WCH TIMES

SUMMER 2010 Issue 13

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Dear Doctors and Office Managers,

Welcome to WCH Times Summer 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

AAPC Members Amongst WCH

Zukhra Kasimova,
Billing Department
Supervisor

Slava Kurdov,
Vise Manager

WCH is pleased to announce that Zukhra Kasimova, Billing Department Supervisor and Slava Kurdov, Vise Manager have become members of the nation's largest medical coding training and certification association, AAPC. Furthermore; Slava Kurdov is preparing for the examination to become a Certified Professional Coder. The exam is scheduled for September 11, 2010.

In addition, we are also proud to announce that Oksana Pokoyeva, CPC will be taking the Certified Professional Medical Auditor (CPMA™) examination this month.

CPMA's responsibilities: Ensuring medical necessity, correct coding and compliance with regulatory issues auditing focuses on many areas of a practice including:

- Compliance and Regulatory Guideline Knowledge
- Coding Concepts
- Scope and Statistical Sampling Methodologies
- Medical Record Auditing Skills and Abstraction Ability
- Quality Assurance and Risk Analysis
- Communication of Results and Findings
- The Medical Record

AAPC American Academy of Professional Coders

Medical Chart Auditing

Medical documentation standards and coding is a quite difficult field. More often one needs to bear in mind that rules and regulations are rapidly changing. Improper coding and documentation often cause delay in filling claims and reimbursement; overpayment, which will be subtracted in the future, and underpayment. Insurances are in high demand of requesting medical documentation more than ever! It is highly important, that preformed procedures are parallel to patient medical condition documented in their charts.

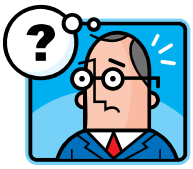
Accurate and timely analysis of physician coding can identify practice insufficiencies and can positively affect your reimbursement. Armed with the most up-to-date information, WCH Service Bureau AAPC certified experts can analyze your charts and review your documents and offer you recommendations based on insurance guidelines.

Our charting auditing service is designed to improve productivity and quality of your business as well as cash flow. For more information about medical chart auditing, please call Olga Khabinskaya @ (718) 934-6714 ext 1201 or email: olgak@wchsb.com

You Have an Idea? Let Us Create It!

WCH IT department is composed of programmers and designers that are equipped and knowledgeable to handle the development of unique software/programs which would eliminate paper process, task management, payroll, and/or any other office accommodations. Some of our clients turn to WCH for help in effort to reduce their chaotic office daily operations, by creating a simple program to maintain patient scheduling. We understand that your practice may need similar solutions; therefore, feel free to contact our IT manager, Alexandr Ivanov @ Alexi@wchsb.com, once he will receive your request, he will evaluate and estimate a reasonable price for the design.

Questions from Clients



Can a Certified Occupation Therapy Assistant Perform Initial Evaluation?

COTAs cannot perform initial evaluations. “The services of COTAs used when providing covered therapy benefits are included as a part of the covered service. These services are billed by the supervising occupational therapist. COTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating occupational therapist and in accordance with state laws.”

Source of information obtained from: Directly from CMS Manual

DDS Hired by MD?

WCH had a question come up recently regarding if a Medical doctor has the right to hire a DDS or the right to register a corporation that will be providing dental services. We’ve found out that only one profession can be practiced in one professional entity. The owner of the professional entity must be licensed in that particular profession, and cannot share fees with other professions. In conclusion an MD is unable to hire a dental provider.

What is the PT Frequency of Treatment?

“Refers to the number of times in a week that the type of treatment is provided. Treatment more than two or three times a week is expected to a rare occurrence. Treatment frequency of greater than three times per week, requires documentation to support this intensity.”

Statement was obtained from the Outpatient Therapy Policy.

What is the Medical Necessity for Outpatient Occupational Therapy?

A patient can have occupational therapy treatment after physician therapy course, which can only be done if the medical necessity criteria are met for occupational therapy service. The medical necessity guidelines from the Medicare LCD (policy) for outpatient physical and occupational therapy are as follows:

Medical Necessity
Section 1862(a)(1)(A) of the SSA states: “No Medicare payment shall be made for expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable as therapy services. Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation, do not constitute (covered) therapy services for Medicare purposes.

To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of outpatient therapies have basic requirements in common.

- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time.

- If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be covered because this is not considered rehabilitative or reasonable and necessary.

