WCH Bulletin

November 2014

3,580 readers

Stop the credentialing madness!

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Welcome to our November edition!

INSIDE THIS ISSUE

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LETTER FROM THE COO

> We have always been and continue to be by our clients side, offering real solutions and working to replace constant industry headaches
>
> Olga Khabinskay, COO

Dear Readers,

As we get closer to the end of the year mark, we are ready to handle the overbearing demands of the insurance companies and welcome with open arms that early stages of ICD 10 transition. The year ahead is a big one for everyone, because it will change the way insurance companies do business. Knowing the strength of our team in WCH, we had overcome many other difficulties before, this is another wave of challenges we are ready to encounter.

In the upcoming year we will be also making many changes internally in WCH. Our fundamental objective right now is to improve quality and efficiency of our services. We have the strongest technology platforms which allow us to run our daily operations efficiently and allow our clients to have full control of claims and payments data and any other reporting.

We are learning quite often from our clients situations how to improve and expand our services to better serve the needs of practices. As director of operations, I always want to know what can we do better, please if any of our clients have any concerns, recommendations, or you just want to pick our brain for ideas don't ever hesitate to contact me.

I can always be reached at olgak@wchsb.com.

Happy Holidays!

Warm Wishes,

Olga Khabinskay

WHY I LOVE WORKING IN WCH

Oksana Pokoyeva
CPC, CPMA, CUC

What do you do at WCH?

I have been in WCH long enough to be involved in many different aspects of operations in the company. I work in the Medical billing department, but sometimes I'm involved in IT department projects. I also do Chart auditing.

What is most interesting about your job?

I am always learning something new while doing my job. Medical billing and coding is a rapidly changing industry and we have to be ready to face any and all changes that government and insurances implement. My approach to problem solving is backed up by years of experience and learning.

What do you like most about working in WCH?

Working at WCH allows me the opportunity to work in a professional workplace environment, while also retaining a comfortable family atmosphere, and flexibility to my schedule. Personal and professional growth are imperative in the workplace, and WCH offers opportunities for both. Management is professional and knowledgeable, which allows for employees to receive useful training day in and day out.

Stop the Credentialing Madness on the payers side!

From the time WCH credentialing department was developed in 2001, many providers and healthcare practitioners benefited from excellent credentialing services. In the past 14 years, WCH credentialing team has grown to be an experienced and professional team that serves healthcare professionals nationwide. With constant new government regulations and insurance change, WCH credentialing team has always been on top of all challenges, in order to provide fast and accurate service. However, our job is becoming increasingly more difficult, due to enormous amount of mistakes that are made on the insurance side. Many processes become longer; insurances have downsized their credentialing department or fully outsource their workforce which results in disruption of the processing of applications.

WCH has enough expertise and experience to realize that there is major chaos in the credentialing world, almost in every payer enrollment department. From our work with insurance companies, here are some of the issues we have seen occurring over and over again. We share our experience with you:

Major issues in Medicare Credentialing Department:

- Errors in application processing: Closing application incorrectly, assigning wrong provider numbers, linking providers to wrong groups, closing PECOS applications without any reason.
- Frequent and rapid staff change: Difficult to get to speak with knowledgeable representative that handles an application from beginning to end
- Closing applications without site visit and for other inaccurate reasons

Major issues with other Payers:

- Panels are closing and/or insurances are giving preferential treatment
- Urgent Care centers are being purchased by insurance companies, limiting new centers from joining and opening up
- Simple demographic updates that normally took 30 days now can take up to 180 days to process, you can only imagine what is the time frame for more complicated cases
- Insurance mistakenly removing doctors from network and then requesting for them to complete new enrollment packages and assign new effective dates
- Insurances not extending contract participation to providers as of new year

WCH takes action when times are tough and seeks fast solutions; this is how we are working around these challenging situations:

- We have enough years of experience in this industry to understand when there is a problem and we are the one telling the insurance how to fix it
- We offered professional help with processing applications to NGS Medicare, they refused to make us their contractors to help with enrollment
- We use our network connections to speed up many of the ignored requests and unprocessed applications
- We created a system of control that allows us to be on top of due dates and follow ups
- We set up educational training internally to make sure everyone is aware of the updates and issues with accounts
- We participate in training webinars providing information and sharing tips for improvement of credentialing processes
- We adapted a new way to submit applications to make the area representative's job easier with understanding what is needed from the enrollment side
- We call area representatives daily for updates because there is no choice anymore
- We have been filling complaint with insurance management
- We have been filling complaint with the Department of Financial services (2 recent big complaints that we filed worked in our favor, which resulted in getting our clients contracts)

We, at WCH, need to stop the madness and bring back credentialing departments to efficiency. We cannot afford to have closed or unprocessed applications, wrong effective dates or anything of the kind. We fight for our clients to ensure they get what they need, we get providers on networks they need, even when it's difficult. We need to call for help now, and take action to make sure credentialing is done right. We ask YOU, dear providers, to join us in a fight for the future of credentialing. Bring your requests to us and we will show you a way to make it happen.

WCH EHR offers Anytime, Anywhere Access

Mobility has become one of the main attributes of the efficient EHR. WCH Ismart electronic health record allows providers to have access anytime and anywhere to their clinical and financial data. We highly recommend using EHR on portable technology for access convenience and simplicity of use as opposed to the stationery desktop environment. Of course it's important to consider the size of the screen of the portable device and ability to fit all needed data. Many providers prefer to use laptops over smartphones and tablets, because it has larger screen, comfortable keyboard and full data access with multiscreen capability. Those providers are using the tablets are limited to the data they can see in one screen and are also prohibited to access some of the vital features important for full record documentation.

Because mobility has become an expectation in healthcare it still as important to understand the data access you are getting from your EHR provider on your portable device. WCH can only focus on the features that we present on mobile devices to our clients.

Here is the list of some features easily accessible on mobile EHR:

- Computerized Provider Order Entry (CPOE) and visit information
- Communications
- Encounter documentation
- Patient Chart
- e-Prescribing
- Appointments

WCH Ismart EHR allows you to work from anywhere, anytime - your practice, hospital, secondary office or home.

Inquire about WCH iSmart EHR portable device adaptability by calling our office at 718-934-6714 x 1201

Specialty tailored webinars for your practice

WCH offers training for you and your staff using specialty tailored educational webinars. Webinars are available on topics of interest; you choose the topic or let us train you on today's hottest topics. Our individual webinar or webinar series are designed specifically to provide information to Healthcare Professionals, and Administrative Staff who want to broaden their understanding of healthcare related topics. Our professionally created webinars are administered online with narration by WCH Specialist. The educational webinar is typically an hour long. Slideshows are available upon request.

CEU credits are also offered for participating in the webinars for members that require having for their professional certification. Detailed information about EU credits can be received directly from WCH.

Hot webinar topics to consider:

- ICD 10
- Preventive Medicine
- Most common denials
- Insurance audits
- Available technology that can really help your practice
- Coding
- Credentialing
- Front desk training

Contact us today to request an educational webinar for you and your staff.

NYIPA

December 19th, 2014, 5PM
WCH Sponsored Webinar

New York Independent Practice Association
presents a discussion on the health and welfare of today's practices

Topics

- Current medical practices
- Pros & cons in building strategic alliances
- Establishing partnerships with key hospitals, IPAs, MSOs, ACOs and associations
- Risk reward and incentive models
- Engaging with shared savings plans to realize substantial revenue growth
- Ownerships structures:
- independent, group, sell out to hospital networks

What's Happening in Insurance

The hard shift into value based medcine has sent the industry sprawling in the last few years. As such, the insurers are now looking to get the best care possible for as little money as possible. At the same time, they are utilizing new standards by Medicare and Medicaid to gain higher reimbursements which all equates to more money in with less and less going out. Chart audits, reviews and new guidelines for care mean the physicians are doing more work for the same pay.

Your Roles as a Physician

You are the 1st point of contact and the engine that drives your patients' well-being. Now, aside from the execellent care you provide your patients, there are new goals in private practice:

- Elimited duplication of services and systemic waste
- Meet and exceed new quality guidlines
- Properly diagnose, code and bill for all patients

By taking small steps collectively, everyone can share in the savings and earn more money for their work.

