- Creates immediate options for people who can't get insurance today.
- Ensures free preventive services.
- Supports health coverage for early retirees.

Seniors:

- Lowers premiums by reducing Medicare's overpayments to private plans.
- Reduces prescription drug spending.
- Covers free preventive services.

Small businesses:

- Could be helped by small businesses tax credit proposal that makes premiums more affordable

States:

- Reduces state employee premiums.
- Reduces uncompensated care.

Health Insurance Reform Provides Stability, Security, and Choice.

1. Provides relief from rising health care costs: Ends the "hidden tax" and Provides premium tax credits.
2. Promotes health insurance portability and choice.
3. Supports long-term home and community based services.

Health Insurance Reform Improves Quality and Reforms the Delivery System.

- Reduces preventable readmissions.
- Lessens Paperwork.
- Incentivizes primary care.
- Invests in the health care workforce.

Source of information obtained from: http://www.healthreform.gov/reports/statehealthreform/newyork.html

Insurance News

Centers for Medicare & Medicaid Services

CMS has changed its Web site address from www.csm.hhs.gov to www.cms.gov, please take note of this change.

Advanced Diagnostic Imaging Accreditation Requirement

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) implements the law for suppliers including but not limited to, physicians, non-physician practitioners and IDTFs that provide the technical component (TC) of advanced imaging services be furthermore accredited. Suppliers are required to be accredited by **January 1, 2012**. CMS has approved three national accreditation organizations – The American College of Radiology (ACR), The Intersocietal Accredi-

tation Commission (IAC), and The Joint Commission (JCAHO) – that can provide the required accreditation.

MIPPA defines advanced diagnostic imaging procedures as: MRI, CT, and PET; X-ray, ultrasound, fluoroscopy, diagnostic and screening mammography procedures are excluded from the accreditation requirement.

Source of information: www.cms.hhs.gov

CMS Changes Banks

Centers for Medicare & Medicaid have recently undergone a switch with banks to U.S. Bank and JP Morgan Chase. Providers do not have to take any action; this is just an alert that your Medicare payments may be made by a different bank.

Source of information obtained from: CMS Learn Resource: 021004-06

CMS Begun Implementing Changes of the Health Care Reform Provision

Centers for Medicare & Medicaid have begun changes to implement Patient Protection and Affordable Care Act (PPACA). The changes include (directly takes from http://news.aapc.com/index.php/2010/04/health-care-reform-provision-implementation-begins/):

In Part I of **Subtitle B – Improving Medicare for Patients and Providers** of the PPACA (HR 3590):

Section 3102: Extends a floor on geographic adjustments to the work portion of the Medicare Physician Fee Schedule (MPFS) through the end of 2010, with the effect of increasing practitioner fees in rural areas.

Section 3103: Extends the process allowing exceptions to limitations on medically necessary therapy until Dec. 31.

Section 3104: Extends a provision that directly reimburses qualified rural hospitals for the technical component of certain clinical laboratory services through the end of 2010.

Section 3105: Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2010, retroactive Jan. 1.

Section 3106: Extends Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 for two years.

Section 3107: Increases the payment rate for psychiatric services by 5 percent for two years through the end of 2010.

Section 3111: Restores payment for dual-energy X-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006.

In Part II of Subtitle B:

Section 3121: Extends the existing outpatient "hold harmless" provision through the end of 2010, and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of fiscal year (FY) 2010.

Section 3122: Reinstates the policy included in the Medicare Modernization Act of 2003 (MMA) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals from July 1, 2010 to July 1, 2011.

In Part III of Subtitle B:

Section 3131: Among other things, establishes a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1 through 2015.

Section 3135: Increases the practice expense units for imaging services from a presumed utilization rate of 50 percent to 65 percent for 2010 through 2012; 70 percent in 2013; and 75 percent thereafter. Low-tech imaging, such as ultrasound, X-rays and EKGs, are excluded from this adjustment. This provision also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent.

Section 3136: Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied.

Section 3137: Extends reclassifications under section 508 of the MMA through the end of FY 2010.

Section 3131: Requires application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than state-specific, basis through a uniform, national adjustment to the area wage index starting Oct. 1.

There are many more provisions of interest in this bill, such as:

Title VI, Subtitle A, Section 6001: Prohibits physician-owned hospitals that do not have a provider agreement prior to Aug. 1 to participate in Medicare.