- When there is limited potential for restoration of function, establishment of a safe and effective maintenance program must require the unique skills of a therapist.

- A therapy plan of care is developed either by the physician/NPP, or by the physical therapist that will provide the physical therapy services, or the occupational therapist who will provide the occupational therapy services, (only a physician may develop the plan of care in a CORF). The plan must be certified by a physician/NPP.

- All services provided are to be specific and effective treatments for the patient's condition according to accepted standards of medical practice; and the amount, frequency, and duration of the services must be reasonable.

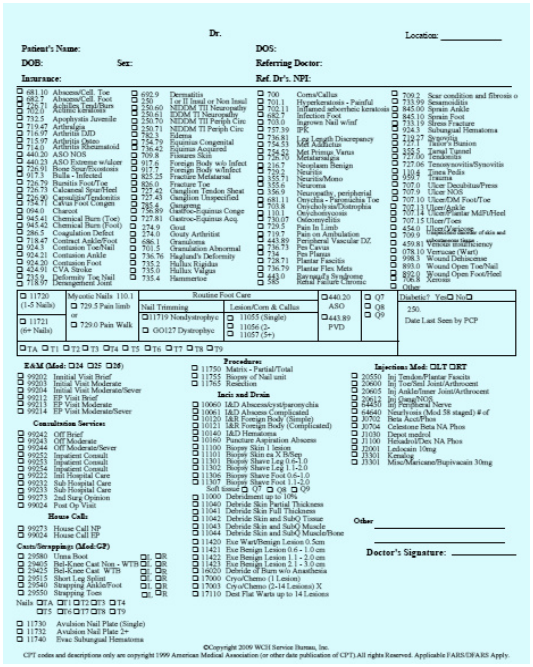
The services, that are provided must meet the description of skilled therapy below.

Skilled Therapy
Services, that do not require the professional skills of a therapist to perform or supervise, are not medically necessary. The skills of a therapist may also be furnished by an appropriately trained and experienced physician or NPP, or by an assistant (PTA, OTA) appropriately supervised by a therapist. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self management program, restorative nursing program, or caregiver assisted program, payment cannot be made for therapy services. Consider the following points when determining if a service is skilled.

Prepared by: *Slava Kurdov, Vise Manager*

What Does A Clean Superbill Consist Of?

A superbill is an itemized form utilized by providers for reflecting rendered services. Superbill is the main data source for creation of healthcare claim, which will be submitted to payer for reimbursement. Although, the superbill form is not unified, and it created/modified depending on the healthcare providers specialty, type of services rendered, additional requirements, as well as ease of handling, there is a set of obligatory attributes, relevant to all superbill types.


Dr. Location:
Patient's Name: DOS:
DOB: Sex: Referring Doctor:
Insurance: Ref. Dr's. NPI:
Routine Foot Care
Nail Trimming
Lesion/Corn & Callus
Diabetic? Yes☐ No☐
Procedures:
Injections: Med: CLT ☐RT
E&M (Med: ☐24 ☐25 ☐26):
Consultation Services
House Calls:
Casts/Strappings (Med:GP)
Incis and Drain
Other
Doctor's Signature:
©Copyright 2009 WCH Service Bureau, Inc.
CPT codes and descriptions only are copyright 1999 American Medical Association (or other date publication of CPT).All rights Reserved. Applicable FARS/DFARS Apply.

A superbill form consists of 4 main parts, containing mandatory field to be completed for accurate claim creation.

Part I – Provider Information

Rendering Provider: Last/ First name and degree, service location, signature

Ordering/referring/attending physician: Last/First name and degree, NPI

Part II – Patient Information

Patient's first and last name, DOB, insurance information (name and ID), date of first symptom (upon necessity), last date seen (upon necessity)

Part III – Visit Information

Date of service, procedure codes (CPT) – list of commonly used codes by medical provider according to the provider specialty, diagnosis codes (ICD-9) – list of commonly used codes by medical provider according to the provider specialty, modifiers (location and conditions modifiers), time (for timed coded), units, quantity for drugs, authorization information (if applicable)

Part IV – Additional Information

Notes and comments

Superbill utilization rules:

1. Each superbill must be signed by rendering provider of service. Superbill without a signature cannot be processed by a medical biller. By signing the document the healthcare provider is acknowledging the services rendered and confirming that information on superbill is permitted to be sent to insurance company by medical biller.
2. All required fields should be completed.
3. Provided information should be readable.
4. CPT and ICD-9 codes should be marked clearly.
5. In case if required CPT or ICD-9 code could not be found in the given lists, provider should give legible handwritten description of service/diagnosis along with additional information (units, time, type, etc.)
6. Only generally accepted medical terminology and abbreviations are allowed.

