WCH Bulletin

July 2014

CLARITY, COMFORT, SECURITY

BE PROTECTED - HIRE WCH SERVICE BUREAU AND RELAX!

3,300 READERS

WCH Service Bureau is a proud member of the following professional organizations:

25th Anniversary PAHCOM

Health Care Compliance Association | HCCA

AHIMA Quality Healthcare Through Quality Information

AAPC Advancing the Business of Healthcare

CAMBRIDGE WHO'S WHO®

AMBA

CEU CREDITS

Welcome to our Summer Edition!

INSIDE THIS ISSUE:

Your Feedback is Important to Us, WCH it Let us know what topics you would like to see inthe upcoming issues. We are always looking forward to your feedback about our performance.

Get your CEU credits TODAY

For more information please **CONTACT US** at **718-934-6714** or by e-mail to: nanak@wchsb.com

FOLLOW US:

Be Smart, Use iSmart EHR

FREE demo request

Use iSmart EHR to Improve Quality of Your Practice

- EASY TO USE
- AFFORDABLE
- WON'T SLOW YOU DOWN
- INTERFACES WITH OTHER VENDORS

Sign Up for iSmart EHR package today call Olga Khabinskay 718-934-6714 x 1201 or via email: olgak@wchsb.com

This Complete EHR is 2014 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of the U.S. Department of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments.

Product Name: iSmart EHR; **Vendor name:** WCH Service Bureau, Inc.; **Date Certified:** 03/20/2014; **Product Version:** 1.1.0.0; **Criteria Certified:** 170.314(a)(1-15), 170.314(b)(1-5, 7), 170.314(c)(1-3), 170.314(d)(1-8), 170.314(e)(1-3), 170.314(f)(1-3), 170.314(g)(2-4) **Certification ID Number:** 03202014-2403-5; **Clinical Quality Measures Certified:** CMS002v3,CMS050v2, CMS065v3, CMS068v3, CMS069v2, CMS074v3, CMS075v2, CMS090v3, CMS122v2, CMS123v2, CMS124v2, CMS125v2, CMS126v2, CMS127v2, CMS128v2, CMS130v2, CMS134v2, CMS138v2, CMS139v2, CMS147v2, CMS149v2, CMS155v2, CMS156v2, CMS159v2, CMS161v2, CMS163v2, CMS164v2, CMS165v2, CMS166v3; **Additional software requered:** DrFirst Rcopia

WCH Buzz

Be Protected, Hire WCH Billing Service

As the Healthcare business growing to be more complicated it is becoming increasingly difficult to find medical billing services that adds value to your practice. Medical Billing is a crucial component of any practice; it is also an area of complexity that is to be handled by Medical billing specialist with concrete knowledge and understanding of the processes, rules and regulations. It is important that the Medical billing staff have the experience and skill necessary to conduct effective billing practices that bring the right reimbursement back to your practice while remaining absolutely compliant with federal and state regulations.

While physicians and practice managers deal with many issues such as ensuring high quality patient care, increasing technology constrains, declining insurance reimbursements, policy changes, new coding regulations and administrative burdens, it is important to keep Medical Billing in prospective and on the top of the list. Many experienced healthcare professionals would argue that working with the right Medical Billing service improves all areas of the practice and helps to increase the bottom line, even in today's challenging times. **Do it Right, WCH it!**

At WCH Service Bureau, our Medical Billing department has been designed to help medical providers and practice managers navigate through the complex process of medical billing and collection to other practice needs. At WCH, our experienced professionals provide high quality service for over 13 years to practices nationwide. To ease the burden of medical billing and other related issues in your practice choose WCH for your Medical billing needs. Our medical billing specialist have concrete knowledge and understanding of the procedures and regulations that will help you increase

profits while remaining fully compliant by state and federal regulations. We provide more than just a claim submission service; we provide you with confidence, security and comfort that your data is accurately submitted to the insurance company and deliver to you 97% - 98% reibursment on your claims.

