



WCH Bulletin

December 2014

3,612
readers

WCH
COOK-OFF
WINNER

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nanak@wchsb.com



Happy Holidays!

Greetings WCH Family,

This time of year is a time for reflection, making resolutions, and spending quality time with friends and family.

Decisions made in 2014 will guide the plans and processes of the company in this new year. We continue to improve the quality of our services; we continue to improve our knowledge and have on board more and more certified professionals; we implement grading system for our employees; we implement new and efficient processes which make communication between clients and our office easier; we continue to improve our customer service; we continue WCH public involvement in the healthcare industry, including webinars, live conferences and other professional association involvements. As you can see this year will be filled with hard work and improvements.

We are grateful to those who have given their time and support to us, and we appreciate your trust at every step of the way.

We expect that 2015 will be a year that will bring success and growth to us as a family as well as our clients and community. We are ready to face all the challenges that this year will bring. We encourage our providers to implement the use of iSmart EHR system. We will keep providing full support to our clients, we are always here for you. Your trust and reliability in WCH is our pride.

With many challenges behind us and many new opportunities ahead, we at WCH want to wish everyone Happy Holidays and a prosperous New Year!

Best wishes from your devoted and trusted WCH Team!



Cooking Contest

What's cooking in your house this holiday?

This year, WCH had a holiday cooking contest! Met our winner Nelly!

Nelly made delicious Turkish stuffed grape leaves and mouthwatering cheese roles.

Share with us photos of your dishes.

We will post it in our January issue.

Send your creations to nanak@wchsbc.com



Turkish stuffed grape leaves



Cheese Filled Pastry Rolls





CONGRATULATIONS!

Tatyana Kantor,

Certified Professional Biller,
WCH Service Bureau, Inc

WCH is investing in the success of our staff and clients!

We have another Certified Professional Biller on Staff, **Congratulations** Tatyana Kantor on your new certification!

Tatyana inspired and motivated by her supervisor Zukhra Kasimova, CPC, CPB accepted a challenge to become next Certified Professional Biller (CPB) in WCH. On December 13, 2014 with support from her coworkers and hard work, Tatyana has successfully passed the 200 question Certified Professional Biller exam adding CPB to her title. Tatyana is the second employee of many that will undergo CPB certification in WCH. These certifications will enhance the knowledge of our staff in submitting claims in accordance with government regulations and private payer policies, following up on claim statuses, resolving claim denials, submitting appeals, posting payments and adjustments, and managing collections. WCH management team acknowledges this great achievement and is proud to share it with our clients.

The certification enhanced the following skills of our medical billing staff:

- Understanding different types of insurance plans
- Applying payer policy, Local Coverage Determinations (LCD), and National Coverage Determinations (NCD) for successful claim submission
- Knowing CPT®, ICD-9-CM, and HCPCS Level II coding guidelines
- Navigating the varying rules and regulations which apply to the healthcare industry, including HIPAA, False Claims Act, Fair Debt Collections Act, and Stark.
- Knowing the life cycle of a medical billing claim and how to improve the revenue cycle Expertise in effective claim follow-up, patient follow-up, and denial resolution.

Congratulations Tatyana, we are proud!



CONGRATULATIONS!

Anna Kim, Esq

Compliance Officer,
WCH Service Bureau, Inc



Anna Kim, Esq has been appointed as WCH Compliance Officer.

We are confident that Anna Kim, Esq is up for the job and become a trusted compliance officer that will help WCH comply with the rules and regulations posed by the healthcare industry in efforts to protect our clients. Anna's extensive knowledge and background in the laws pertaining to the healthcare industry will serve as a basis for a long and successful commitment.

As the Compliance officer of WCH, Anna Kim, Esq will oversee the compliance program and function as an independent and objective body that reviews and evaluates compliance issues within WCH.

Compliance Officer Responsibility also include:

- Various risk areas including following internal billing guidelines and conflict of interest
- Healthcare fraud and abuse laws including the False Claims Act, Stark Laws and Anti-Kickback Statute
- Education of staff in all departments about issues of fraud and abuse laws and WCH compliance

Anna Kim, Esq understands the importance of compliance and possesses the tactical skills to implement a customized program designed to fit the organization to ensure organizational compliance with current standards.

Congratulations Anna on your new position!





Avoid Conflicts between Your trusted Billing Company and Your New EHR vendor

WCH has a great strategy and tremendous experience for processing and collection of medical claims and plays a crucial role in its client's reimbursement process! So, Do Not let your new EHR vendor dictate the work flow of your trusted billers.

Whether or not you are using WCH EHR along with our billing service, this software is just an essential tool to have for every practice, small or large. WCH provides our clients with certified EHR program that offers comfortable features and friendly, easy to use interface. By having both products provided by WCH, it eases the stress of managing charts and financial data. Since WCH handles the whole aspect of practice you can relax a little and enjoy the time you get back.

Of course, not all of our clients are taking advantage of having two services provided together. Some of the client's choices for EHR vendor are still driven by price. WCH is not a publicly traded company that can offer clients Free EHR. However, at the current fair market value, cost we do provide is a very unique. Our program allows you to have full control, maintenance, customization and support, complete with company and people that care about your practice.



Those clients that chose to go with another non-WCH EHR vendor and keep their billing service with us, we ask you not to allow the new EHR vendor to make any changes in WCH established processes of billing. We have been by our client's side the longest and proved our billing service by delivering clean claim submission to receive maximum eligible reimbursement. Let WCH team do its job right! WCH team provides much more than just EHR, billing, collection and audit services. Our primary focus is to help and protect our clients.

We assist our clients with PQRS measures reporting, meaningful use reporting, incentive programs, and many other vital issues, which other EHR vendor do not provide.