Which insurance network covers mental health?

Name of Insurance	Covered by:
UnitedHealthcare ID start with 9****	United Behavioral Health
AmeriChoice	United Behavioral Health
ValueOptions: Empire Plan ID with 890	United Behavioral Health/ OptumHealth Behavioral Solutions
Guardian	Magellan (for pricing)
HealthNet	MHN
Neighborhood Health Plan	Beacon Health Strategies
GHI	Value Options
Touchstone	United Behavioral Health
Liberty Health	Value Options
CIGNA	CIGNA Behavioral Health/COMPSYH (not always)
BlueShield ID with "R"	Federal Employee Program
BlueShield with prefix YLS 930***	GHI
Affinity Health Plan	Beacons Health Strategies
Anthem BCBS NJ-CT-	BlueCard Program
GHI-HMO(Medicaid ID#)	Magellan
ConnectiCare,Inc	UBH
WELLCARE	Harmony Behavioral Health
Horizon Health Care	Magellan
NHP SHP	Magellan
HUMANA	PSYCHCARE
Family Health Plan	Health Integrated

THIS IS NOT A GUIDE FOR CLAIM SUBMISSION! This chart is for your reference only. To obtain patient eligibility and authorization, please call the number on the back of the patient's insurance card.

Healthcare News

Before You Dismiss a Patient

Before you dismiss a patient from your practice, you should know the important factors that go into this process. Proper documentation is extremely important to support any reasons for dismissing a patient. If you fail to have supporting documents for dismissal or improperly notify the patient of the dismissal, you may become against patient abandonment and are liable for any resulting damages. Here are several reasons to dismiss a patient:

- **Non-payment of services**
- **Non-compliance with medical treatments, i.e.; repeated refusals of follow-up testing**
- **Non-compliance with office policies, i.e.; consistently missed appointments**
- **Harmful behavior to office staff or patients**
- **Illegal patient behavior, i.e., altered prescriptions, drug abuse**

Steps to terminate patient/physician relationship

- Face-to-face notification followed by a follow-up letter of dismissal. If face-to-face meeting is not possible, certified letter should be sent.
- Notify the patient in writing by certified mail, return receipt requested. Identify the reason(s) why you are terminating the relationship. Typically 30 days is given for the patient to locate a new provider.
- Document the reasons for termination in the patient's medical record and your processes used to notify the patient

Information in letter of dismissal

- Date of notification, Effective date of termination, Reason for termination and attempts made to rectify the situation, Balances due, Termination of which family members, i.e.: Entire family or only certain family members, Names of providers in their area and offer to assist them in locating a new physician, Offer to transfer records to new provider, Explaining the physician's role in taking care of the patient during the 30 days prior to termination, Contact information for any additional questions to include: Phone numbers, Email of the contact person, Contact person's name

Documentation

Documentation of clear attempts to explain concerns to the patient and attempts to rectify non-compliant patients need to be well-documented in the medical record. Explain communication, i.e.; face-to-face, letters, practice policies, and conversations with the patient of the existing problems. Conversations must be explained in non-medical terms, so the patient distinctly understands the issues. These conversations must be included in the documentation.

Source of information obtained from: http://news.aapc.com/index.php/2010/05/youre-fired-dismissing-a-patient/#more-6069

Physician Practice Management (PPM) Company's Duties:

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

The following are responsibilities which must be maintained by management staff of the office:

1. Providing "overall management and administration services";
2. Providing office space;
3. Providing all clinic staff other than physicians or physician assistants;
4. Providing all furniture, fixtures, and equipment required for the operation of the clinic,
5. Including medical equipment;

6. Purchasing all medical inventory and supplies;

7. Providing all billing and collecting, bookkeeping and accounts payable processing, and their accounting services;

8. Maintaining all patient medical records;

9. The PPM should be required in the management agreement to comply strictly with all federal and state confidentiality laws and regulations. The PPM should be required to file promptly all new entries in patient charts and produce patient charts in a timely manner when requested by physicians for the purpose of treating patients.