With WCH Medical Billing Service **YOU ARE IN CONTROL.** Control and again control, can't be without it and we do not want you to give it up. WCH provides clients with full transparency by giving access to information about your practice 24 hours a day. As a WCH Client, you get to see every bit of detail about the practice. Our sophisticated, customized software allows you to run reports, enter reminders for patients or staff, view insurance and patient payment history, get paid information by insurance, procedure, patient, dos, by group member, etc. Your trust is very important to us, therefore you have access to valuable information regarding the state of your claims, payments or other practice details.

With WCH Medical Billing Service **WE TALK AND LISTEN**. Communication is key to success in any relationship. We communicate with our clients on a regular basis. As our client we are obligated to talk to you on weekly basis, give you feedback, report to you on your practice performance and give suggestions to improve. We often respond to your needs at a moment's notice to ensure that you get timely answers to your questions. In addition to excellent medical billing service and constant communication with your Medical Billing representative, our communication is expressed in many other ways such as newsletters, emails, constant industry updates and news from our partners.

With WCH Medical Billing Service **YOU BENEFIT**. In WCH, clients work with our certified and trained medical billing staff that has the experience and knowledge on a broad range of issues. Our staff gets instant industry updates and so do our clients. Our clients get to enjoy the perks of high quality service and best of support for the practice. At WCH we do everything for our clients!

We develop long lasting relationships with our clients which is based on trust, professional knowledge's, industry expertise, and undivided attention to the details of our work which is why clients stay with us for the life of their practice.

WE LAUNCHED NEW WEBSITE FOR iSMART EHR

Visit us today to learn the benefits, features, pricing and get to test drive the EHR.

Introducing iSmart EHR Packages

iSmart multispecialty EHR has been designed with your practice needs in mind. WCH offers a variety of different packages and pricing options to fit the specific needs of your practices. Our iSmart EHR packages cover a broad range of options to help your practice run smoothly.

iSmart is a complete meaningful use certified EHR system is what you need to be able to attest and receive the funds allocated by government incentive programs. The funds are available for the use and implantation of an EHR system in your office. It is still not too late to attest for meaningful use and receive government incentives before the October 1, 2014 deadline by which all Medicare providers need to attest in order to avoid penalty in 2015.

Learn more about the iSmart EHR packages that are available and chose the right one for your practice:

iSmart EHR System Pricing

Licensing Plans	BASIC	STANDARD	PROFESSIONAL	ENTERPRISE
Price per month	$245	$245**	$245**	$245**
Number of Licenses	1 License	3 License	Unlimited	Unlimited
Billing Service	✗	✓	✓	✓
Commission from Billing Service	✗	7%	9%	10%
Credentialing Service	✗	✗	✗	✓
iCode Service	✗	✗	✓	✓
Minimum monthly revenue required	✗	$100k	$300k	$400k
	Purchase	Purchase	Purchase	Purchase

**All approved licensed EHR users must be contracted and use WCH Billing Service

Live Webinar with Our Host Olga Khabinskay, Join Us!

Don't allow insurance companies to shut you out by stating they are "closed." This blocks you from an entire population of patients, and in turn the revenue they would generate for your practice.

And depending on the panel, this could be a significant amount of reimbursement.

There are ways to get on "closed" panels. Most of the time you just have to be willing to fight for the spot (with the right tactics). But before you start on your quest, you need to be sure getting on the panel is really worth it. Not all insurance panels are created equal.

So where should you start? **Olga Khabinskay, COO** of WCH Service Bureau, has the answers. Her years as a credentialing, auditing, billing and compliance specialist have allowed her to amass insider, practical tactics that will ensure you get on the insurance panels you want to be on with the least amount of hassle possible.

Olga has condensed her years of experience into an online 60-minute training session scheduled for **Thursday, July 31st at 2pm EST** that will give you the tools you need to identify which panels you really want to be one, and how to get on them.

- Stop wasting your time, **know which panels to fight for**
- 3 insider traits that **make insurance panels give you access** to their patients
- Master **reapplication tactics** that will pry open the "closed panel" door
- How **your patients and colleagues can get you on** the panels you want
- Maximize your revenues by **identifying which panels you should get out of**

Stop taking insurance company "closed panel" notifications as the rule of law. Get the tactics you need to blow open the doors and get on the panels you need to be on to make your practice even more successful.

