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WCH Bulletin

August, 2015

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Let's Talk About ICD-10 We Are Ready! Are You?

WCH has taken critical measures to prepare for the October deadline. We have upgraded and tested our software to be able to submit claims with ICD-10, and we are still finalizing the education process for the billing department. Since many of our professional billers are members of AAPC, we are following all recommendations and training modules to become efficient in ICD-10.

We are ready to help our clients transition to ICD-10. The journey ahead is not easy but together, we will be able to overcome many of the obstacles of ICD-10 in billing coding claim processing and documentation maintenance.

Please ask your dedicated account representative how to sign up for our ICD-10 webinars.

ICD 10 will go in effect for DOS on October 1, 2015. With less than 2 months left to the major transition date, WCH cannot stress more the importance of preparing yourself and your office staff for this transition. Some providers are assuming that this implementation will be done by their billing specialists. However, billing specialists can only create a claim based on the medical data provided by the practitioners.

Also, please be informed that usage of "unspecified" codes will result in requests for medical records, which will significantly delay your reimbursement and may cause claims to be rejected and denied. And the reason for that is that by using an "unspecified" diagnosis, the provider shows to the insurance company that "Inadequate information was provided to select more specific codes."

Moreover, knowledge of ICD10 is mandatory for your office staff as well. Please don't forget that valid diagnosis codes are critical in successfully obtaining authorization for PT/OT, diagnostic testing, etc. The person responsible for that in your facility has to know the specifics of ICD10 coding, such as terminology, Specificity, and laterality .We strongly recommend investing your time and resources to prepare your practice for this transition.

Bizarre ICD-10 Code

We are Credentialing Gurus! Here is why…

In the past 14 years, the WCH credentialing team has grown to be an experienced and professional team that serves healthcare professionals nationwide. We have always been on top of all the challenges that it has faced such as constant new government regulations and insurance changes. We have many years of experience in this industry to understand that when there is a problem, we are the ones that tell the insurances how to fix it. All of our credentialing staff is in constant training to prepare themselves for the constant changes in the healthcare industry.

We participate in training webinars providing information and sharing tips for improvement of credentialing processes. Our credentialing staff is never behind, and is always staying on top of things. The benefits of working for 14 years with insurances is that our credentialing department has teamed up with multiple area representatives and managers to quickly and efficiently add our providers to insurances and update their applications. We call representatives daily for updates and created a system of control that allows us to be on top of due dates and follow ups. We also adapted a new way to submit applications to make the area representative's job easier with understanding what is needed from the enrollment side. WCH credentialing team always fights to get things done!

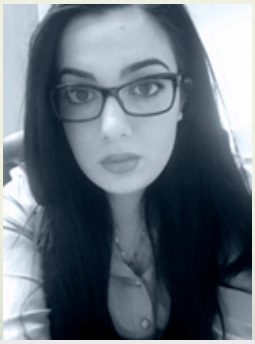
We fight for our clients to ensure they get what they need. Regardless of the difficulties that we encounter with insurances, **we get providers in networks they need!**

We specialize in:

- Individual Contracts (All Specialties)
- Multi-Specialty Groups
- (IDTF) Independent Diagnostic Testing Facilities
- Urgent Care Centers
- Pharmacies, Labs, DME
- Establishing PC, Inc, PLLC
- Accreditation, Security Bond
- Civil Surgeons
- Hospital Affiliations
- Any Practice Updates, Revalidation Medicare and Medicaid

The #1 company for your practice insurance enrollment!

PLEASE CONTACT OUR CREDENTIALING DEPARTMENT.



Nana Kazhiloti

Credentialing Specialist
Phone: 718-934-6714 EXT 1202

CONGRATULATIONS

Zukhra on your new certification!

Zukhra Kasimova,

CPB, CPC, CSFAC
Supervisor of Billing Department

Zukhra, CPC, CPB, CSFAC is an experienced biller and coder. She recently took an exam through AAPC and became a Certified Surgical Foot and Ankle Coder specialist (CSFAC). The WCH management team acknowledges this great achievement and is proud to share it with our clients.