Don't lose your benefits,
be part of WCH trusted
network.

Currently, many EHR vendors are complicating the billing process for doctors simply because they are pushing the providers to use their preferred billing partner rather than trusted existing billing service. Additionally these vendors are pushing their clients to use favored service providers for lab and pharmacy orders, charge for training of new staff, force charges for support of the program and for any customization.

Many of the EHR vendors are using this system to make more sales rather concentrating on your needs as a medical provider. WCH cares about you and about your practice!

WCH billing experts are responsible for clean claim submission and collection of rightful reimbursement to the client. We are not responsible for downloading and gathering data for billing. We are advising our clients not to allow any EHR vendor to dictate your billing process, especially if you are with WCH already. Our billing requirements for billing documentation are simple. We need to receive electronically or by paper: patient information, signed super bill and insurance card. Once we have this on our side, we are ready to submit your claim and start the collecting process. Any EHR should be flexible enough to accommodate their client with this information. If you are still deciding on the EHR vendor, talk to your account representative, let us show you a demo of WCH ISmart EHR! Worse scenario, you still get more knowledge about EHR products on the market. We know you will not regret it.

YOU ALREADY TRUST US WITH YOUR MONEY, TRUST US WITH YOUR EHR PROGRAM.

DO IT RIGHT, WCH IT!





NYS OMIG December Annual Certification 2014



WCH Certified UNDER THE MANDATORY COMPLIANCE LAW

WCH is in compliance with the NYS law. WCH has submitted a certification for the **Mandatory Compliance Law** for Medicaid providers.

Here is what you need to know about WCH compliance program.

The **Mandatory Compliance Law** was established by the New York State Office of the Medicaid Inspector General (OMIG), which requires that Medicaid providers develop, adopt and implement effective compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program. The purpose of this compliance program is to require providers to implement and maintain appropriate systems and processes to detect and prevent fraud, waste and abuse in the Medicaid program. This promotes program integrity in the Medicaid program and saves the Medicaid program dollars by reducing inappropriate payments and maximizing appropriate payments for covered services that are delivered to Medicaid recipients.

WCH and Mandatory Compliance Law:

The compliance program is required for other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or who submit claims for care, services or supplies for or on behalf of another person for which Medicaid is, or should be reasonably expected by the provider to be a substantial portion of their business operations.

Under this classification WCH meets the description and therefore by law, must have a compliance program in place and must conform to the mandatory compliance program obligation.

What does WCH Compliance program contain?

Written policies and procedures that describe



compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues:

1. Designated employee vested with responsibility for the day-to-day operation of the compliance program;
2. Training and education of all affected employees and persons associated with the provider;
3. Communication lines to the responsible compliance position are accessible to all employees, persons associated with the provider, executives, and governing body members, to allow compliance issues to be reported;
4. Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assisting in their resolution;
5. A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas;
6. A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;



Be Protected, Hire WCH Billing Service

7. A policy of non-intimidation and non-retaliation for good faith participation in the compliance program.

Should you have any questions regarding our policies please contact our compliance officer Anna Kim at Annakim@wchsb.com





Sign Updated Contract

Important updates to your WCH billing agreement:

As we announced in previous WCH newsletter issues, Effective January 1, 2015 there will be new amendments to the existing WCH billing agreement. WCH Clients will receive an updated billing contract and be expected to review changes and submit signed copies to WCH account representative within 2 weeks.

Please take the time to review the following updates, these new changes will benefit both parties, make operations in WCH more transparent and help protect parties, client and WCH.

The account terms changes include, but are not limited to, the following:

Client's obligation to comply with WCH requests to perform random review of medical records

According to HHS/OIG "Compliance Program Guidance for Third-Party Medical Billing Companies" WCH performs random review of all and any records related to billing services and has a right to request such information from our clients. Client is obligated to provide WCH with all requested documentation including but not limited to signs in sheet, progress notes, progress reports and etc.

Benefit for you:

It's another way WCH is protecting our clients against submission of erroneous claims to insurance companies. All claims must reflect the services performed at the time of the visit. By randomly selecting to review the medical records, we are checking that the claims we submit contain accurate data.



Clients are responsible for providing all statement/documents resulting from WCH billing services to WCH within 5 days upon its receipt.

Any payments, EOB, patient's statements, etc received by clients must be sent to WCH within 5 days.

Benefit for you:

WCH can start processing and appealing partially paid and denied claims much faster compare to previous time frame of 10 days. We will also post the payments faster and update your account to reflect the most current status.

Payment refunds for patient bills

WCH changes the terms of issuing patients checks back to you within 2 weeks compare to 30 days processing waiting time. Under the new agreement we will issues checks for patient payments that are processed through WCH, same day as WCH bi-weekly billing invoice is issued.

Benefit for you:

You will get your patients bills payments faster.

Termination clause for billing service

WCH is adding a 30 day termination clause to our billing service agreement. Either party has a right to terminate the agreement, for any or no reason, upon 30 days written notice. WCH is responsible to finish all work for a client and process all claims that have been submitted on their behalf. To fulfill this obligation WCH reserves 90 days upon the termination of agreement for most collection cases.

Charges for denied claims

WCH will charge \$6.79 per claim that has been denied due to client's fault or mistake.

Benefit for you:

These charges will motivate your office to reorganize your front desk operations and overall improve internal eligibility and authorization process.

It's a Law! Clients must have direct communication with WCH Account Representatives

According to recommendations of OIG frequent communication between the billing company and the billing health care provider is fundamental to the success of any compliance process. Besides routine communication between WCH and clients' office staff, WCH and billing health care professionals must have direct regular communication to gather and provide accurate billing information. Effective communication between a practitioner and WCH is a significant aspect of a practice's efficiency, documentation improvement, medical claims processing, correct and potentially increased reimbursement and compliance.