Don't wait. Attendance space is limited to ensure an optimal learning experience for all.

Register at www.codingleader.com/closed-panels

Live Webinar Details:

Date: Thurs, July 31st
Time: 2:00pm - 3:00pm ET
1:00pm - 2:00pm CT
12:00pm - 1:00pm MT
11:00am - 12:00pm PT
Price: $157

3 Easy Ways To Register:

1. Register **Online** at: codingleader.com/pages/closed-panels
2. **Call** 800-767-1181
3. **Mail** a check to:
   1854 Trade Center Way
   Suite 201
   Naples, FL 34109

Meet Your Expert:

Olga Khabinskay
WCH Service Bureau

Olga has over 12 years or experience in provider credentialing, contract negotiations, controlling the work procedures of the billing department and in-depth understanding of general routine operations to run successful medical practice.

Important News for Our Clients: We Updated Our Billing Service Agreement, Find Out What Has Changed.

Dear Clients, updates to the WCH Medical Billing agreement have been sent to clients in July 2014. The Medical Billing service contract has been updated with some administrative changes that we believe will improve our services. We at WCH work around the clock to ensure our clients get quality service. We always improve our procedures and policies to better support our operation and expand our services. Existing WCH clients as well as new clients are subject to the updates as outlined in the amended Medical Billing Service agreement contract.

*****Please note: THE BILLING RATE FOR SERVICES HAS NOT BEEN CHANGED*** Summary of Changes in WCH Medical Billing agreement:**

1. Time frame for payment to WCH for services has been amended from ten days of the date of billing invoice to five days.

- **Section 11:** Fee due to WCH shall be promptly paid by the Client within 5 days after being billed for the last billing cycle submitted by WCH to the Client.

Charges on the WCH billing invoice are based on payments that were already made to client or third party for amount received by client. WCH invoice does not include charges for money that has not been received by the client nor does it include any future charges.

2. Flat fee per claim has been amended to $6.79 from $4.01 for capitation and denial of submitted claims resulted from the fault of client mistake.

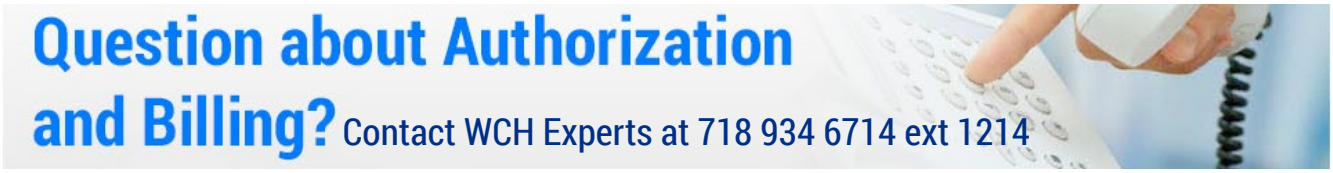
- **Section 28**: An additional charge of $6.79 will be billed for capitated services
- **Section 39:** If the claim in any of the cases mentioned above will be denied due to the fault of client mistake, WCH will charge the client $ 6.79 per claim

The Flat fee charge is compensation for work performed by WCH in relation to creating, submitting and working with claim.

3. In the event client request to have an insurance payment check reissued, a fee for reissuing a check is $15 per check.

- **Section 34:** Client agrees to pay WCH a $15.00 per check if WCH will reissue lost, undeliverable or request a duplicate copy of the check from the insurance company.

The $15 charge is compensation for work preferred by WCH in relation to submitting the request to have checks reissued. Please review the updated service contract agreement and return a signed signature to WCH at your earliest convenience. Should you have any questions please do not hesitate to ask your dedicated account representative.



WCH and DrFirst Join Forces to Educate and Improve Your Prescribing Practice !

WCH Service Bureau has joined forces with DrFirst which is a healthcare technology solutions company that empower physicians while reducing costs by providing leading e- prescribing solutions.

WCH clients now have the opportunity to learn more about the e-prescribing software solutions and begin using DrFirst's award-winning software that will help the practice improve patient outcomes at the point of care, increase workflow efficiency while maximizing cost savings.