For information about NYIPA

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New York Independent Practice Association
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For information

on this NYIPA educational series contact Andrew Jarrah
RSVP to Olga Khabinskay at WCH
Olga Khabinskay, COO
P: 888 - 924 - 3573 X1201 | E: olgak@wchsb.com

Our **tips** for **front desk** operations

- Identify whether or the patient is new, existing or a referral
- Identify the specific reason for the patient visit
- Record the patient's full name as it is spelled on his/her insurance card
- Verify whether there has been any change in the patient's health insurance information (For a return or established patient)
- Request any missing or incorrect patient information previously received
- Make a copy of the patient's health insurance card and one picture ID
- Collect the patient's contact information and his/her preferred place of contact
- Rview the practice's payment policy with the patient
- Indicate what types of payment forms are accepted by the practice
- Collect or remind the patient of any outstanding balance
- Request that the patient complete the history form (new patients and update every 6 months to a year)
- Identify any additional practice policies (i.e., prescription refills, no-shows, etc.)
- Explain and distribute the practice's payment and privacy policies
- Explain and receive a signed acknowledgement from the patient that should include the practice's policies on patient billing, primary and secondary payer processing and patient payment expectations.
- Obtain the signed notice of privacy practices (required under HIPAA)
- Explain when and how test results will be communicated back to the patient and receive a signed waiver that acknowledges if the patient gives permission for leaving test results on an answering machine or in a voice mail
- Explain and collect the patient's co-payment and/or deductible.

Power of Compounding

We hear it all the time on TV and the Radio and see it on the Internet: Investing for retirement requires consistency and commitment. We are told the stories of people who put away $100 dollars a month for 30 years and ended up with over $200,000. But are all the stories true and what is behind this remarkable growth? Albert Einstein once said: 'COMPOUND INTEREST is the EIGHTH WONDER OF THE WORLD. He who understands it, earns it ... he who doesn't ... pays it'. Compounded returns are the key principle in wealth creation and understanding how it works is the first step toward reaching your investment goals. Put simply, compounding means earning returns on the returns you earn over time. In the short term, its effects can be relatively minor. But give it some time and compounding may increase your returns exponentially. Consider this example.

Let's say you start with an initial investment of $10,000. And on that you earn 10% every year after fees and tax. After your first year you'd have $11,000 (your initial $1,000 + 10% returns = $1,000).

By the end of year two, your investment is now $11,000 ($10,000 + 10% = $11,100). The thing to note is that compared to the previous year your returns have increased by an extra $1000. That's because you earned 10% on your invested sum, and also 10% on the returns from the previous year. Now that extra $100 might not seem like much. But using this example, after ten years your initial investment would have grown to $25,937 and the returns earned that year would have risen to $2,358. That's the power of compounding.

The example below shows the effect of compounding over 40 years and is for illustrative purposes only.

If you would like to discuss your retirement options or have a general question or comment, please contact Michael Pechersky, CFA at Eagle Strategies, LLC by calling (212) 261-0239 (work), (917) 318-5504 (cell), or by e-mail at mpechersky@ft.newyorklife.com

INTENSIVE OUTPATIENT SERVICE (IOS)

WCH Account Specialist Julia Kruglova

APG CPT /HCPCS Billing Code

S9480 – Intensive Outpatient psychiatric services, per diem.

NOTE: The S9480 code went into effect 1/1/2011; prior to that date if a program utilized a specific IOS track the program could claim two group services on one visit date. After 1/1/2011 programs may only bill for IOS using S9480.

Programs without a specific IOS track are not for any date of service permitted to bill two groups for the same patient on the same visit date.

Category Specific Medicaid Billing Limits

Intensive outpatient treatment is a time-limited service and should not exceed 6 weeks without clinical justification. Programs may not bill for more than 6 weeks of intensive outpatient service without a clinical rationale included in the patient's record in either a progress note or in the treatment / recovery plan. (e.g. ASAM or LOCADTR and in accordance with Part 822 regulations.).