CSFAC allows the billing department to:

- Abstract physician office notes and procedure notes and then apply correct ICD-9-CM, CPT®, HCPCS Level II codes, as well as apply correct modifiers
- Correct evaluation and management code usage using both 1995 and 1997 guidelines
- Apply Medicare billing rules and regulations, including, but not limited to, consultations, NCCI edits, and global surgery
- Coding of surgical procedures performed by foot and ankle specialists
- Apply Anatomy and physiology of the lower extremities

Congratulations Zukhra, we are proud!

WHY I LOVE WORKING AT WCH

INTERVIEW WITH SUSANNA BEKIROVA

Susanna Bekirova

What is your position at WCH? Explain what you do.

I am an account representative for several WCH clients. I help medical providers do their job. I collect all the information necessary to prepare insurance claims and bill the patients. I enter patient demographic and insurance information into the medical claims software. Then we submit and follow up on any claims in order to receive payments on time for services rendered by health care providers. I am responsible for making sure medical office revenue cycles run smoothly, handle routine medical documentations, and work with administrative duties.

What is most interesting about your job?

I am pretty interested in this job because of the variety of different kinds of situations that we are put in. We have to deal with a different situation everyday and when I get out of the situation, it makes me proud of myself. I like the fact that our job requires someone who is detail oriented. Since we are working with sensitive data, we need to make sure that all the information is perfect. This type of challenge always interested me.

What do you like most about working at WCH?

I am very impressed and thankful for the professional work environment and attitude at WCH. In addition, as for the company, it pays a lot attention on individual development including professional improvement and career growth. I like our professional team, our training, and preparation to be successful at our job.

What are your favorite hobbies and why?

I have so many interests and hobbies that I never seem to have enough time to get to them all. First of all, I love my family and friends. I love spending time with my family whenever it's possible. I do yoga that helps me reduce my stress levels. I love sports because I want to be healthier and being physically active is one of the healthiest things I can do for myself. Besides, I have a lot of energy and I like active recreation. Being physically active can help me stay strong and fit enough to keep doing the things I like to do. I like reading because books teach us to know a lot of things, tell the stories of people we don't know, places we haven't been, and worlds we can only imagine. As we know, there are no limits of knowledge. And I must say that there is one more thing that makes me happy which is traveling. It is so interesting to see new places, other countries, meet different people, and getting to know different cultures. I am a dreamer…

Bizarre ICD-10 Code

W61.33
PECKED BY A CHICKEN

In observance of important Jewish Holidays, WCH will be closed.

DATE	DAY	HOLIDAY
September 14	Monday	Rosh Hashanah
September 15	Tuesday	Rosh Hashanah
September 23	Wednesday	Yom Kippur
September 28	Monday	Sukkot
September 29	Tuesday	Sukkot
October 5	Monday	Shmini Atzeret and Simchat Torah
October 6	Tuesday	Shmini Atzeret and Simchat Torah

Famous Doctor in Medicine!

Frederick G. Banting

Founder of Insulin

When people get diabetes, they are comforted knowing that it could be treated with insulin. But before the discovery of insulin, diabetes was a disease that everyone feared. People knew that if they would get diabetes, it would almost certainly lead to death. That's why Frederick G. Banting's discovery of how to make insulin work in patients changed the lives of many people around the world. With his discovery, people around the world were able to get the proper treatment so that they could live longer and healthier lives.

Frederick Grant Banting was born on November 14, 1891 in Ontario, Canada. Throughout his younger life, Banting was educated at the local public schools in Alliston, Canada. He later studied divinity at the University of Toronto, but felt that it wasn't right for him. So he decided to change his major to the study of medicine. In 1916, Banting joined the Canadian Army Medical Corps and served during the First World War.