Learn about the following products and services that are offered to you:

- Rcopia® — the nation's #1 standalone e-prescribing solution
- RcopiaMU℠ — the nation's #1 standalone e-prescribing solution plus Meaningful Use tools
- EPCS Gold℠ 2.0 — controlled substance e-prescribing
- Patient Advisor℠ — medication adherence solutions

To learn more about DrFirst product and service solution for physicians contact WCH for more information about DrFirst.

WCH together with DrFirst supports I- STOP!

Put an I-STOP to the controlled Substance Abuse Epidemic in New York and nation wide. The I-STOP Act, passed in New York, is the first piece of statewide legislation enacted in order to help combat the rising rates of prescription drug abuse.

Beginning in 2015, New York state providers will be mandated to query the state prescription monitoring program (PMP) and review a patient's recent medication history prior to writing any prescriptions for Schedule II, III, or IV controlled substances. This will give providers real-time information regarding a patient's medication history, helping to detect potential drug shoppers and prescription drug abusers.

Efective March 27, 2015 all prescriptions for legend drugs and Schedule II, III, IV, and V controlled substances must be sent electronically. This will provide greater security measures around potential tampering or fraudulent activity for all prescription drugs.

DrFirst is fully equipped to deploy EPCS Gold SM 2.0, the first-ever fully compliant solution for sending electronic prescriptions of controlled substances, in the state of New York upon enablement by pharmacies, which is anticipated shortly. EPCS Gold 2.0 builds on Rcopia®, DrFirst's award-winning e-prescribing system, allowing providers to send both legend and controlled drug prescriptions electronically. EPCS Gold 2.0 is fully compliant and secure.

WCH iSmart EHR is fully compatible with Dr First E- prescribing solutions and can help you begin using the software immediately to be prepared for changes that are coming up in 2015 for prescribing controlled substances.

Contact WCH today for more information. DO IT RIGHT, WCH IT!

Patients Now Know How Medicare Pays their Doctor, What's Next?

As part of the Obama Administration's efforts to make our healthcare system more transparent, affordable, and accountable, the Centers for Medicare & Medicaid Services (CMS) has prepared a public data set, the Medicare Provider Utilization and Payment Data.

The US government made public data about Medicare payments to doctors, providing details such as the procedures doctors performed and how much they were paid and place of service. The date reflects calendar year 2012 for Part B Medicare fee for service providers. The data shows that Medicare made total payments to more than 880,000 medical providers in 2012, totaling $77 billion.

The data provides information on payment and utilization for Medicare Part B services but also has a number of limitations. Primarily, the data does not reflect physician's entire practice as it only includes information on Medicare fee-for-service beneficiaries. Also, this data are not intended to indicate the quality of care provided and are not risk-adjusted to account for differences in underlying severity of disease of patient populations.

Aside from adding transparency, the exposure of the Medicare reimbursement for providers has not added any value to the providers. The data is now available to the public to view the reimbursement Medicare

Source: http://www.slane.co.nz/

providers receive but there is no benefit to the providers from this information. People often jump to conclusions thinking that if the provider received large reimbursement means the providers did something wrong. People often make that assumption without looking at the large picture and taking into account other details which are not available to the public. Seeing a large number paid out to the provider doesn't always mean fraud is involved. Although the data is detailed and provides a lot of information, it does not and cannot reflect the physician's entire practice.

Share your opinions with us regarding releasing Medicare payment information with with our readers the public by emailing us at ilanak@wchsb.com

Source: http://www.cms.gov

ICD-10 SAMPLER
R46.1
Bizarre Personal Appearance

Healthcare News

HealthFirst Leaf Plan Members

As of July 1, referrals from PCP will be required for HealthFirst Leaf Plan members. These referrals will be made through Emdeon.

Platinum Leaf Plan
$0 annual deductible, low copays, and an annual out-of-pocket limit of $2,000.

Gold Leaf Plan
$600 annual deductible, modest copays, and an annual out-of-pocket limit of $4,000.

Silver Leaf Plans
$2,000 annual deductible, modest co-pays, and an annual out-of-pocket limit of $5,500. Subsidies are available that can help reduce the Silver Leaf copays and deductibles.