Programs bill for IOS daily and patients must attend at least 3 hours of service on any given day. Patients must be scheduled for 9 hours of service each week to meet the level of care requirement, however, IOS is billed on a daily basis regardless of the total weekly attendance of any individual patient.

Programs can bill for medication administration, medication management, complex care, peer services and collateral contacts in addition to IOS but may not bill other service categories while a patient is in the IOS service. The only exception to this is if a patient attends IOS services for less than 3 hours on a given day, in which case, the program may bill for the discrete services delivered.

NOTE: Programs that do not have a formal IOS program or have patients who cannot attend the IOS, may meet this level of care, admit and treat patients in need of IOS services, through a more intensive group, individual and family counseling at the outpatient clinic level of care providing the increased intensity/ frequency of services is adequate to meet the needs of the patient. In this circumstance the program would not use the single IOS code S9480, but instead deliver; document and bill for the individual services delivered during the visit date. HOWEVER, in no event may the program bill for two of the same services on a single visit date e.g program may not bill for two individual or two groups service to the same patient on the same visit date.

Time Requirements

The patient is scheduled to attend at least 9 hours of treatment sessions per week provided in 3 hours of daily service.

Delivering Staff

Clinical staff (including medical staff) as defined in Part 822 (working within their scope of practice).

Waivers and exceptions

Specific specialties excluded: Veterinarians

All other practitioners are required to issue electronic prescriptions unless granted a waiver or meet one of the limited situational exceptions. In addition, practitioners who are not veterinarians may be excluded if they meet the criteria defined within article 2A Section 281 of the Public Health Law and section 80.64 Title 10 part 80 Rules and regulations on controlled substances.

What exceptions are from the requirement to electronically prescribe?

- Prescriptions issued by veterinarians
- Prescriptions issued during circumstances where electronic prescribing is not available due to temporary technological or electrical failure.
- Prescriptions issued by a practitioner under circumstances where the practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition. In addition to these circumstances, the quantity of controlled substances cannot exceed a five day supply if the controlled substance were used in accordance with the directions for use.
- Prescriptions issued by a practitioner to be dispensed by a pharmacy located outside the state.
- Practitioners who have received a waiver or a renewal thereof for a specified period determined by the commissioner from the requirement to use electronic prescribing.

Can practitioners apply for a waiver from the requirement to electronically prescribe? The Prescription Drug Reform Act –Chapter 447 of the laws of 2012 and Title 10 Part 80 of the Official Compilation of Codes, rules and Regulations of the state of New York (S80.64 c3) allows the Commissioner of Health to grant a practitioner a waiver, not to exceed a time period of one year, from the requirements to electronically prescribe. Waivers may be granted based upon showing of:

- Economic hardship
- Technological limitations that are not reasonably within the control of the practitioner
- Other exceptional circumstances demonstrated by the practitioner

If a practitioner already has a waiver from the requirement to consult the Prescription Monitoring Program registry, a separate waiver is required to be exempt from electronic prescribing.

Bizarre ICD -10 Code

W22.02XA - Walked into lamppost

Timely Filing Deadlines Not Always The Final Word

Did you know that carriers may not be able to apply a 60 day timely filing limitation to your claims if the patient's policy doesn't specifically state that all claims must be filed within 60 days. Under ERISA, you may be able to file claims much further out. First, you need to understand that ERISA does not apply to Medicare, Medicaid, Work Comp, Government Employer and Personal Injury claims. It only applies to employer plans. ERISA overrides timely filing state laws as well. What you would need to see is the patient's actual policy provisions.

Once you see that, for example, the policy allows the patient to file claims for up to one year, then you can send a letter on behalf of the patient demanding that your claim be paid under ERISA requirements. According to Don Self's webinar yesterday, 96% know nothing about ERISA and therefore, don't use it to get claims paid.

You can learn more about ERISA at http://www.dol.gov/dol/topic/health-plans/erisa.htm

Results of compensation survey

UCAOA conducted an informal survey to obtain a synopsis on the average hourly pay rates for full-time employees in an urgent care center. Of those urgent care centers that participated, 33 percent indicated their pay rate for medical assistants is between $12.01 and $14 per hour while other centers (33 percent) indicated a pay rate between $14.01 and $16 per hour. To view the complete results for physicians, physician assistants, nurse practitioners, and medical assistants, click here, and be sure to take notice of the national averages graphs posted from the newly released 2014 Benchmarking Survey Results.