Earlier in life, Banting was always interested in diabetes. Earlier scientists such as Naunyn and Schafer believed that diabetes was caused by a lack of protein hormone that is secreted by the islands of the Langerhans in the pancreas. Schafer had given the name insulin to the hormone and tried to test it out on patients by feeding them pancreas. That failed because the protein insulin in the pancreas had been destroyed by the enzymes of the pancreas. So the problem that Banting faced was how to extract the insulin before it was destroyed.

J.J.R. Macleod, Professor of Physiology at the University of Toronto gave him a place for experimental work. Dr. Charles Best was appointed as Banting's assistant. Banting began his experiment by removing the pancreas from a dog. When that happened, the dog's blood sugar rose and it became extremely thirsty. The dog eventually developed diabetes. Banting and Best legated the pancreas so the pancreas degenerated. After that, they removed the pancreas and froze it in a mixture of water and salts. When they were half frozen, they were ground up. Then they injected the extract into the dog. Its blood sugar went down and became less thirsty. They gave the dog a few more injections a day, and realized that by doing this, they could keep the dog healthy.

Frederick G. Banting could easily be regarded as one of the most influential people in medical history. Without his discovery, many people would not have the proper medicine to treat the deadly disease that killed so many people.

Source: http://www.nobelprize.org/nobel_prizes/medicine/laureates/1923/banting-bio.html

Source: http://www.nobelprize.org/educational/medicine/insulin/discovery-insulin.html

Poem of a Cranky Old Man

CRANKY OLD MAN

What do you see nurses? ……What do you see?

What are you thinking .. . when you're looking at me?

A cranky old man, … …not very wise,

Uncertain of habit …. … . .. with faraway eyes?

Who dribbles his food …..… and makes no reply.

When you say in a loud voice . .'I do wish you'd try!'

Who seems not to notice …the things that you do.

And forever is losing … …… A sock or shoe?

Who, resisting or not … … lets you do as you will,

With bathing and feeding … .The long day to fill?

Is that what you're thinking?. .Is that what you see?

Then open your eyes, nurse .you're not looking at me.

I'll tell you who I am … . .. As I sit here so still,

As I do at your bidding, …. . as I eat at your will.

I'm a small child of Ten . .with a father and mother,

Brothers and sisters …. .. . who love one another

A young boy of Sixteen … .. with wings on his feet

Dreaming that soon now …… a lover he'll meet.

A groom soon at Twenty … ..my heart gives a leap.

Remembering, the vows .. .. .that I promised to keep.

At Twenty-Five, now … . .I have young of my own.

Who need me to guide … And a secure happy home.

A man of Thirty . …. . . My young now grown fast,

Bound to each other …. With ties that should last.

At Forty, my young sons .. .have grown and are gone,

But my woman is beside me . . to see I don't mourn.

At Fifty, once more, .. …Babies play 'round my knee,

Again, we know children … . My loved one and me.

Dark days are upon me … . My wife is now dead.

I look at the future … … . I shudder with dread.

For my young are all rearing …. young of their own.

And I think of the years … And the love that I've known.

I'm now an old man … … .. and nature is cruel.

It's jest to make old age … … . look like a fool.

The body, it crumbles .. .. . grace and vigour, depart.

There is now a stone … where I once had a heart.

But inside this old carcass . A young man still dwells,

And now and again … . . my battered heart swells

I remember the joys … . .. . I remember the pain.

And I'm loving and living … … . life over again.

I think of the years, all too few …. gone too fast.

And accept the stark fact … that nothing can last.

So open your eyes, people …. . …. open and see.

Not a cranky old man .

Look closer … . see .. ….. …. . ME!!

Link: http://www.nurseland.net/poem-cranky-old-man/814

IS OBAMACARE CREATING CORPORATE BEHEMOTHS IN THE HEALTH CARE MARKET?

For a while now, five big players — Anthem, Humana, UnitedHealth Group, Aetna, and Cigna — have dominated the U.S. health insurance market. But it looks like that number will soon drop to three: A few weeks ago, Aetna inked a deal to buy Humana, and this week saw the final touches put on a merger between Anthem and Cigna.