10. Providing management and administrative services with respect to "risk" or capitation contracts, including processing and paying claims of "downstream" or sub-capitated providers, providing utilization review reports and analysis, establishing "Incurred But Not Reported" ("IBNR") reserves, buying stop-loss coverage, etc.;

11. Preparing financial reports;

12. Since the PPM is in control of the finances and accounting functions of the Practice, the Practice needs equal access to financial information, including periodic and detailed reports from the PPM as to the Practice's financial performance, particularly with respect to payment of expenses and calculation of the management fees. The Practice should have full access to all information and reports prepared by the PPM, including on-line access to the PPM's management information system related to the Practice. Trial balances, general ledger reports, and other information supporting the PPM financial reports as reasonably requested by the Practice, should be provided within a reasonable time;

13. In some agreements, the PPM agrees to prepare tax returns for the Practice. The Practice should reserve the right to have an independent CPA review and amend as needed the tax returns, and the CPA needs access to the appropriate work papers of the PPM to prepare the tax returns;

14. The Practice may want to attach exhibits to the management agreement that are to be the form of various reports to be prepared by the PPM. This will also help the Practice to track its financial performance and make necessary adjustments to improve financial performance.

15. As discussed below, a key financial issue is in which performance duties of the PPM are separately chargeable to the Practice, and which functions are included within the general management fee that is paid to the PPM.

If the PPM also plans to operate, own, or manage an IPA in the market, the management agreement needs to identify specifically what services the PPM is to provide under its obligations under the management agreement versus services the PPM will provide through the IPA. The PPM may charge for the services that are provided separately through the IPA, and the Practice's management agreement needs to specify parameters concerning reasonableness, etc. If the PPM currently operates an IPA, the form of the Practice-IPA agreement should be resolved at the time of closing. Even if the PPM does not currently own an IPA, the Practice needs to consider in a long-term management agreement that the PPM may later decide to form an IPA. That IPA may obtain the key contracts with payers. The Practice may then need to procure contracts through the PPM-managed IPA on terms to be negotiated.

The PPM frequently controls the flow of funds. The basic economic structure is an allocation of revenues or payments between PPM and Practice and an allocation of responsibility for various expenses or payments to third

parties.

PPMs typically have pervasive and even unilateral control over the financial affairs of the Practice. The PPM manages and performs all operational accounting functions. PPMs usually perform billing and collecting for the Practice. Some PPMs do this more effectively and efficiently than the Practices previously did. Other Practices have been less fortunate. Where there has been poor financial performance of Practices after entering into PPM arrangements, a principal reason has been a decline in the collection percentage after PPMs take over billing and collecting. As noted above, this is a particular area where performance standards are warranted for the protection of the Practice.

The management agreement may provide that the Practice assigns all accounts receivable to the PPM. The PPM may have sole ownership and control over the bank account into which the Practice's collections are deposited. The PPM may have the sole authority to make withdrawals and write checks from this account. The PPM uses the funds to pay the practice overhead, the PPM management fee, and compensation to the Practice, from which the Practice may pay its physician employees and other Practice-related expenses.

In some PPM arrangements, there are monthly purchases of the outstanding accounts receivable of the Practice. The purchase price is typically the gross billings for the previous month (minus adjustments) less expenses reimbursed to PPM and management fee payable to the PPM. The amounts paid to the Practice under the management agreement are then used by the Practice to pay compensation and benefits to physicians and other expenses. The purchase provisions in the management agreement may be explicit, or the practical effect of the assignment and payment provisions may be a purchase or periodic purchase of accounts receivable.

Many PPM agreements have provisions whereby the Practice and the physicians grant a power-of-attorney to the PPM for the purpose of billing and collecting all revenues associated with the Practice and applying the collected funds pursuant to the terms of the agreement.

Payment to PPM

There are at least four common models of compensating the PPM for the services it provides under the management agreement:

- PPM gets percentage of gross revenues;
- PPM gets percentage of net revenues after paying expenses;
- PPM gets fixed fee, which may include additional fixed fee performance bonuses;
- PPM gets all revenues, from which it pays expenses, pays the Practice a percentage of the "net profits", and keeps the remaining funds.

In each model, the PPM will usually pay and be reimbursed for expenses attributable to the practice's overhead (rent payments, utilities, etc.), and in addition, the PPM is getting an income stream or return on its investment, particularly where the PPM has paid substantial upfront consideration to the physicians or the Practice to enter into the relationship.