Source: http://www.ucaoa.org/surveys/results.asp?qs=ed-05783387cb29

Definition

A clinical treatment service for individuals who require a time-limited, multi-faceted array of services, structure and support, to achieve and sustain recovery. Intensive outpatient treatment programs generally provide a minimum of 9 treatment hours per week delivered during the day, evening or weekends. A team of clinical staff must provide this service. The treatment program consists of, but is not limited to, individual, family and group counseling; relapse prevention and coping skills training; motivational enhancement; and drug refusal skills training.

Clinical Guidance

Intensive outpatient services are appropriate for patients who need more intensive treatment in order to attain or maintain recovery from chemical dependency, this also includes patients with a dual diagnosis and corresponding functional deficits. Patients should meet the level of care requirements as defined by ASAM or the OASAS LOCADTR tool or the program clearly summarizes the functional deficits that clearly identify the need for an intensive level of care. These services may be provided in 3 hour blocks of time where patients are seen in group, family and/or individual sessions that address multiple issues and are designed to help patients initiate a period of recovery from chemical dependency. Intensive outpatient services may be provided in as little as a week or over a period of time, not exceeding 6 weeks without clinical justification (e.g. ASAM or LOCADTR and in accordance with Part 822 regulations.).

Intensive outpatient services are not simply longer versions of outpatient programming, but structured group and individual interventions targeted to specific functional areas including: mental health functioning, vocational/educational, life skills and attainment of initial abstinence. Intensive outpatient services may be provided by a single counselor working as part of a team or programming may be provided by multiple staff.

Individual counseling should be provided based on patient need and is usually incorporated into the IOS.

Programs can bill for an individual session on a day when IOS has not been billed, however, this practice should be an exception and not routine.

Documentation

A clinical staff person directly involved in providing the intensive outpatient treatment must provide a written note for each day of service that includes: the date and duration of the service, which of the patient's treatment / recovery plan goals / objectives were addressed what was delivered and how it addresses issues of early recovery, patient response to treatment and plan. The note can be written by multiple staff members providing discrete services within the IOS, but there must be a record of a minimum of 3 hours of services that meet the criteria for IOS. Alternatively, programs may write the note as a team, with each member who provided a service signing.

Bizarre ICD -10 Code

E843.0 -
Fall in, on, or from aircraft

New York News

Healthcare Provider Rights

(INSURANCE LAW SECTIONS 3217-B, 3224-A, 3224-B, 4325, 4803 AND PUBLIC HEALTH LAW SECTIONS 4403, 4406-C & 4406-D)

Health Insurance Resource Center

The Insurance Law and Public Health Law include important protections for health care providers with respect to network participation, provider contracting, claims processing, and prompt payment for health care services. Some protections apply to all HMO and insurance coverage, while others apply only to HMO coverage and to managed care contracts offered by insurers (which most insurers do not offer).*

CLAIMS PROCESSING:

- HMOs and insurers must accept and initiate the processing of all health care claims submitted by physicians that are consistent with the current version of the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the centers for Medicare and Medicaid services (CMS) health care common procedure coding system (HCPCS).
- HMOs and insurers must provide the name of the commercially available claims editing software product that the health plan utilizes and any significant edits on their provider websites and in provider newsletters. Health plans must also provide such information upon the written request of a participating physician.

PARTICIPATION IN A HEALTH PLAN'S NETWORK:

- New York does not have an any willing provider law and HMOs and insurers are not required to accept any provider who wishes to join their network.
- HMOs must maintain a network that is sufficient to deliver comprehensive services to their enrolled population.
- HMOs and insurers offering a managed care contract must make available, upon request, written application procedures and minimum qualification requirements that a provider must meet to be considered for participation in the health plan's network.
- HMOs and insurers offering a managed care contract must complete review of a provider's application to participate in their network within 90 days.
    - HMOs and insurers offering a managed care contract must notify the provider as to whether the provider is credentialed or not, or if additional time is needed in spite of the health plan's best efforts or because the health plan is waiting for additional information from a third party. The health plan must also make every effort to obtain the information as soon as possible.
    - If an incomplete provider application is received or if the HMO or insurer offering a managed care contract is not currently accepting additional providers of the applicant's type, the health plan should respond to the provider with such notice as soon as possible, but no later than 90 days from receipt of the application.