Benefit for you:

You have only one license, and we are here to protect it. By having scheduled communication with your account representative you will be fully aware of all billing processes currently handled by WCH. You will know the status of claims, appeals, and reasons for denied claims and receive the latest healthcare updated from the insurance industry. Benefits all served to inform and protect you!



WCH compliance program

According to HHS/OIG "Compliance Program Guidance for Third-Party Medical Billing Companies" WCH maintains compliance plan as a service bureau. The compliance plan includes internal company policies, regulations, billing, coding and collection manual. This compliance plan is submitted every year to OMIG as required by the compliance office.

Benefit for you:

WCH provides service based on state regulations and internal protocols, all serving to protect and support our clients.

Contracted with Experian Credit Bureau to report all payers

As part of our commitment for excellence in cash flow management, WCH continues to work with Experian Credit Bureau to keep improving operation efficiency. Experian produces credit reports that measures and records company's and its client's payment habits to ensure that cash flow and revenue processes are up to date. All clients' accounts are recorded by Experian in order to ensure constant cash follow so that WCH can meet its obligations to suppliers, customers and employees.

Signature on super bills

WCH will not accept any superbill that has not been signed by a rendering health care provider for billing

Benefit for you:

WCH is protecting you as a provider to make sure that we bill the services that you had performed.

Suspension of billing services for non-payment

In case a client defaults in payment to WCH for billing services, WCH has a right to suspend services until the full payment is received. The client will be informed of the suspension by their account representative or supervisor. WCH will resume billing services after payment in full amount is received and cleared by the bank.

The updated agreements will be sending out to our clients starting January 2015. Should you have any questions, please do not hesitate to contact your account representative. We appreciate your full cooperation in returning signed agreements to WCH in timely manner.

Health Insurance Company CEOs' Total Compensation in 2013



Joseph Swedish, WellPoint

\$17.0 million

(\$49,853 per day)

WELLPOINT



Michael Neidorff, Centene

\$14.5 million

(\$42,560 per day)

CENTENE Corporation



Stephen Hemsley, UnitedHealth

\$12.1 million

(\$35,484 per day)

UnitedHealth Group



Mark Bertolini, Aetna

\$30.7 million

(\$90,029 per day)

aetna



David Cordani, Cigna

\$13.5 million

(\$39,589 per day)

CIGNA



Bruce Broussard, Humana

\$8.8 million

(\$25,807 per day)

HUMANA

Did you know?

One of the consequences of Obamacare is that health insurance company profitability is soaring, causing corporate CEOs of health insurance companies to pocket millions of dollars in annual salaries and bonuses. This is what happens when a government colludes with private industry to force the entire population to purchase a for-profit product that many don't want (or need). Sales skyrocket and profits head for the stratosphere.

thetruthseeker.co.uk

Average income of all occupations in 2013: \$35,239

Sources: AFL-CIO Executive Pay Watch and 2013 SEC 14A schedules

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM / WWW.PNHP.ORG



WCH AT NYSADSA CONFERENCE

Recap of presentation day!



Olga Khabinskay,
WCH Service Bureau, COO

Successful program MUST HAVE

1. Services that are consistent with the needs of the participants and community
 - Socialization – ACTIVITIES!!
 - Personal care
 - Nutrition
 - Transportation
 - Optional services: enhancement of daily living skills, use of supplies, family involvement etc.
2. Administration Standards
 - Policies and Procedures
 - Qualified Personnel
 - Program Director
 - Service staff – Ratio staff to client (1:6)
 - Volunteers
3. Active Membership with NYSADSA
4. Focus on your referral sources – Get the word out!
 - Physicians, Social workers, nurses, therapists, religious groups, other aging disease organizations, etc

Today's Challenges

1. Increased competition for Adult Day Care Providers
 - No set regulations for operating centers
 - Define your target population
 - Demonstrate Demand for Services
 - Hours and Days of Operation
 - Customer Satisfaction
2. Lengthy Contracting process
 - 6-8 Months before you can start billing
3. Panel are closing
 - Effects new providers & established providers planning expansion
4. Fraud & Abuse
 - Reporting false claims!!!!
 - Overbilling visits
 - Billing wrong location
 - Billing for services not rendered
 - Billing for services for another adult day care center
 - Illegally soliciting patients
 - Paying for patients referrals
 - Paying bribes to get into MLTC panels

MLTC Contracting

1. Select & Contact as many MLTC listed in your County
2. Prepare letter of intent with supporting documents
3. Be ready for site visit – Get the facility ready
4. Establish good relationship with provider representatives
5. Complete application and Contract
6. Be on top for follow ups and keep ongoing log of all calls
7. Keep in mind all time frames



Bizarre ICD -10 Code

S10.87XA - Other superficial bite of other specified part of neck, initial encounter.



Famous Doctor in Medicine!