Definition of and Responsibility for Expenses

Expenses under PPM agreements fall into three categories:

1. PPM expenses, which are expenses to be paid by PPM out of its management fee;

2. Common" expenses, which are to be paid out of the Practice's revenues before determining any split of profits or bonuses or other profit-related payments tied to net revenues; and

3.Practice expenses, which the Practice pays out of its share of the revenues. Practice expenses usually include all salaries and benefits of the physicians, continuing medical education expenses, medical professional liability insurance (although sometimes this is a "common" expense), etc.

The Healthcare Reform: What's Ahead

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

Healthcare reform should be implemented step-by-step during 10 years, its purpose – to provide health insurance to 32 million Americans who do not have it at present time. For these purposes from the federal budget in the next decade will be spent about trillion dollars – 938 billion dollars.

Now, nearly 48 million Americans (population approximately 305 million) have no medical insurance. The result is their rejection from visiting doctors and savings on medications. A health problem in the absence of health insurance is one of the main causes of American's bankruptcies.

Health system reform according the version of Barack Obama, in particular, provides:

- Increase the number of people participating in public health insurance programs Medicare and Medicaid.
- Large-scale insurance coverage of poor children.
- Subsidies to the insurance system, COBRA (can lose their jobs some time to maintain the same health insurance, which partially or fully paid by the employer).
- Tighter regulation of health insurance companies (in particular, it must issue insurance on a single scale - without regard to its existing customer diseases).
- Tax incentives for small businesses, to encourage employers to buy insurance for their employees
- Permit the import of cheap medicines (drugs now in the U.S. are the most expensive in the world) - their analogs are often sold in other countries (including those in neighboring Canada) is much cheaper. This step has long debated, but faces fierce resistance of pharmaceutical companies.
- Increased funding of preventive medicine.

Insurance companies will no longer be able to deny people already suffering from any serious illness, and would have to insure them on general grounds. Increased costs will pass on to other clients, so that the cost of insurance will increase.

The reform is expected to tighten the requirements for private insurance companies, denying them the opportunity to provide health insurance for persons already suffering from any illness, as well as the denial of registration for life insurance.

Meanwhile, the Government has no plans to run a special program for the public, but as an alternative to the market of private insurers would be established special centers where citizens can buy insurance policies without the coop-

eration of employers.

The reform also provides for imposition of administrative liability, against those whom refuse to buy insurance, and on companies that refuse to sell it. At the same time, persons are not covered under the state program of medical care Medicaid, will receive special support. In addition, under the legislative changes, there will be an improvement in the system for the elderly citizens with necessary medicine in the program Medicare.

The project of health reform in the U.S., developed by Democrats, provides for additional tax for wealthy Americans at the rate of 5.4%, for those whose income is slightly lower - 350 thousand dollars a year.

According to the sponsors, additional taxation would finance the health sector, which is aimed at providing health insurance for all Americans and reducing the cost of treatment. There are currently 50 million Americans that do not have health insurance.

Implementation of the project in life means that, in conjunction with the introduction of the tax, the highest tax threshold in the U.S. will grow to 45%. Currently, the wealthiest Americans pay only 23% tax, while their contributions to the gross income increased over the past 20 years, from 11 to 22%.

Against the reform aimed to increase taxes on the income of the richest citizens and cuts growing government payments to doctors, were made by Republicans. They believe that such innovations will lead to the introduction of national health insurance system. It will only increase the costs of the budget and would deprive Americans opportunities to choose their own doctors.

Health reform will cost the government a billion dollars. It must provide health insurance for all citizens. Those citizens who cannot buy insurance through private insurance companies, as do most Americans need to subsidize.

Health insurance should become more affordable, insurance companies are banned inflate prices of insurance in connection with the deteriorating health of clients; will be eliminated a number of loss-making papers.

Meanwhile, critics of the reform believe that the treatment for the millions of new patients who still have no access to health care, will increase the budget deficit or lead to significant tax increases.

Within One Year of Enactment (2010-2011)

Insurance companies barred from dropping people from coverage when they get sick. Lifetime coverage limits eliminated and annual limits restricted.

Insurers barred from excluding children for coverage because of pre-existing conditions.

Young adults able to stay on their parents' health plans until age 26. Many health plans currently drop dependents from coverage when they turn 19 or finish college.

Uninsured adults with pre-existing conditions will be able to obtain health coverage through a new program that will expire once new insurance exchanges begin operating in 2014.

A temporary reinsurance program is created to help companies maintain health coverage for early retirees between the ages of 55 and 64. This also expires in 2014.