* Please note, a managed care contract offered by an insurer is defined as a contract which requires that all health care services be provided by a referral from a primary care provider and that services be rendered by a provider participating in the insurer's network. In addition, in the case of an individual contract or a group contract covering no more than 300 lives, imposing a co-insurance obligation of more than 25% upon out-of-network services, which has been sold to five or more groups, a managed care contract also includes a contract which requires all services be provided pursuant to a referral from a primary care provider and that services provided pursuant to the referral be rendered by a participating provider in order for the member to obtain the maximum reimbursement.

PROVIDER CONTRACTS:

- HMOs and all insurers must include the following items in participating provider contracts:
  - The method by which payments to the provider will be calculated, including any retrospective or prospective adjustments;
  - The time periods within which calculations will be completed, the dates payments and adjustments will be due, and the rates upon which payments and adjustments will be made;
  - A description of the information relied upon to calculate payments or adjustments, and how a provider can access a summary of the calculations or adjustments;
  - The process to resolve disputed, incorrect or incomplete information, and the process to adjust payments which were made using the incorrect or incomplete information; and
  - The right of either party to seek arbitration under Article 75 of the Civil Practice Laws and Rules for disputes regarding payment terms of the contract.
- HMOs and insurers cannot transfer liability to the provider for activities, actions or omissions of the health plan.

TERMINATION OF PROVIDER CONTRACTS:

- HMOs and insurers offering a managed care contract cannot terminate a participating provider contract unless the health plan gives the provider a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing. This requirement does not apply in cases of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the provider's ability to practice.
- HMOs and insurers offering a managed care contract must include the following in a notice of a proposed contract termination:
  - The reasons for the proposed action;
  - Notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by the health plan;
  - A time limit of not less than thirty days within which the provider may request the hearing; and
  - A time limit for a hearing date which must be held within not less than thirty days after the date the hearing was requested.
- HMOs and insurers offering a managed care contract must adhere to the following requirements with respect to any hearing:
  - The hearing panel must be made up of three persons appointed by the health plan. At least one member of the panel must be a clinical peer reviewer in the same discipline and the same or similar specialty as the provider under review. The panel may consist of more than three persons however one third must be clinical peers.
  - The hearing panel must render a timely decision. Decisions shall include reinstatement of the provider, provisional reinstatement of the provider subject to conditions, or termination. Decisions must be in writing.
  - A hearing panel's decision to terminate the provider will be effective at least thirty days after the provider receives the decision. However, the termination cannot be effective earlier than sixty days from the receipt of the notice of termination.

PATIENT CARE AND TREATMENT:

- HMOs and insurers cannot restrict a provider from telling their patient:
  - All treatments available for the patient's condition, including treatments that may not be covered by the health plan.
  - The provisions or terms of the patient's health plan as they relate to the patient.
- HMOs and insurers cannot restrict a provider from filing a complaint to an appropriate governmental body regarding policies or procedures the provider believes may negatively impact the quality of care or access to care.
- HMOs and insurers cannot prohibit or restrict a provider from advocating on behalf of a patient for coverage of a particular treatment.

PROMPT PAYMENT OF HEALTH CARE CLAIMS:

- Health care providers must be paid timely for their claims. HMOs and insurers are required to pay claims for health care services within 45 days of receipt, except in cases where the obligation to make payment is not reasonably clear or there is evidence that the bill may be fraudulent.
- If the obligation to pay is not reasonably clear, then an HMO or insurer shall pay any undisputed portion of the claim and either notify the member or provider, in writing, within 30 calendar days of the receipt of the claim that the health plan is not obligated to pay and the reasons, or request additional information needed to determine liability to pay the claim.
- Upon receipt of the information requested, or an appeal of a claim for the denied health care services, an HMO or insurer shall comply with the 45 day requirement for clean claims.
- Each claim or bill processed after the 45 day time period is a separate violation.
- If an HMO or insurer violates the prompt payment law, the HMO or insurer must pay interest on the claim. Interest is calculated as the greater of 12% per annum or the rate set by the commissioner of taxation and finance for corporate taxes pursuant to New York Tax Law Section 1096(e)(1). Interest is calculated from the date the claim or health care payment should have been made. However, when the amount of interest due is less than two dollars, the HMO or insurer is not required to pay the interest.
- To report a prompt payment violation to the Department of Financial Services, please select this link.