The latter deal isn't finished yet, and may face scrutiny from antitrust regulators. But if it goes through, the new health insurance giant would cover 53 million people in the employer and commercial insurance markets, as well as its work with Medicare and Medicaid. The Aetna-Humana merger would serve a combined population of 33 million, while UnitedHealth Group serves 45 million people.

This raises a chain of political and economic questions. What's causing the consolidation? Will it raise prices? And more broadly, is it ultimately bad for Americans and their ability to get affordable and effective health care?

Answering the first question is tricky because two big shocks — the Great Recession and the passage of ObamaCare — recently hit the health care industry in rapid succession. And the effects of each are difficult to disaggregate. A big economic collapse reduces the number of paying customers, in health insurance as much as elsewhere, so business models have to retool to accommodate. Mergers take advantage of economies of scale, serving more customers with less overhead.

Meanwhile, hospitals are subject to the same forces, and have also been merging. When it comes to determining the price of health care, hospitals and providers sit on the opposite side of the bargaining table from insurers. If one side goes through a round of mergers and consolidations, that can

maintain the same bargaining clout that comes with size.

MORE PERSPECTIVES

There's reason to suspect that changes wrought by ObamaCare are encouraging these moves as well. The health care reform law vastly expanded the number of Americans on Medicaid, and that program's reimbursement rates for providers are pretty low compared to private insurers in the employer-based markets or on ObamaCare's exchanges. The law also set up a long-term reduction in the reimbursement rates Medicare pays, which will ramp up in the coming years. The logic of both those forces also encourages mergers on the provider side, since they increase the customer base, but at a relatively low rate of revenue per customer.

The surge in hospital mergers actually began in 2010, after the recession and before ObamaCare took effect — though it's not as if providers didn't know what passage of the law foretold.

On the insurance side, ObamaCare introduced regulations that require insurers to pump less of their revenue into profits, and more of it into actually buying care for the customers. It also established a baseline set of benefits that all insurance packages are required to provide. That, too, introduced new potential costs that mergers can help deal with.

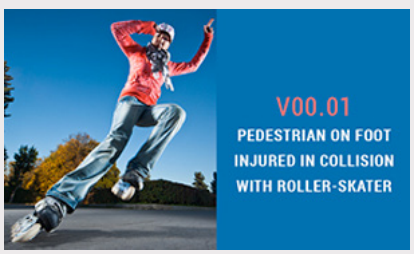
As a result, ObamaCare's critics have pounced on it for driving the insurance and hospital markets towards a smaller number of bigger players, thus driving up premiums. Several studies have suggested a correlation between hospital and insurance consolidation on the one hand, and premium hikes on the other. And the latest round of requests for premium increases by insurers in a number of states certainly include a few eye-watering numbers. (Though the requests have yet to be approved by state regulators.)

Yet the causal arrow is not so simple. There's no intrinsic reason why an increasing Medicaid population or tightened Medicare reimbursements rates should drive up costs elsewhere. They can, but they don't have to.

For one thing, as mentioned above, if insurers and providers maintain roughly equal bargaining clout, they can keep one another in check. For another, like any other market, the operating costs for insurers and providers are not fixed. They're established by the give and take of competition, as another recent study demonstrated. The market for health insurance in America is still broken up on a state-by-state basis: If both Aetna and Humana operate in the same state, it's possible their merger could drive up premiums in that state. But if only one of them operates there, it's not clear why it would matter.

There's also a certain intellectual dishonesty to the criticisms of ObamaCare. One way to slow down the mergers on the hospital side would be to increase Medicaid and Medicare's reimbursement rates.

Bizarre ICD-10 Code



But most of ObamaCare's naysayers are, of course, conservatives, and are ferociously opposed to letting those programs' costs increase. (Never mind that the U.S. government actually has far more room to tax and borrow, without hurting the economy, than critics allow for.)