Medicare drug beneficiaries who fall into the "doughnut hole" coverage gap will get a $250 rebate. The bill eventually closes that gap which currently begins after $2,700 is spent on drugs. Coverage starts again after $6,154 is spent.

A tax credit becomes available for some small businesses to help provide coverage for workers.

A 10 percent tax on indoor tanning services that use ultraviolet lamps goes into effect on July 1.

During 2011

- Medicare provides 10 percent bonus payments to primary care physicians and general surgeons.
- Medicare beneficiaries will be able to get a free annual wellness visit and personalized prevention plan service. New health plans will be required to cover preventive services with little or no cost to patients.

- A new program under the Medicaid plan for the poor goes into effect in October that allows states to offer home and community based care for the disabled might otherwise require institutional care.
- Payments to insurers offering Medicare Advantage services are frozen at 2010 levels. These payments are to be gradually reduced to bring them more in line with traditional Medicare.
- Employers are required to disclose the value of health benefits on employees' W-2 tax forms.
- An annual fee is imposed on pharmaceutical companies according to market share. The fee does not apply to companies with sales of $5 million or less.

During 2012

- Physician payment reforms are implemented in Medicare to enhance primary care services and encourage doctors to form "accountable care organizations" to improve quality and efficiency of care.
- An incentive program is established in Medicare for the acute care in hospitals to improve quality outcomes.
- The Centers for Medicare and Medicaid Services, which oversees the government programs, begin tracking hospital readmission rates, and puts in place financial incentives to reduce preventable readmissions.

During 2013

- A national pilot program is established for Medicare on payment bundling to encourage doctors, hospitals, and other care providers to better coordinate patient care.
- The threshold for claiming medical expenses on itemized tax returns is raised to 10 percent from 7.5 percent of income. The threshold remains at 7.5 percent for the elderly through 2016.
- The Medicare payroll tax is raised to 2.35 percent from 1.45 percent for individuals earning more than $200,000 and married couples with incomes over $250,000. The tax is imposed on some investment income for that income group.
- 2.9 percent excise tax is imposed on the sale of medical devices. Anything generally purchased at the retail level by the public is excluded from the tax.

During 2014

- State health insurance exchanges for small businesses and individuals open.
- Health plans no longer can exclude people from coverage due to pre-existing conditions.
- Employers with 50 or more workers who do not offer coverage face a fine of $2,000 for each employee if any worker receives subsidized insurance on the exchange. The first 30 employees aren't counted for the fine.
- Health insurance companies begin paying a fee based on their market share.
- Expand Medicaid eligibility; individuals with income up to 133% of the poverty line qualify for coverage
- Establish health insurance exchanges, and subsidization of insurance premiums for individuals with income up to 400% of the poverty line, as well as single adults. According to Congressional Budget Office estimates, in 2014 the income-based premium caps for a "silver" plan would be the following:

Income	Amount paid for premiums
133–150% of federal poverty level	4–4.7% of income
150–200% of federal poverty level	4.7–6.5% of income
200–250% of federal poverty level	6.5–8.4% of income
250–300% of federal poverty level	8.4–10.2% of income
300–400% of federal poverty level	10.2% of income

During 2015

Medicare creates a physician payment program aimed at rewarding quality of care, rather than volume of services.

During 2018

An excise tax on high cost employer-provided plans is imposed. The first $27,500 of a family plan and $10,200 for individual coverage is exempt from the tax. Higher levels are set for the plans covering retirees and people in high risk professions.

Order your Official Prescriptions Online

By ordering your official prescriptions online is much more timely and efficient than ordering them manually. The new online system also has some advantages:

- You may order larger quantities of Official Prescriptions with faster delivery
- You will be able to customize your prescriptions to include multiple practitioners' names (group practices) as well as multiple address locations
- You will have the option to order Official Prescription paper for EMR systems
- You can choose to have your Drug Enforcement Administration (DEA) number preprinted on your prescription
- You may designate other to order Official Prescriptions on your behalf
- You will have the ability to easily revise and update you Practitioner Profile so that your Official Prescription ordering information remains current

To apply for an HPN account go to: https://hcsteamwork1.health.state.ny.us/pub/top/html

Affordable Care Act Program Announces the PCIP Which Offers Temporary Coverage to Americans Without Insurance Due to Pre-Existing Conditions

The U.S. Department of Health and Human Services (HHS) announced that the new Pre-existing Condition Insurance Plan (PCIP) will offer medical coverage to Americans who have not been able to be covered due to a pre-existing health condition. The Pre-Existing Condition Insurance Plan will provide health coverage option for Americans, who have been uninsured for over 6 months, are not able to get health coverage due to a health condition, and are a U.S. citizen/residing in the U.S. legally.