PERFORMANCE AND PRACTICE INFORMATION:

- HMOs and insurers offering a managed care contract must develop policies and procedures to ensure that participating providers are regularly informed of the information maintained by the health plan to evaluate the performance or practice of providers.
- HMOs and insurers offering a managed care contract must consult with health care professionals when developing methodologies to collect and analyze provider profiling data.
- Any profiling data used by an HMO or insurer offering a managed care contract to evaluate providers must be measured against stated criteria and an appropriate group of participating providers using similar treatment modalities serving comparable patient populations.
- Providers must be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the provider's profile and to work cooperatively with the HMO or insurer offering a managed care contract to improve the provider's performance.
- No HMO or insurer offering a managed care contract may terminate or refuse to renew a participating provider contract solely because the provider has:
  - Advocated on behalf of a patient.
  - Filed a complaint against the health plan.
  - Appealed a decision of the health plan.
  - Provided information or filed a report with an appropriate government body regarding the health plan's actions.
- No participating provider contract with an HMO or insurer offering a managed care contract may contain provisions which supersede or impair the provider's right to a notice of reasons for the termination and an opportunity for a hearing.

Non-renewal of a Participating Provider Contract:

- Either the health plan or the provider may exercise the right of non-renewal at the expiration of an HMO contract or a managed care contract offered by an insurer. If no express expiration date is given, either the provider or the health plan can exercise the right of non-renewal each January 1st upon sixty days notice to the other party. A non-renewal is not considered a termination and no appeal rights are granted.

Source: http://www.dfs.ny.gov/insurance/hprovrght.htm

Questions and Answers

I am selling my practice and the buyer wants to use keep my name on the signage and in advertising for the next few years. Should I allow this?

First, even though this question came through a client we are working with on the sale, but I thought it made for a good listserv question, it is imperative you work with a healthcare attorney for any sale or purchase of a practice. Second, a request from a potential buyer for continuity in the seller's presence at the practice is standard. The goodwill being transferred and paid for in a purchase is intrinsically tied to the name/reputation of the selling practitioner. As a direct ramification of the preceding sentence, use of name is a regular deal point negotiated upon sale/purchase of a practice. Concerns related to use of name post-closing are legitimate. I recommend that if you, as seller, are not staying on as a treating provider during a transition period, that any use of your name be properly identified as "formerly the practice of Dr. O." Do not authorize continued use of your name post-closing indicating you are still at the practice. Doing so would be a misrepresentation to your patients and the world of your involvement and may give rise to your association and involvement in potential exposure, i.e., potential malpractice matter should one arise....

Typically, as part of deal terms the parties will work together and approve a transition letter to the patients notifying of the change in ownership. I recommend use of such a device to assist in transition and also break the news that you, as seller, will not be involved or have limited involvement, as the case may be, in the practice after the designated closing date.

Questions on practice transfers or transitions? Contact **Jennifer** to discuss at Jennifer@Kirschenbaumesq.com or 516 747 6700 x. 302.

How can I update my medical records if error is discovered or amendment/correction must be inserted ?

3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 442, Issued: 12-07-12, Effective: 01-08-13, Implementation: 01-08-13)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.

A. Amendments, Corrections and Delayed Entries in Medical Documentation

Providers are encouraged to enter all relevant documents and entries into the medical recordat the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, and ZPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in section B below. The MACs, CERT, Recovery Auditors, and ZPICs shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

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B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and

2. Clearly indicate the date and author of any amendment, correction or delayed entry, and

3. Not delete but instead clearly identify all original content

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision.

Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles wed above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

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