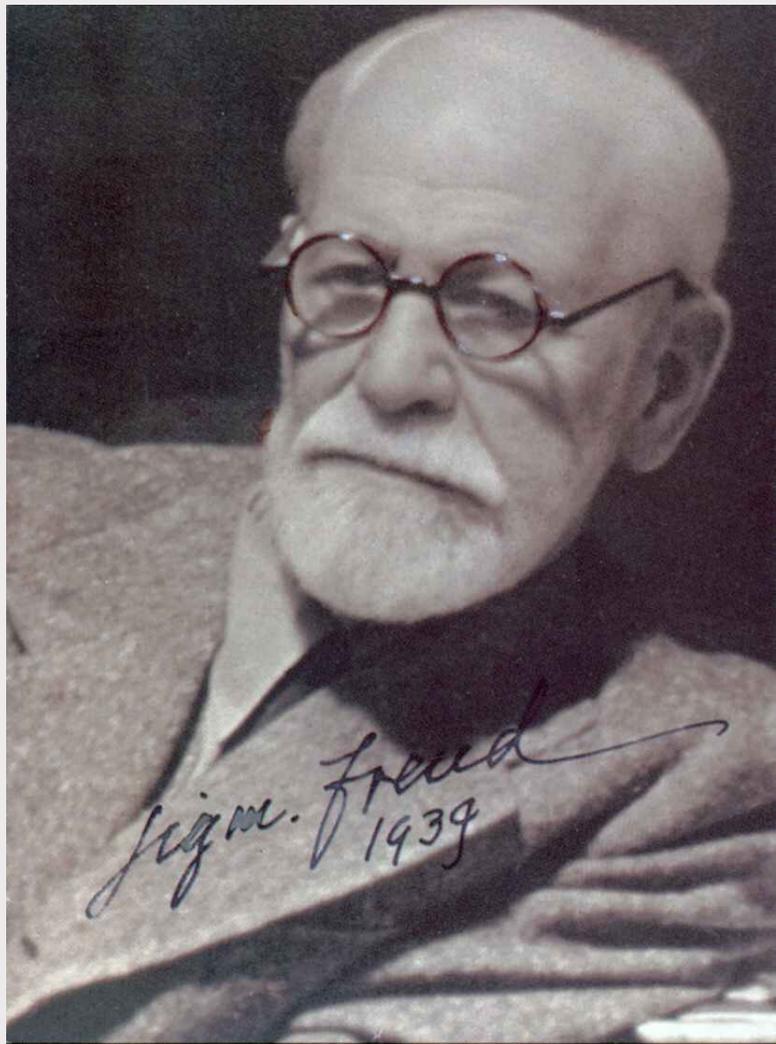
Sigmund Freud

Sigmund Freud was an Austrian neurologist best known for developing the theories and techniques of psychoanalysis. He was born in the Austrian town of Freiberg on May 6, 1856.

Freud received his medical degree in 1881. After graduation, Freud promptly set up a private practice and began treating various psychological disorders. Considering himself first and foremost a scientist, rather than a doctor, he endeavored to understand the journey of human knowledge and experience.

Freud's many theories—including those about "psychic energy," the Oedipus complex and the importance of dreams—were no doubt influenced by other scientific discoveries of his day. Freud's work has been both rapturously praised and hotly critiqued, but no one has influenced the science of psychology as intensely as Sigmund Freud.

Known as "the father of Psychoanalysis", he developed a famous psychoanalyst's methods. Talk therapy, which plays a primary role in psychoanalytic therapy and has become an important part of many different therapeutic techniques. Using talk therapy, the therapy provider looks for patterns or significant events that may play a role in the client's current difficulties.



Psychoanalysts believe that childhood events and unconscious feelings, thoughts and motivations play a role in mental illness and maladaptive behaviors. Psychoanalysis remains influential within psychotherapy, within some areas of psychiatry, and across the humanities. As such, it continues to generate extensive and highly contested debate with regard to its therapeutic efficacy.

After a life of constant inquiry, he committed suicide after requesting a lethal dose of morphine from his doctor while exiled in England in 1939, following a battle with oral cancer.

Learn more about Sigmund Freud [here](#).



New CMS rules enhance Medicare provider oversight; strengthens beneficiary protections

CMS Administrator Marilyn Tavenner today announced new rules that strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than \$327 million annually.

“The changes announced today are common-sense safeguards to preserve Medicare for generations to come, while making the rules more consistent for all providers that work with us,” Administrator Tavenner said. “The Administration is committed to using all appropriate tools as part of its comprehensive program integrity strategy shaped by the Affordable Care Act.”

CMS Deputy Administrator and Director of the Center for Program Integrity, Shantanu Agrawal, M.D., said, “CMS has removed nearly 25,000 providers from Medicare and the new rules help us stop bad actors from coming back in as we continue to protect our patients. For years, some providers tried to game the system and dodge rules to get Medicare dollars; today, this final rule makes it much harder for bad actors that were removed from the program to come back in.”

CMS is using new authorities created by the Affordable Care Act to clamp down on Medicare fraud, waste and abuse. CMS currently has in place temporary enrollment moratoria on new ambulance and home health providers in seven fraud hot spots around the country. The moratoria are allowing CMS to target its resources in those areas, including use of fingerprint-based criminal background checks. These and other successes continue to protect the Medicare Trust Funds. CMS has demonstrated that removing providers from Medicare has a real impact on savings. For example, the Fraud Prevention System, a predictive analytics technology, identified providers and suppliers who were ultimately revoked, and prevented \$81 million from being paid.

New changes announced today allow CMS to:

Deny enrollment to providers, suppliers and owners affiliated with any entity that has unpaid Medicare debt; this will prevent people and entities that have incurred substantial Medicare debts from exiting the program and then attempting to re-enroll as a new business to avoid repayment of the outstanding Medicare debt.

- Deny or revoke the enrollment of a provider or supplier if a managing employee has been convicted of a felony offense that CMS determines to be detrimental to Medicare beneficiaries. The recently implemented background checks will provide CMS with more information about felony convictions for high risk providers or suppliers.
- Revoke enrollments of providers and suppliers engaging in abuse of billing privileges by demonstrating a pattern or practice of billing for services that do not meet Medicare requirements.

Read a facts about today's final rule [here](#). See the final rule visit [here](#) or [here](#).