There's also something silly about decrying ObamaCare's regulatory minimums. At some point, as a product's costs get low enough, they can no longer be attributed to providers finding better ways to supply a quality product — instead, it's simply because the product itself is bad. And when a product crosses the line into "bad" is a moral and social question rather than a purely empirical one. For instance, requiring apartment developers to include good plumbing and basic sanitation in any dwelling they build drives up the price of housing to some degree. But taking away those regulations would be a pretty terrible way to make housing more affordable.

A better goal would be to tweak ObamaCare's structure to maximize competition. Certainly haggling over the requirements for minimum benefits could be part of that. But arguably the biggest problem is the fracturing of the insurance market along state lines. An underappreciated clause in ObamaCare allows states to come together under one health insurance exchange, and pushing states to take advantage of it would increase the scope and number of players in any given exchange, making competition more robust.

The final thing to remember here is that there's a rather unique moral component bound up with health care markets. In the market for video game consoles like the Wii-U, for example, we let prices bring demand in line with supply. And it's not considered a national scandal if some people get priced out of the Wii-U market, because no one thinks having a Wii-U is a basic human need or right. Not so with health care: there's a baseline of supply we think everyone should be able to get. Market competition can help alleviate the cost of providing that supply, if properly harnessed, but only so much. One way or another, that cost will have to be paid: either through direct government spending (like Medicare and Medicaid) or through government subsidies and regulatory structuring of private insurance markets.

Simply maximizing the freedom of insurers to provide cheaper products isn't going to solve anything, except by jettisoning the moral commitment entirely.

Link: http://theweek.com/articles/568039/obamacare-creating-corporate-behemoths-health-care-market

Bizarre ICD-10 Code

Important HIPPA compliant news from a trusted vendor

For many in the medical sphere, HIPAA is a four-letter-word. It's a painful topic that most medical practitioners would rather ignore. Those that don't ignore it, usually make a half-hearted attempt at compliance and then quickly forget about it.

No matter what category you fall into, HIPAA compliance doesn't have to be a royal pain. In fact, the IT portion of HIPAA compliance isn't painful at all – as long as you know what to do.

Using email services like Gmail, Yahoo, Hotmail, and AOL is probably the most common HIPAA violation among healthcare professionals. Moreover, even those doctors that use something like a doctor@yourcompany.com address are often in violation of HIPAA as well.

Backups - the word you hear all of the time but never really think about until your computer decides to go on a permanent vacation. HIPAA compliance requires that backups be properly encrypted, both local and off-site, and be retained for a minimum of 7 years. Periodically testing your ability to restore that data is another critical part of the puzzle that most people don't bother with. Some even try using cheap/free consumer grade backup solutions to house their critical patient data, which is a recipe for disaster.

Virus's are being release at an alarming rate. By some estimates there are over 300,000 new virus's released into the wild each day. HIPAA guidelines mandate not only the installation of a current AntiVirus solution, but that alerts of infections are promptly addressed. Many offices assume that installing a free Antivirus product is enough to make them compliant. What they don't realize is that the receptionist will not address an issue of her Antivirus not updating properly. She will also not clean an infected machine. What happens more often is that the person just closes the pop-up and goes about their daily work. That not only leaves the entire office susceptible to infection, but also leaves all of your patient data potentially accessible by nefarious individuals across the globe.

Source: www.capaxion.com

Questions and Answers

Many of our clients have brought up a question on Physician Assistant capability to perform initial encounters in NYS. We turned to several different sources to obtain the answer.

Q: Are Physician Assistants in NYS allowed to perform Initial encounters?