Bronze Leaf Plan
$3,000 annual deductible, 50% coinsurance, and an annual out-of-pocket limit of $6,350.

Green Leaf Plan
A health plan for people under 30 years of age. After reaching the annual deductible of $6,350 there is no copay or coinsurance.

Source: http://www.healthfirstny.org

Important Update on Primary Care Rate Increase

New York State has received federal funding from CMS for the Primary Care Rate Increase (PCRI). The funds have been forwarded to health plans to distribute payments to providers for quarter 1 and quarter 2 of 2013. Fidelis Care will mail these payments to providers on June 2, 2014, and a separate remittance advice (RA) will be uploaded to each provider's portal. If you have questions, please contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

Source: http://www.fideliscare.org/

Free In-Home Assessments for Your Eligible Medicare Patients

Our research shows that Medicare members are more likely to comply with certain health prevention screenings when they are offered in the convenience of their own home. That's why EmblemHealth contracts with MedXM to provide free in-home screening assessments for our Medicare HMO/PPO members.

Conducted by licensed and credentialed clinicians, the in-home assessments currently include:

- Bone density scan of the heel
- Spirometry test
- Which members receive this free service?
- EmblemHealth identifies eligible Medicare members with a recent bone fracture and no history of a bone density scan or treatment for osteoporosis for an in-home heel bone density scan.
- EmblemHealth identifies eligible Medicare members with a new diagnosis of COPD or newly active COPD and no history of a spirometry test for an in-home spirometry test.

Participation is at the sole discretion of the member. It does not affect insurance coverage.

How does this free service work?

The in-home assessments do not replace the care you provide. Rather, the goal is to support the work you do to improve health outcomes. For example, MedXM clinicians will encourage your patients to have their preventive care and routine office visits. The clinicians are not involved in the care or treatment of your patients, nor can they prescribe medication.

All results and medical records from the assessment will be sent to you. Please review the report for opportunities to improve patient care. Also, please include it in the member's medical record. If the clinician believes that the member could benefit from case management, they will inform your office and EmblemHealth.

Source: http://emblemhealth.com/

ICD-10 SAMPLER
Z62.891
Sibling rivalry

WCH Service Bureau

We Can Help

Did you ever want to have Internal Lab in your Practice?

WCH CAN HELP WITH THE FULL SET UP!

INCLUDING:

- CLIA permit
- Equipment
- Reagents
- Clinical Training
- Insurance Contracting and MUCH MORE.

Contact Olga Khabinskay at **718-934-6714 ext. 1201** or via email at **olgak@wchsb.com**

Effective July 1, 2014, Healthfirst's New Jersey FamilyCare Members Become WellCare Members.

Services you provide to those members will be billed to WeUCare. Healthfirst's Maximum Plan (HMO SNP) members will remain with Healthfirst. Any services you provide to Healthflrst's Maximum Plan members should be billed to HeaHhfirst, until such time as you are otherwise notified.

Additionally, on July 1, 2014, New Jersey FamilyCare members who receive care via the Medicaid waiver programs listed below will transition to the new Managed Long Term Support Services (MLTSS) program:

- AIDS Community Care Alternatives program (ACAAP)
- Community Resources for People with Disabilities (CAPO)
- Global Options for Long Term Care (GO); or,
- Traumatic Brain injury (TBI)

ML TSS will not be offered in 2014 by D-SNP Medicare Advantage Plans for individuals who receive NJ Medicaid home and community-based services under these programs. Individuals will need to enroll in a NJ FamilyCare managed care organization (MCO) or a Program of All-Inclusive Care for the Elderly (PACE) program to receive their Medicare, NJ FamilyCare medical care and NJ FamilyCare community-based long-term services and supports. Additional ML TSS program information is provided by the State of NJ Department of Human Services website at:
http://www.state.nj.us/humanservicesldmahs/home!ML TSS_Provider_FAQs.pdf

Contact your Network Management Representative or -Provider Services- at 866·889-2523 for questions or clarification Monday to Friday from 9 a.m. to 5 p.m.

Source: http://www.state.nj.us

News by State

NY Becomes the 23rd State to Allow Medical Marijuana Dispensing

New York is now the 23rd state to authorize marijuana as a medical treatment — though it will have one of the more restrictive programs in the country.