The PCIP is a transitional program which is expected to run until 2014 (When insurers cannot turn down health coverage due to a pre-existing health condition, and when individuals and small businesses will be able to obtain less costly private insurance choices.).

There are 21 states where HHS is operating this program, and will begin enrollment by the end of the summer.

"Temporary Coverage to Americans Without Insurance Due to Pre-Existing Conditions"

PCIP will cover a variety of health benefits such as: primary and specialty care, hospital care, and prescription drugs. The plan does not base eligibility on income nor charges more due to a medical condition.

21 elected states: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Virginia, Wyoming.

Source of information obtained from: www.hhs.gov/news/press/2010pres/07/20100701a.html

Physicians May Waive Coinsurance During Retroactive Period

After President Barack Obama signed legislation June 25 granting a 2.2 percent update to physicians' Medicare payments, the Office of Inspector General (OIG) the same day waived a Medicare regulation that would require providers to bill patients for additional coinsurance relative to the rate increase, which is retroactive to June 1.

According to the OIG policy statement, providers will not be subject to OIG administrative sanctions if they choose to waive retroactive beneficiary liability for items and services furnished during the retroactive period (June 1 through June 24).

Participating providers must uniformly offer the waivers to all of their affected beneficiaries (without regard to the types of items and services furnished to a beneficiary or a beneficiary's diagnosis); and may not offer the waivers as part of any advertisement or solicitation.

This OIG policy statement does not apply to waivers of beneficiary cost-sharing amounts that were calculated using the prior, lower payment rates; nor does it apply if the waivers are conditioned in any manner on the provision of items, supplies, or services.

Providers are expected to calculate and collect cost-sharing amounts for items and services furnished after the retroactive period based on the new, increased payment rates. This OIG policy statement, however, does not prohibit physicians from waiving any coinsurance amounts based on a good-faith, individualized determination of a beneficiary's financial need.

Source of information directly obtained from: AAPC Industry News (07/02/2010)

Insurance News

MEDICARE

Audiological Services Coverage By Medicare

Medicare recognizes audiological testing as a covered diagnostic service when a physician orders the testing. Medicare will cover the services if a referral is consistent with at least one of the following reasons: a diagnostic medical evaluation or a determination of the appropriate medical or surgical treatment of a hearing deficit or a related medical problem.

Medicare does not cover routine testing even if your patient already wears a hearing aid. The only way testing will be covered is due to any of the reason listed above.

Before submitting a bill you should check with the private health plan if evaluation and management services (office visits) would be covered; Medicare does not cover these services for audiologists.

If you have ever encountered having to contact a patient's family member because they are in assisted living to discuss matters such as the patient's diagnosis, recommendations, and hearing aids and wondered if there is a code which you call bill Medicare, the answer is no. Audiology is considered as a diagnostic test benefit under Medicare and is limited to the test codes.

If you are billing an insurance company that does not reimburse the full cost of a hearing aid, you can bill the patient for the remainder if the patient signed an Advance Beneficiary Notice, unless the insurance company has made an agreement with you that their payment be accepted in full for certain devices.

Remember: Any unusual billing behavior can trigger an audit. Some examples include: a large number of tests performed on each of many patients, the same test being performed on many patients, most patients being referred from the same physician, or a large number of patients with the same diagnosis.

Source of information obtained from: THE ASHA LEADER | June 8, 2010,Pg. 4-7

Medicare Urges Advanced Imaging Provider towards Accreditation

If your office is providing any advanced imaging services (MRI, CAT scans, PETs, or any nuclear medicine), it is important that your providers become accredited by Jan. 1, 2012. CMS has approved three national accreditation organizations – The American College of Radiology (ACR), The Intersocietal Accreditation Commission (IAC), and The Joint Commission (JCAHO) – that can provide the required accreditation. This is only for the technical component of advanced imaging, if you or your physician is only performing the interpretation you do not have to be accredited. Providers who only perform X-ray, fluoroscopy, and ultrasound are excluded from this requirement.

Source of information obtained from: Supercoder Specialty Alerts | Pg. 154; www.cms.hhs.gov

Provider Enrollment Address Verification Form Now Available Online

For those providers who had who have been placed on payment hold and had their billing privileges deactivated due to correspondence being returned, National Government Services has developed the Provider Enrollment Verification of Practice Location Address form to be completed and faxed to 914-801-3600.