A: Answer from American Academy of Professional Coders:

Under Medicare, PAs are able to perform initial visits and submit claims using their own NPI in most instances. Certain instances in which the physician may be required to perform the initial visit include:

1. In a Skilled Nursing Facility, the physician must perform the initial comprehensive visit

2. If it is the policy of the state or facility (if it is a facility) – Medicare defers to state law guidelines on covered services)

3.In an office setting, if it is the intention to bill "Incident to" (all other "incident to" criteria must also be met)

Refer to: Center for Clinical Standards and Quality/Survey & Certification Group

Refer to: services (Refer to the CMS website under Medicare claims processing manual chapter 15, section 190)

Refer to: (Refer to CMS website for Medicare Carriers Manual transmittal 1764 Section 2050.2)

A: New York State Department Of Health:

As long as all of the other conditions summarized in the Department of Health website that you are referencing (the relevant portion of which I have reproduced below) are met, yes, "all settings" may include home settings as well as office settings.

A physician assistant is considered a dependent practitioner working under the supervision of a licensed physician responsible for the actions of the physician assistant. The supervising physician may delegate to the physician assistant any medical procedures or tasks for which the physician assistant is appropriately trained and qualified to perform and that are routinely performed within the normal scope of the physician's practice. … Duties delegated to a physician assistant may be extensive, including, but not limited to the following:

1. Evaluation-initially approaching a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, delineate problems and record and present the data.

Please refer to the New York state Department of Health website for further information.

Q: My office manager resigned. I would like her to sign a confidentiality document before she goes. What do you think?

A: From the question I will proceed under the assumption your office manager is not bound by any contract, nor do you have in place any handbook that applies to her post-employment obligations. With those presumptions in mind, if you are not offering any additional consideration (money/severance) there will not be a fair barter for her to sign anything.

However, you may want to try to have her sign off on a workforce confidentiality agreement or possibly a non-disparage.

Source: Jennifer Kirschenbaum from Kirschenbaum and Kirschenbaum, PC.

Q: I want something in writing with my employees. Do I need a handbook or contracts? What's the difference?

A: I'm glad you are interested in papering up. Doing so is the only way to start your paper trail to protect against major employment issues.

Both an employee handbook and employment agreements are acceptable and recommended tools to implement, but for very different reasons and oftentimes different types of employees. A standard employee handbook will include the policies and procedures of the practice that are true across the board for all employees bound by the handbook - for instance, vacation days (can vary by years of service or employee classification - i.e., admin v. professional), rules of conduct at the practice (smoking policy, phone ettiquite, dress code, late policy).

By contrast, an employment agreement is a document between the practice and a specific employee that contains, for the most part, details particular to that individual - for instance, compensation, licensure status, termination provisions and notice requirements, non-compete language, etc.

My general rule of thumb - unless you have a high level office manager, most admin will be covered by a thorough employee handbook and a simple 1 page offer letter detailing their compensation and job description. Any professional staff should be issued a contract to nail down specific terms, including how much notice you expect from that person should they wish to terminate. Without a notice provision, your employees are "at will" (in NY) and may leave with no notice - which may leave you in a real lurch.

If you have no paper on file for your employees - and no employee files, watch out! You are putting yourself at real risk for a walk out and potential trouble by way of false claims against you, and you'll have no back up to defend yourself because you failed to properly paper. I'm here to help if requested.

Source: Jennifer Kirschenbaum from Kirschenbaum and Kirschenbaum, PC.

Q: I received a letter from the Attorney General of NY saying I may be conducting my practice using Deceptive Trade Practices because of my website, something to do with disclosing my participating status

A: Yes, I've seen this. This letter has been circulating for a week or so now (as far as I have seen) and it is the Health Care Bureau of the NY AG's office reviewing compliance with the new Surprise Bill law. The What? You read correctly - the Surprise Bill law. The new law that was passed and effective this past spring, which requires each practice to make certain public disclosures to all patients - including participation status (with specifics including what plans).

Source: Jennifer Kirschenbaum from Kirschenbaum and Kirschenbaum, PC.

Bizarre ICD-10 Code

FEEDBACK

Your feedback is very important to us!

In our continued dedication to improve, we want your feedback, opinions, ideas, news and comments. Please send us your feedback today.

Let us know what you would like to read in our next issue and share with us your ideas and thoughts.

Simply Email your comments to us at nanak@wchsb.com