Under legislation signed into law on Saturday by Gov. Andrew Cuomo, patients with one of 10 diseases will be able to obtain non-smokeable versions of the drug. Officials chose to prohibit distribution of marijuana plant material in order discourage non-medical use.

The law requires medical marijuana be ingested or vaporized. The details of exactly how the drug will be administered will be worked out by the state health department.

The law "gets us the best that medical marijuana has to offer in the most protected, controlled way possible," Cuomo, a Democrat, said Monday at a ceremonial bill signing in New York City. "This is the smartest approach that any state has taken thus far."

Some advocates argue the law is too restrictive, however, and said they'll push lawmakers to expand it. Of the 23 states with medical marijuana laws, only one — Minnesota — prohibits the smokeable drug. Advocates also say the state should allow people with more kinds of illnesses to utilize the program.

"It's a first step and it's an important step that will improve thousands of people's lives," Karen O'Keefe, director of state operations at the Washington, DC-based Marijuana Policy Project, said of New York's law. "But it will leave others out."

The first medication isn't expected to be available for at least 18 months as state regulators, physicians and potential distributors of the drug work to implement the new program.

Under the law, the state will approve and regulate up to five businesses authorized to grow and distribute the drug. The operators could each have up to four dispensaries statewide.

Patients would get prescriptions from physicians approved by the state to participate in the program. Approved conditions include AIDS, Lou Gehrig's disease, Parkinson's disease, multiple sclerosis, certain spinal cord injuries, epilepsy, inflammatory bowel disease, neuropathies and Huntington's disease.

Source: http://nypost.com/

New York State Department of Health Requirement – Keep Your Office Hours Up to Date

As part of EmblemHealth's reporting requirements to New York State, we must have accurate office hours on file for your practice. Please take the time to sign in to our secure site and check your online profile (after you sign in, go to "Practice Profile") to ensure all information, including your office hours located on the lower portion of the screen, is up to date. It only takes a few minutes and it's a New York State Department of Health requirement.

Note: Requested changes will not display automatically. Modifications that do not require verification may take up to 10 business days to appear. Some updates, such as to your license number, specialty or school, will be verified by our Credentialing department and may take longer to appear.

Source: http://emblemhealth.com/

Questions and Answers

Question:

As a capital S supervising MD is not present in the suite, may I bill incident-to if a secondary supervising MD is within a suite on the day of service? If so, is it billed under the big S supervising MD, or does it have to be billed under the secondary supervising MD's billing number?"

Answer:

The physician that is in the office that day is the physician whose number the claim goes out under, and the physician who wrote the plan of care for the patient goes in box 17. Your big S supervisor could be a third-party entirely. Your big S supervisor doesn't necessarily come into play. If you look at the information on slide number 34, it defines out a physician that's in the office, the physician that saw the patient, etc. It doesn't talk about the big S or collaborative physician.

Question:

PA direct billing for echo to Medicare is denied due to supervision levels per Medicare. Can you discuss the level of supervision per Medicare?

Answer:

Diagnostic tests have a level of supervision that is required if you go to the Medicare fee schedule database. The RVU table has 36 columns. Go out to the far right hand side, and there's a column that says, "Supervision of diagnostic tests." The supervision that is required by Medicare is the supervision by a physician. There is no substitution of a mid-level for a physician in that instance.

If there's a test that requires direct supervision, it has to be by a physician. If it requires personal supervision, that has to be by a physician. I know that Medicare retroactively changed the level of supervision for several tests to personal supervision, meaning that the physician had to be the one doing the supervision, doing the billing.

Again, there's no substituting. It says it right in the Social Security Act, "You can't substitute anything for a physician when it comes to diagnostic tests." That means that the PAs cannot do that test and bill for it. This level of supervision has to be met by a physician. That rule's been around a while again, because they've been changing it to more of the personal supervision. That's why all of a sudden PA billings are getting caught up in a bunch of rejections

Question:

Can surgeries, such as code 43999 (used for adjustment of gastric band) along with code 74240 and 77002 in the office be billed as incident to? We cannot tell if these fall in a separate category of billing or not. We have been unable to locate anything that specifically states what a NPP can bill as incident to. Are only E&M codes billable as incident to?