Contact CMS Media Relations:

(202) 690-6145 | press@cms.hhs.gov





Time for Change

CMS releases final 2015 payment rules for Medicare

1. The Protecting Access to Medicare Act of 2014 provides for a zero percent PFS update for services furnished between January 1, 2015 and March 31, 2015. Current law requires physician fee schedule rates to be reduced by an average of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert a large reduction in PFS rates before they went into effect.
2. Beginning next year, the Medicare Physician Fee Schedule will include a chronic care management fee. The purpose of the fee is to support physician practices in their coordinated care efforts for Medicare beneficiaries with multiple chronic conditions.

Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

CCM code 99490 (\$42.60) can be billed up to once per month per qualified patient.
3. The program adjusts Medicare payments to physicians based on the quality and cost of care they provide to Medicare beneficiaries, which leads to payment increases for providers that provide high-quality healthcare while reducing costs. In 2017, CMS will begin applying the value modifier to all physicians, including solo practitioners.
4. Medicare will begin paying for beneficiaries to receive annual telehealth wellness visits. Medicare will also pay for beneficiaries to use psychoanalysis and psychotherapy telehealth services.
5. New comprehensive Ambulatory Payment Classifications payment policy is being implemented next year. Under the policy, a single payment will be made for all related hospital items and services, rather than separate payments for each supportive service.
6. To help aid consumer decision-making, CMS will continue implementing quality improvement initiatives for physicians via the PQRS. For 2015 PQRS reporting, CMS is requiring that eligible professionals (EPs) report at least 9 measures, cover at least 3 of the National Quality Domains and report each measure for at least 50 percent of the eligible professionals Medicare Part B FFS patients seen during the reporting period to which the measure applies to avoid the PQRS penalty of 2% in 2017. There is no PQRS incentive payment for reporting in CY 2015. CMS also noted that their intention is to eliminate the claims-based reporting mechanism in future rulemaking.

Other changes include:

- The 2015 therapy cap will be \$1,940, up \$20 from the 2014 cap.
- If Congress fails to act before March 31, 2015, the process for exceptions to the therapy cap will end, including the \$3,700 manual medical review process.



“FIDA (Fully-Integrated Dual Advantage)” - Managed Care Expansion for Dual Eligibles in NYC Metro Area - Jan. 2015

What is a FIDA plan?

FIDA starts with Medicare Advantage

All FIDA plans are also Medicare Advantage plans. The basic structure of how they work and the rights of members are based on Medicare Advantage.

Under Federal law, Medicare recipients must have freedom of choice as to whether to enroll in a Medicare Advantage plan or stay with Original Medicare. Thus, a Medicare recipient can never be forced to enroll in any type of managed care plan that includes Medicare benefits.

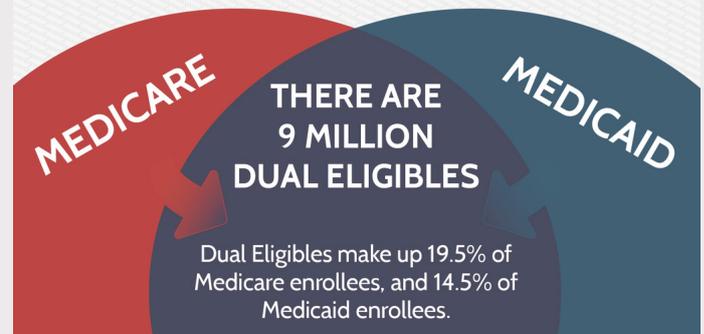
However, the Medicaid program does not contain such a right. Thus, Medicaid recipients (i.e., the poor) have long been required to enroll in private managed care plans in order to get State-funded Medicaid coverage. However, until recently, dual eligibles were exempt from Medicaid managed care as well. Therefore, dual eligibles are one of the last groups in the country who have never been enrolled in managed care.

Medicaid Managed Long-Term Care

In 2012, New York State first began to require a certain sub-set of dual eligibles to enroll in a special type of Medicaid managed care plan. While they were not required to change how they received their Medicare benefits, they were excluded from fee-for-service Medicaid and automatically assigned to Medicaid Managed Long-Term Care (MLTC) plans. Thus, there is now a population in New York State of about 135,000 dual eligibles who are enrolled in MLTC plans. Their plans manage their long term care and some other Medicaid services but not their primary and acute medical care, delivered through Medicare. Thus they still experience uncoordinated care because their Medicare and Medicaid benefits remain completely separate. Those in MLTC plans typically have

“partially-capitated” plans, which only include the Medicaid long-term care benefits. This means that they still receive their Medicare coverage through either Original Medicare or a separate Medicare Advantage plan.

DUAL ELIGIBLES OF MEDICARE AND MEDICAID



Medicare Advantage + MLTC = FIDA

A FIDA plan is like a Medicare Advantage plan combined with an MLTC plan. The FIDA benefit package includes everything covered by Medicare, plus everything covered by Medicaid (including long-term care). Thus, FIDA plans are considered “fully-capitated.” Beginning in January 2015, *New York State will start enrolling some MLTC participants into FIDA plans offered by the same company as their MLTC plan.*

This means that affected individuals will need to go through their FIDA plan to meet all of their medical and healthcare needs, regardless of whether covered by Medicare or Medicaid. *FIDA participants must only go to providers in their plan’s network (as with Medicare Advantage).* And the FIDA plan is responsible for both authorizing any medically necessary care, and coordinating among its members various providers.



COMPARE: Medicaid Advantage and Medicaid Advantage Plus vs. FIDA

FIDA plans are not totally new. Even up till now, Dual Eligibles have had an option of enrolling in a single plan that combines all of their Medicare and Medicaid services in one managed care plans. These are called MEDICAID ADVANTAGE Plans (as opposed to MEDICARE Advantage plans) and PACE plans. The name is misleading because these plans cover MEDICARE as well as MEDICAID services.

TO make it more confusing, only some MEDICAID ADVANTAGE plans include Medicaid personal care and other long term care services. These are called MEDICAID ADVANTAGE PLUS Plans. PACE plans also cover Medicaid long term care services as well as all Medicare services.

People in Medicaid Advantage Plus plans, but NOT PACE plans, in the Demo area, will be subject to FIDA passive enrollment.

Like PACE and Medicaid Advantage Plus, FIDA plans will combine under one managed care plan: (1) a Medicare Advantage plan, (2) a Part D prescription drug plan, (3) a Medicaid Managed Long Term Care plan, and (4) a regular Medicaid card covering all other Medicaid services. FIDA plans will cover not only Medicaid long-term care services, as MLTC plans do, but also cover ALL other medical care covered by Medicare and Medicaid.

In other words, a FIDA member will essentially trade in ALL of their insurance cards -- Medicare (Original or Medicare Advantage), Medicaid, MLTC, Medigap, and Medicare Part D -- and only have one health plan -- their FIDA plan.

WHERE

As a demonstration program, NYS is targeting a smaller group of dual eligibles, not the whole state. The demonstration area is NYC, Long Island, and Westchester.

WHO

Not coincidentally, the target group includes ADULT dual eligibles (age 21+) in NYC, Long Island, and Westchester who:

- Receive or need MANAGED LONG TERM CARE services - those adults age 21+ who receive or need community-based long term care services, AND
- ALSO - Dual eligibles living in nursing homes or who come to be permanently placed in nursing homes AFTER JANUARY 1

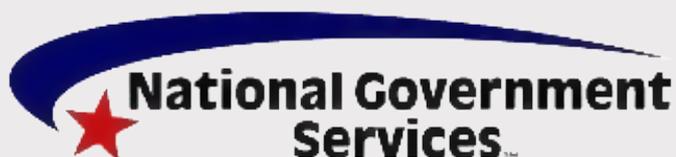
Resources:

List showing types of plans offered by each insurance company, with column indicating which will be FIDA plans, posted at www.wnylc.com/.

MLTC plans NOT becoming FIDA plans - United HealthCare, Extended, HHH Choices. [Download PDF](#).



Medicare updates by MAC:



Jurisdiction K Prepayment Service-Specific Edits

Evaluation and Management Services

Home Visits: CPT codes 99348-99350 Podiatry (NY Only)

Hospital Visit- Subsequent: CPT code 99233 All specialties (All Jurisdiction K)

Hospital Visit- Initial: CPT codes 99222-99223 All specialties (All Jurisdiction K)

Nursing Home Visit: Subsequent: CPT codes 99309-99310 All specialties (CT, MA, NY Only)

Prolonged Care: CPT codes 99354-99357 All specialties (All Jurisdiction K)

Chiropractic Services Chiropractic Manipulation: CPT codes 98940-98941 Chiropractors (CT and NY Only)

Diagnostic Services Noninvasive Vascular Studies: CPT codes 93880-93882 with 93970, 93971, 93925 and/or 93926 All specialties (All Jurisdiction K)

Electrocardiographic Interpretation and Report: CPT code 93042 Cardiology (CT and NY Only)

Rehabilitation Services Physical Therapy: CPT codes 97002-97140 Family practice (All Jurisdiction K)

Source: [Jurisdiction K Medicare Part B News Flash](#)

Novitas Solutions delay in claim processing

Novitas Solutions has been informed of a systems problem that may result in delayed processing of a limited number of Medicare Part B claims. This systems problem is preventing the finalization of certain claims that require Out of Service Area (OSA) processing. The OSA process is not properly applying the OSA reply and the claims are recycling. The standard system maintainers are aware of this issue and are working on a fix. However, this correction is not expected to be implemented until early January. Providers do not need to take any action at this time. Once the fix is implemented, the OSA process will complete and impacted claims will finish processing.

Modifier 52

National Government Services has found that on many occasions providers are billing for reduced services with modifier 52 appended to the CPT code; however, they are billing the regular charged amount for the procedure. In some of these cases, this type of billing could lead to an overpayment.

When billing for a reduced service, providers should reduce the billed amount by 50% just as providers are to increase a bilateral billing by 50%. Maintaining the same charge for a reduced service is not proper billing. Please make sure that when you submit any CPT code with modifier 52 that you are also reducing the billed amount by 50% prior to submission to Medicare.





2015 CPT UPDATE

A LOOK AHEAD: 2015 CPT CHANGES

Arthrocentesis

Three new codes (20604, 20606 and 20611) were proposed to describe ultrasound imaging guidance as an inclusive component of arthrocentesis, aspiration and/or injection of a joint or bursa. Fluoroscopic-guided arthrocentesis will remain component coded. Revisions were made to 20605 and 20610 to denote the procedures are performed without ultrasound guidance.

20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting

(Do not report 20600, 20604 in conjunction with 76942)

(If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

20606 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting

20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

(Do not report 20610, 20611 in conjunction with 27370, 76942)

(If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)



The American Medical Association RVS Update Committee also reviewed the following codes:

- 92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- 92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording
- 92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545 Oscillating tracking test, with recording

Committee assessed and revised the “professional work” value for each procedure. Professional work value includes factors such as mental effort and judgment, technical skill, and psychological stress. This is part of the valuation process established by the American Medical Association’s Relative Value Update Committee (RUC).

As part of the AMA RUC valuation process, the survey results garnered by each of the specialty societies are used by the AMA RUC to make recommendations to CMS. CMS accepted the RUC recommended values for 92541, 92542, 92544, and 92545, but did not accept the RUC recommended value for 92543 despite the advocacy efforts of the Academy and other stakeholders. Due to changes in time, equipment, and supplies, there was also a reduction in practice expense for the four other vestibular codes

Overall, CPT codes 92541, 92544, and 92545 will have lower reimbursement rates for CY 2015. These changes are detailed in the chart below:

CPT Code	DESCRIPTION	CY 2014 Work RVU	CY 2015 Work RVU	CY 2014 PE RVU	CY 2015 PE RVU	CY 2014 Rate	CY 2015 Rate
92541	Spontaneous nystagmus test	0.40	0.40	0.44	0.21	\$30.81	\$22.55
92542	Positional nystagmus test	0.33	0.48	0.39	0.24	\$26.51	\$26.49
92543	Caloric vestibular test	0.10	0.10	0.33	0.33	\$16.12	\$16.11
92544	Optokinetic nystagmus test	0.26	0.27	0.39	0.15	\$24.00	\$15.75
92545	Oscillating tracking test	0.23	0.27	0.33	0.15	\$20.78	\$15.75

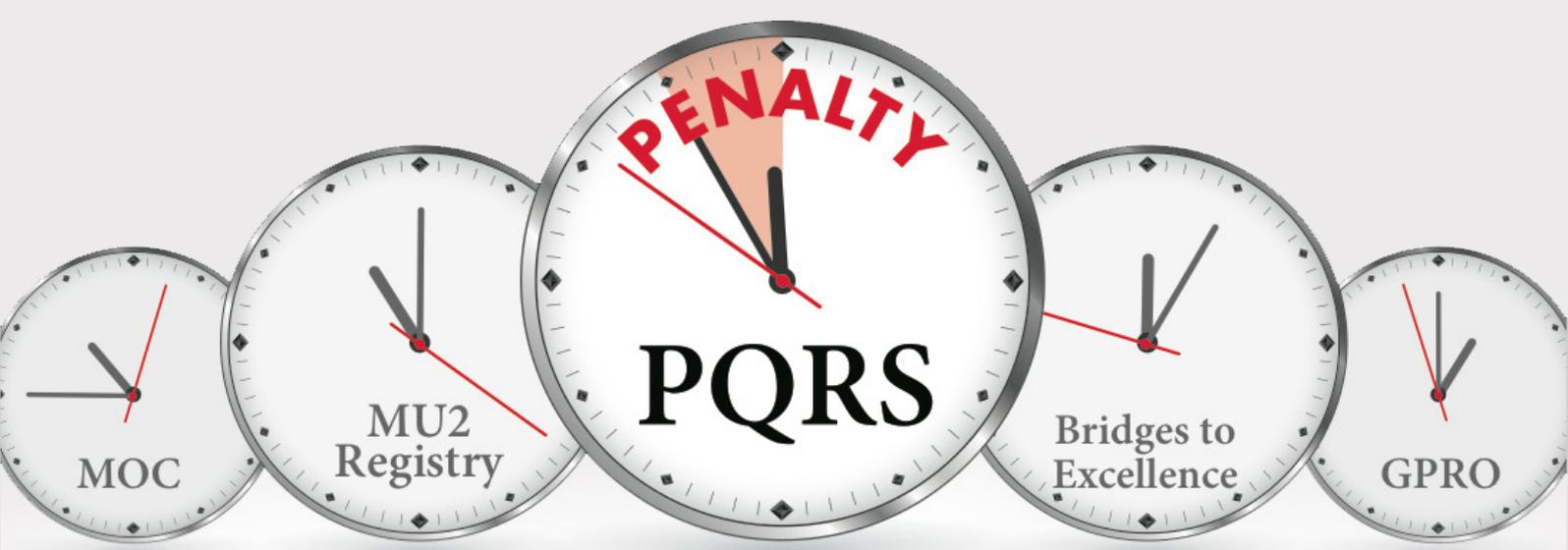
The Academy is scheduled to meet with CMS in January to discuss the decrease in reimbursement for the vestibular codes.



Bizarre ICD -10 Code

W55.41XA - Bitten by pig, initial encounter





ARE YOU READY?

CMS Distributes PQRS Penalty Letters

Recently, the Center for Medicare and Medicaid Services (CMS) issued letters to eligible professionals (EPs) and group practices who will receive negative penalty adjustments to their 2015 Medicare payments.

Those eligible professionals (EPs) and group practices who did not satisfactorily report PQRS quality data measures in 2013 should have received letters from CMS informing them that a negative 1.5% payment adjustment would be taken from their Medicare Part B payments starting January 1, 2015.

Group practices and EPs who believe they have been inappropriately penalized may appeal via an information review process to CMS during the time period of January 1, 2015 through February 28, 2015. CMS has provided a fact sheet about the 2015 PQRS negative payment adjustment as well as step-by-step guidance for requesting an information review. Once CMS receives the review from the EP or group practice, they will investigate and determine whether the negative payment outcome was appropriate.

The fact sheet and detailed instructions on how to file for an informal review can be found [here](#).



How to submit a 2013 PQRS informal review request in order to avoid 2015 PQRS penalty?

The Eligible Professional can request the 2015 PQRS Payment Adjustment Informal Review to avoid the 2015 PQRS Payment Adjustment by doing the following steps, if they feel that the payment adjustment is being applied in error:

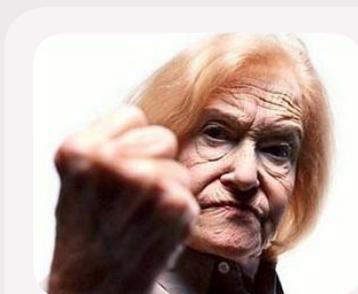
- Go out to www.qualitynet.org/pqrs
- Choose the “Communication Support Page” on the left hand side of the page
- Then choose the “2015 PQRS Payment Adjustment Informal Review request”
- Fill out the form utilizing the Individual NPI# and make sure that you utilize the “Justification Box” to explain your situation – this information is what CMS will use in their review of your Informal Review request.
- Once you’ve filled out the request form we would suggest printing off a copy of it for your records before you submit it. Also we would suggest printing off the confirmation page that states your request has been sent, and staple the two together for your future reference.

The PQRS Informal Review period for the 2013 PQRS incentive and 2015 PQRS payment adjustment will run from 1/1/2015 to 2/28/2015.

CMS will review the requests and make a final determination of whether they will “Approve” or “Deny” the request – if they deny the request then you will be subject to the 1.5% Payment Adjustment for 2015.

	2013	2014	2015	2016
Successful Participation	.5%	.5%		
Unsuccessful Participation			-1.5% (based on 2013)	-2% (based on 2014)

For any new requests please contact the Qnet Help Desk
866-288-8912 | qnetsupport@hcqis.org



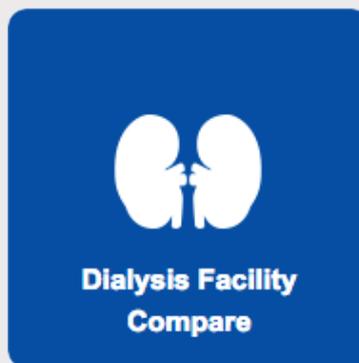
Bizarre ICD -10 Code

Z63.1 - Problems in relationship with in-laws.



Official Physician Compare Data

Physician Compare is a Centers for Medicare and Medicaid Services (CMS) [website](#).



What information is available on Physician Compare?

Currently, Physician Compare is a website that allows consumers to search for physicians and other healthcare professionals who provide Medicare services. Some of the information on the site includes:

- Physicians' and other healthcare professionals' names, addresses, phone numbers, specialties, clinical training, and genders.
- If physicians and other healthcare professionals speak languages other than English.
- The hospitals physicians and other healthcare professionals are affiliated with.
- If physicians and other healthcare professionals accept the Medicare-approved amount (patient will not be billed for any more than the Medicare deductible and coinsurance).
- Group practice information including their location addresses, phone numbers, maps and directions, specialties, as well as a list of physicians and other healthcare professionals within that practice.

How are CMS' quality programs related to Physician Compare?

Physician Compare includes information about physicians and other healthcare professionals who satisfactorily participate in CMS quality programs:

1. The Physician Quality Reporting System (PQRS): Profile pages show whether physicians and other healthcare professionals have taken part in PQRS.
2. The Electronic Prescribing (eRx) Incentive Program: Profile pages show if physicians and other healthcare professionals are participating in the eRx Incentive Program
3. The Electronic Health Record (EHR) Incentive Program: Profile pages will show if physicians and other healthcare professionals are participating in the EHR Incentive Program.

Source: www.cms.gov



Questions and Answers

DEA License Required for Credentialing Purposes?

I enjoy reading your valuable input on many issues. I am a tele-radiologist. I do not prescribe any controlled substance nor do any injections. Do i still need to keep DEA license for credentialing purpose?

That's a good question and one I do not know the answer to because it really falls outside of the legal scope, moreso into credentialing. I asked Barry Haitoff, CEO of Medical Management Corporation of America to opine and Barry graciously provided the below:

In our experience of performing credentialing services for our revenue cycle management clients, DEA License information is a standard request. Based on specialty however, it is not a requirement for participation.

We also posed this question to a national professional credentialing company who also stated:

"If a provider has no intention of prescribing medication than they do not need a DEA license. For instance this radiologist (reading only) would not need a DEA in order to credential with a payer/facility/hospital.

If a physician intends or his specialty demands that he/she prescribe medication in any form than the payer/facility/hospital would press to find out why they did not have one (suspended/revoked etc.). There is no blanket requirement for a DEA license UNLESS THE PROVIDER INTENDS TO PRESCRIBE. In that instance where there is a physician licensing or credentialing with a specialty typical of prescribing meds but won't be prescribing, the payer/facility/hospital will want to know in writing #1. Can someone prescribe on his behalf #2. They will prescribe no drugs under any circumstance within their practice."

Should the doctor have any further questions, I can be reached at the below. Happy to help.

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

Answered by: Barry Haitoff

CEO, Medical Management Corporation of America,

1620 Route 22, Brewster, NY 10509

T: 845-363-4833 | F: 845-278-8796

www.mmcoa.com | bhaitoff@mmcoa.com



Can I bill out of network through another tax ID?

I am in-network with most plans at my office, but was approached by another doctor to join him in a venture where we will bill services out of network out of a new practice we are forming. Is this okay?

Sounds like a potential case of “cherry picking”, and will most likely not be a kosher arrangement. Your relationship with carriers as an in-network provider is a contractual one, and depending on the terms of the contracts, you may be bound to accept in-network rates and provide services to that carrier’s insureds for the agreed-upon fee schedule regardless of the entity you are operating out of. Such are the contractual restrictions placed on many practitioners. However, should your contractual in-network arrangements reflect a commitment for a specific tax ID number, and not extend to you individually, you may be entitled to charge on an out of network basis at the new practice. So, the answer is, without seeing your participating provider contracts, I cannot give a definitive opinion.

Happy to review. My advice, do the required due diligence before proceeding with the proposed arrangement.

Answered by: Jennifer Kirschenbaum

200 Garden City Plaza, Garden City,

NY 11530

T: 516-747-6700, ext. 302

jennifer@kirschenbaumesq.com



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