To read the full section-by-section analysis, please visit: http://dpc.senate.gov/healthreformbill/healthbill53.pdf

Time Extension for Enrollment Applications

CMS has extended timeliness standards for submission of paper Medicare enrollment applications to carriers and Part A and Part B Medicare Administrative Contractors. These applications include:

1. CMS-855I initial application
2. CMS-855B initial application
3. Change requests and reassignments

This is not applicable to online-based applications.
MLN Matters MM6807 summarizes the timeliness standards:
"Medicare contractors shall process 80 percent of all initial CMS-855I applications where no contractor development is needed within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt. (Development refers to the need for the Medicare contractor to contact the provider for additional information.) In addition, contractors shall process 80 percent of all initial CMS-855I applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial CMS-855I applications where at least two development request are made by the contractor within 90 calendar days of receipt.
For 855B initial applications submitted by suppliers other than independent diagnostic testing facilities (IDTFs), Medicare contractors shall process 80 percent of these applications where no contractor development is needed within 60 calendar days of receipt , and 95 percent of such applications within 90 calendar days of receipt. In addition, contractors shall process 80 percent of all initial CMS-855B applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial CMS-855B applications where at least two development requests are made by the contractor within 90 calendar days of receipt.
For initial 855B applications submitted by IDTFs, Medicare contractors shall process 70 percent of such applications where no contractor development is needed within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt."
For more information on paper enrollment timeliness standards, see CMS Transmittal CR 6807.

Source of information obtained from: http://news.aapc.com/index.php/2010/04/extra-time-for-paper-enrollment-applications/

MEDICARE

INCIDENT-TO BILLING

When billing "incident-to" the physician must have seen the Medicare patient and established a plan of care, and the non - physician practitioner is following the plan of care. If the non-physician practitioner is treating a new problem for the patient, or the physician did not establish a plan of care for the patient, an incident-to visit cannot be reported. Direct supervision should be present (a supervising physician must be immediately available); although, the supervising physician does not have to be the physician that established the plan of care.

Source of information: Part B Insider | Vol.11, No. 9, pg 69

Provide Physical Therapy without a Referral

Under The Medicare Patient Access to Physical Therapy Act (HR 1829), physical therapists are allowed to evaluate and treat Medicare Part B members who require outpatient physical therapy without a physician's referral. As long as the physical therapist has more than 3 years of practical experience, s/he can render services without a referral.

If you have any additional questions, you may contact the State Board by calling (518) 474-3817 ext 180 or emailing ptbd@mail.nysed.gov
Source of information obtained from: NYS Physical Therapy: FAQs

Fee-For-Service Claims Have New Timely Filing Requirements

On March 23, 2010, President Obama sign into law the Patient Protection and Affordable Care Act (PPACA), which designates a time filing person for Medicare fee-for-service (FFS) claims. This provision and many others in the act are aimed to eliminating fraud, waste, and abuse within the Medicare program. The maximum time period for submission of all Medicare FFS claims is one calendar year after the date of service. Claims with dates of service before October 1, 2009, should follow the pre-PPACA timely filing rules, therefore claims with dates of service October 1, 2009 through December 31, 2009 must be submitted by December 31, 2010.

Source of information obtained from: CMS Learn Resource: 201004-02

UNITED HEALTHCARE / AMERICHOICE

Company Background

UnitedHealthcare of New York, Inc. (d/b/a AmeriChoice by UntiedHealthcare), a business unit of UntiedHealth Group, is the nation's largest health and well-being company. AmeriChoice has serviced the public sector exclusively since 1989 and nationally, they service more than 2.6 beneficiaries in 21 states plus Washington D.C.

Health Care ID card Swipe Launch

United Healthcare has released a "Health Care ID Card Swipe". With the instant of a swipe, you will have eligibility and personal health record for your patient. Using the card swipe technology can save your office time and reduce transaction errors. Each United Healthcare member's ID card has a magnetic stripe; a keyboard emulator magnetic stripe card reader that plugs into your computer is all that is needed to begin using this feature. There is a discounted price for in network physicians and health care professionals for a reader, at the price of $55. You can order your discounted card reader through BayScan Technologies by calling (877) 229-7229 or visiting www.bayscan.com.

Source of information obtained from: Untied Healthcare Online

TRICARE

Eligibility and Referral Determinations Available on the WEB and IVR

Effective March 17, 2010, all eligibility verification and TRICARE referral requirement inquiries must be performed using either online tools or the IVR system.

Online @ www.healthnetfederalservices.com - Register @ www.nyTRICARE.com or by phone via IVR @ 877-TRICARE, Option 2.

Topics to be discussed in our Summer 2010 newsletter:

- Healthcare Bill
- IDTF Credentialing
- CPC Examinations
- Coding Services
- Software Development

Our Partners:

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Relax & enjoy!

WCH Feedback Form

Please use this form for your suggestions and comments.

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