As directed by the CMS in CR 6278, National Government Services completed a one-time mailing to all practice locations on the National Government Services provider file advising them of their reporting responsibilities.

The new Provider Enrollment Verification of Practice Location Address form is published in the **Resources > Forms** section of the NGSMedicare.com Web site under the **Enrollment** category.

Questions regarding this form should be directed to the Provider Contact Center call: 877-869-6504

Source of information obtained from: Important Part B News from National Government Services for July 7, 2010

Non-Par Practitioners Have Two Weeks to Switch to 'Par'

Switching from non-par to par is usually a long process; credentialing your participation now will take two weeks! You have until July 16 to make a change from non-par to par due to the new Medicare opportunity.

Source of information: SUPERCODER | July 2010 | pg 186

CMS Processes Claims Despite PECOS Enrollment Status

Providers that did not get their Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications approved by the July 6 deadline are getting a temporary reprieve. The Centers for Medicare & Medicaid Services (CMS) says it will not, for the time being, implement automatic rejections of claims submitted by providers that are not enrolled in PECOS. Until the automatic rejections are operational, submitted claims will continue to be reviewed and paid as usual.

While more than 800,000 physicians and other health professionals have enrolled and received approved applications in the PECOS system, the Centers for Medicare & Medicaid Services (CMS) says some providers have encountered problems.

CMS issued an interim final regulation May 5, implementing provisions of the Affordable Care Act that permit only a Medicare enrolled physician or eligible professional to certify or order home health services, durable medical equip-

ment, prosthetics, orthotics, and supplies (DMEPOS), and certain items and services under Medicare Part B. The new law applies to orders, referrals, and certifications made on or after July 1. The comment period for the regulation closed on July 6.

The agency says it will employ a contingency plan to meet the Affordable Care Act requirement that written orders and certifications are only issued by PECOS enrolled eligible professionals effective July 1, but did not go into detail.

Meanwhile, CMS says it will continue to send informational notices to providers reminding them of the need to submit or update their enrollment and will process all applications expeditiously.

Source of information directly obtained from: AAPC Industry News (07/02/2010)

Physician Quality Reporting Initiative (PQRI) 2010

Important Changes for 2010:

- Introduction of an electronic health record based reporting mechanism
- Addition of 30 new individual quality measures
- Addition of six new PQRI measures groups
- Addition of a six-month reporting period for claims-based reporting of individual measures
- Addition of a Group Practice Reporting Option

The number of PQRI reporting mechanisms will increase from two to three in 2010. As in 2009, eligible professionals (EPs) can submit data on individual quality measures of measures groups through claims or a qualified registry. In addition, individual EPs can submit data on a subset of individual PQRI quality measure for the 12-month period using a qualified HER product.

Source of information directly obtained from: What's New for the 2010 PQRI | January 2010

AETNA

Changes in Coverage for Certain Services Performed by PCPs

Effective September 1, 2010 Aetna will no longer pay primary care physicians for performing nerve conduction studies, non-invasive vascular studies, and echocardiograms in the office setting. Aetna's reason to terminate these procedures from primary care physicians is due to that, in the past two years, there has been a rapid expansion of providers performing diagnostic studies and imaging procedures in their office, making it difficult to monitor the quality of care and appropriate utilization of technology. Also, because that these studies require sophisticated equipment and skilled technicians to perform, and specialty training and expertise to interpret.

Aetna is asking to refer your patients to specialist for these procedures.

Source of information obtained from: AETNA Notification Letter | May 24, 2010

UNITED BEHAVIORAL HEALTH | United Health Care

United Behavioral Health will begin to transition the behavioral health care network for members with an Oxford HMO licensed plan to the United Behavioral Health of New York, I.P.A., Inc. network and for members with an Oxford insurance licensed plan to United Behavioral Health. To facilitate a smooth transition to the UBH network and streamline contracting, United Behavioral Health will be terminating your present Oxford Agreement effective **April 1, 2010**. Your Oxford Agreement applies to services you provide to members with an Oxford plan until the termination date stated above. For more information, please call 1-877-499-4237.

Source of information directly obtained from: Doc#UHC0369d NY-09-676p Clinician – Oxford Notification to UBH-Oxford Only - NY

WCH Feedback Form

Please use this form for your suggestions and comments.

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Your Name

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Email Address