Answer:

Procedures excepted for a limited number of minor ones MUST be billed under the performing provider (Medlearn). Incident-to does not apply. You could not have a physician delegate brain surgery to a NPP as incident-to. Other surgical procedures are the same. They must be billed by the performing provider. Matters SE0441 has valuable information. There is no specific mention of surgery because it is not part of the concept.

Additional NPP Coding Q&A's are also available to you when you purchase this valuable NPP services coding tool. Here are a few of the additional topics the expert presenter provided answers to:

- Sharing NPP Services Between Physicians in Different Practices
- Billing PA Services (NPI)
- Physician Oversight for Shared Services
- Infusion Documentation
- Critical Care Shared Services
- and so much more

Source: http://codingleader.com/pages/incident-to

Question:

Patients often ask us to fill out disability forms and other applications/documents. For example, we have been requested to complete New York State Office of Temporary and Disability Assistance Division of Disability Determination forms for a patient. Can we charge the patient a $25 fee to fill out these forms even though New York State pays the doctor a $10 fee? Also, in general, are we allowed to charge fees to complete state/city forms in order for patients to obtain benefits from the city or state?

Answer:

Certain states regulate charges from providers for patient paperwork, NYS does not. See the NYS DOH frequently asked questions page on the website. Which means, you may charge for administrative time so long as you are not subject to a contractual or other limitation prohibiting from you from charging. For instance, if you are a participating provider you are contractually agreeing to accept a set, designated reimbursement (hopefully negotiated) for certain services to patients, for which such negotiated fee is contractually required to represent certain administrative work associated with such are - i.e., prescriptions. Where a patient has paid a visit to your practice and you have been reimbursed for their visit your in-network rate, and you have prescribed related to that visit, the prescription may be deemed a part of the service you have been reimbursed for and any additional charge may be seen as a contractual violation.

Here, the paperwork specified is a disability form which in most instances calls for the patients treating provider to complete information related to the disability, which may be unrelated to insurance reimbursement or provider payment, however, NYS as you have specified provides reimbursement. You may run the risk of a potential patient complaint, since patients never want to pay for anything, let alone where the practice may already be receiving reimbursement and "double dipping". I am also generally concerned that charging for cer-

certain forms, specifically for disability, and not other forms, may result in potential liability, inclusive of potential claim of discrimination if you regularly perform certain administrative duties for other patients who are not claiming disability - which is a protected class under federal and state statutes. Of course there is a difference between complying with administrative duties for patients versus devoting hours of your time towards completing absurd forms. While you may not wish to adopt a strict charging policy, you may also settle on defining a fine line of efforts expended complying with burdensome administrative requests.

Admin you absolutely can charge for - services not covered by any insurance or reimbursed by any third party - which is why colleagues of yours may successfully be charging for certain "concierge" services, including "exclusive" access, after hours care, email capability, etc.

Question:

Are there any state regulations about having security camera in the waiting room of my office?

Answer:

NYS allows cameras anywhere where an individual does not have an expectation of privacy - so your waiting area, presumably, is absolutely appropriate for cameras, as is monitoring your front desk, hallways and even offices or treatment rooms (unless you foreseeably have patients changing there). Bathroom stalls or in changing areas would be inappropriate and not authorized.

Most other states follow the above rule, but each state has slight variations. For instance, in NY, we are a 1 party consent for audio - meaning at least one party to a two party conversation must consent to being recorded - so you are not authorized to capture audio in your waiting room because you could foreseeably capture a conversation where the participants are not aware they are being recorded. Posting a sign in the area stating you are recording audio may not be enough to save you from potential exposure with audio because audio recording in violation of NYS statute is a criminal violation - amounting to a potential Class E felony (Mechanical Overhearing - Eavesdropping - NY CLS Penal § 250.00).

Answered by **Jennifer Kirschenbaum, Esq**

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 want to see in upcoming issues or changes to the format that you would like to see.
You can simply E-mail your comments to us at
nanak@wchsb.com

Message:

Name:

E-mail: