WCH Bulletin
August 2013

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ICD-10
Are you ready?

Smart
electronic medical records
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WCH Service Bureau is a proud member of the following professional organizations:
WCH invites you for an educational conference

How to Overcome the Occurring Healthcare Industry Challenges

**When**
October 29th, 2013 at 6:30-9:30 PM

**Where**
Bank of America Tower 1 Bryant Park (W 43st), New York, NY

Direction: 42 St - Bryant Pk (B, D, F, M) 5 Av (7, 7X)
Times Sq - 42 St (S)

Light dinner will be served. There is no cost to attend this event. You may bring guests with you!

**Featured Speakers:**

Olga Khabinskay, COO, WCH Service Bureau Inc.
Solving today's challenges between doctors and insurances.

Kenneth Music, Vice President, Bank of America Practice Solutions
Medical Practice financing solutions.

Mathew J. Levy, Principal/Partner, Kern Augustine Conroy & Schoppmann, P.C.
A legal view on physician practice audits from insurance companies.

John V. Pellitteri, CPA, Grassi & Co.
Merger Mania - is it the right option for your practice?

Peter Bechtel, President of Well Track One
Medicare annual visit program compliance and patients health improvement.

Click here to register TODAY!
Register on our website [www.wchsb.com](http://www.wchsb.com)
For information call us at 718-934-6714 Ex. 1202 or 1214
Or e-mail [ilanak@wchsb.com](mailto:ilanak@wchsb.com)
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For more information please contact Marianna Shapiro at 718-934-6714 ex. 1202 or by e-mail to: mariannash@wchsb.com
WCH efforts in preparing and implementing the ICD-10

As we reported earlier this summer, WCH was selected by CMS to be interviewed by their contracted market research consultants Alan Newman Research on the ICD-10. Olga Khabinskay provided an in-depth look of how WCH is internally and externally preparing for the migration process to ICD-10.

During these complex times of transition, WCH is making efforts to prepare early for the sake of our clients for a smooth, successful transition. We understand that a well-planned and well-managed implementation process is inevitable for the success of the process completion.

We present to you parts of our implementation plan for ICD-10 transition:

1. Market research and analysis: WCH billing department are in constant contact with our clearing houses. We work with specialists in order to get instant updates for ICD-10 transition. All commercial payers will follow CMS transition and they will be compliant for ICD-10 by October 2014. WCH will begin the testing period with all commercial payers who will be ready by the beginning of 2014.

2. Ongoing education for the coding and anatomy/pathophysiology to all WCH staff conducted on a regular basis by Yuliya Kiseleva MD. Moreover, this education will be repeated in 2014 as well. Upon education completion all WCH employees will have a better understanding of anatomy, body systems, and disease process. WCH employees are being trained to convert Diagnosis codes from ICD-9 to ICD-10 and will follow AMA and CMS guidelines for correct Diagnosis coding. Necessary trainings and ICD-10 updates are regularly implemented to all WCH employees in the billing department.

3. Perform necessary updates in our electronic claim form, data base of our billing software (PMBOS) and perform all necessary review and upload specific updates for ICD-10 EDI standards if any. Add applications and option for selective billing using ICD-10. After all program installation and updates will be made, WCH Service Bureau will be ready to submit ICD-10 claims.

4. Convert each individual WCH clients SB form ICD-9 to ICD-10. Due to the fact that number of ICD-10 diagnoses will be increased by 5 times in comparison with ICD-9, we strongly recommend to our clients to use our Electronic superbill. The ICD-10 definition of each diagnosis code will be more expanded and will cause problem for the providers who are still using paper superbills. Each of our providers will get updated superbill with converted diagnosis codes and will be contacted by assigned account representative for further discussion and transition process consulting.
WCH REFERRAL PROGRAM
FOR OUR CLIENTS

Refer WCH to Your Colleagues and Friends for billing service!

Only happy clients refer others, and we want to make sure we exceed the expectations of every client who passes through our doors. We understand that, we only grow if you are happy with our service. If you know anyone who needs billing service, WCH is here to help.

We are grateful for referrals that come our way and pleased to offer a Referral Reward Program. WCH will provide you with WCH GOLD certificate that has added value.

For more information contact Ilana Kozak

General Manager
skype: ilanak.wchsb
(718) 934-6714 ext. 1214
ilanak@wchsb.com
WCH proudly introduces the WCH iSmart EMR. The WCH IT department, has been working around the clock, as much as 17 hours a day to develop and design an Electronic Medical Record that is easy to navigate, efficient to use and is integrated with our billing service. The WCH iSmart EMR is currently undergoing the process of certification to ensure that the necessary technological capability, functionality and security standards are met. The road for certification is difficult and lengthy. However, WCH follows a defined process to ensure that our EMR technology meets the adopted standards to so that our providers achieve the measures and objectives of Meaningful use as outlined by the Centers for Medicare and Medicaid services (CMS).

WCH iSmart EMR is more than 50% complete and is currently being further developed. In the near future we are planning to get certified by Dr. First (e-prescribing vendor) to meet one of the next certification criteria. At this time we began the certification process with Drummond group Inc. This upcoming fall the WCH iSmart EMR is going to be fully certified.

To inquire about WCH iSmart EMR, please contact Ilya Mirolyubov

E-mail: ilyam@wchsb.com
Skype: wchsb.ilyam
phone: (718) 934-6714 ext. 1111
The Race is on!
WCH panthers in pink are ready to go!!!

WCH is a firm believer and supporter of the Susan G. Komen foundation.

Since 2009, WCH team has been an active contributor to the Susan G. Komen foundation for a cause we believe is extraordinary. Each year, WCH panthers gather together with many other New Yorkers in central park, wearing pink customized T-shirts, to partake in the Susan G. Komen New York City Race for the Cure. This is the most widely known, largest and best funded breast cancer organization in the United States. It is important to us at WCH to help increase awareness of breast cancer screenings and promote education and outreach programs in the fight against breast cancer.

As always, the WCH team will be running on September 8th 2013 in Central Park. In the meantime, with the help of our dedicated staff, clients and supporters we hope to reach our goal of $500 of donations to the Susan Komen foundation in an active fight against breast cancer.

If you wish to support our team, please kindly make your contribution by following this link: http://goo.gl/W65OLz

Thank you!
WCH Receives 2013 Best of Business Nomination

PHOENIX, July, 10th 2013, WCH has been nominated for the 2013 Best of Business Award.

Being in business sets people apart from most ordinary people and the Small Business Community is dedicated to helping others understand that running a business is an obtainable goal and that everyone should try their best at living their dreams.

The Small Business Community recognizes and awards business owners because they often do not receive the recognition they deserve. Business owners are role models for everyone whether they know it or not. Small Business Community 2013 Best of Business Award Nominees are a valuable asset to their community and exemplify what makes small businesses great.

About WCH

WCH Service Bureau, Inc. (“WCH”) is a nationwide multi-service company that specializes in medical billing, credentialing, chart auditing, software development and other medical practice management services. Since 2001, WCH has proudly served thousands of healthcare providers nationwide. WCH’s clients, include private clinics, hospitals, laboratories, imaging centers, pharmacies and supply companies. WCH distinguishes itself from other practice management services by providing an integrated “all-in-one” service that allows its clients to be more focused on growing their practices.

About Small Business Community

The Small Business Community Association is dedicated to collecting and organizing information, training, and services that are vital to small business owners, entrepreneurs, and anyone else that needs help running a business, operating a business, or wants to know how to start a business.

The mission of the Small Business Community is to promote a vibrant and growing small business community, support education that will preserve and extend the future of small business and use our gifts within the small business community to serve others for the betterment of our world.

The Small Business Community vision is to enthusiastically advance small businesses in three key areas:

1. Growth-To assure a vibrant and growing small business community, our goal is to introduce, engage and mature the next generation of small business owners.
2. Advocacy-We feel it is fundamental to support education and action outside the small business community that will preserve and extend the future of small businesses.
3. Compassion-We believe it is essential that we use our gifts within the small business community to serve others for the betterment of our communities and world.

Source:
Small Business Community / FTM Marketing

Contact:
FTM Marketing, Inc.
Email: Press@smallbusinesscommunity.org
URL: http://smallbusinesscommunity.org
At Bank of America Practice Solutions, you can rely on our industry leadership. Our financing professionals understand the challenges of managing and growing a practice. Let us help you succeed.

- **New office start-ups** — get started with up to 100% project financing,* including design, construction, equipment and working capital.

- **Practice sales and purchases** — our team of experts can provide the experience and industry knowledge you need for buying and selling.

- **Business debt consolidation†**— to improve your cash flow.

- **Office improvement and expansion** — remodel, refurbish, or expand.

- **Commercial real estate** — choose from a suite of comprehensive real estate loan options to buy, refinance,* or relocate, terms up to 25 years.

- **Equipment financing**— choose from a variety of options and flexible terms tailored to meet your needs.

**Product Features:***

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  - Practice sales and purchases
  - Office improvement and expansion

- Loans up to $5 million

- Flexible repayment options

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* All programs subject to credit approval and loan amounts are subject to creditworthiness. Some restrictions may apply. The term, amount, interest rate and repayment schedule for your loan, and any product features, including interest rate locks, may vary depending on your creditworthiness and on the type, amount and collateral for your loan. Some restrictions may apply. Loans greater than $300,000 may be eligible for a 15-year term.

† Bank of America Practice Solutions may prohibit use of an account to pay off or pay down another Bank of America account.

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WCH Service Bureau Inc. Receives 2013 Best of Brooklyn Award

Brooklyn Award Program Honors the Achievement

BROOKLYN July 22, 2013 - WCH Service Bureau Inc. has been selected for the 2013 Best of Brooklyn Award in the Best Medical Billing Service category by the Brooklyn Award Program.

Each year, the Brooklyn Award Program identifies companies that we believe have achieved exceptional marketing success in their local community and business category. These are local companies that enhance the positive image of small business through service to their customers and our community. These exceptional companies help make the Brooklyn area a great place to live, work and play.

Various sources of information were gathered and analyzed to choose the winners in each category. The 2013 Brooklyn Award Program focuses on quality, not quantity. Winners are determined based on the information gathered both internally by the Brooklyn Award Program and data provided by third parties.

About Brooklyn Award Program

The Brooklyn Award Program is an annual awards program honoring the achievements and accomplishments of local businesses throughout the Brooklyn area. Recognition is given to those companies that have shown the ability to use their best practices and implemented programs to generate competitive advantages and long-term value.

The Brooklyn Award Program was established to recognize the best of local businesses in our community. Our organization works exclusively with local business owners, trade groups, professional associations and other business advertising and marketing groups. Our mission is to recognize the small business community's contributions to the U.S. economy.

Source:
Brooklyn Award Program

Contact:
Brooklyn Award Program
Email: PublicRelations@awardprogram.org
URL: http://www.awardprogram.org
Our COO, Olga Khabinskay will speak at the AMBA 2013, 13th Annual national Medical Billing Conference on October 10-11, 2013 in Las Vegas!!!

As a trusted member of AMBA Olga Khabinskay has been chosen to speak based on her expertise in Medical Billing and Credentialing.

Olga will present “Credential Successfully with Confidence.” Often, credentialing is viewed as an unwelcome distraction, but it shouldn’t be. Attendees will learn the general rules of credentialing and understand the strict requirements and regulations as well as learning how to increase revenue by negotiating fees with insurers and finally, how to successfully complete a credentialing process. We all know how time-consuming credentialing is. Learn shortcuts that will help you submit successful applications.

Olga Khabinskay, COO, WCH Service Bureau, Inc., Chief Operating Officer of WCH Service Bureau and Manager over the Credentialing Department. Olga is a member of the American Medical Billing Association (AMBA), American Health Information Management Association (AHIMA), American Association of Professional Coders (AAPC), Professional Association of Healthcare Office Management (PAHCOM) and Health Care Compliance Association (HCCA). She graduated with a B.A. from Adelphi University and is currently working on her masters in healthcare management.

Alex Romanychev, CEO and Zukhra Kasimova, CPC will join Olga at the conference, we encourage our clients and partners to join us at this wonderful event. To learn more about the AMBA annual national conference in Las Vegas, please visit http://www.ambanet.net/2013.htm
Healthcare News

The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014

What are the employer requirements?

The Affordable Care Act (ACA) does not require employers to offer insurance coverage to their employees, but it imposes a penalty on businesses that fail to insure their employees in certain circumstances. Small employers with fewer than 50 employees are exempt from any penalties. Beginning January 1, 2014, large employers can be assessed a free rider penalty if their workers receive premium subsidies through the Exchanges.

In addition, an employer with more than 200 employees who offers at least one health plan must automatically enroll employees into one of the plans offered, though employees may opt out. This approach to enrolling in employer-sponsored coverage is expected to increase employee participation.

What happens if employers don’t meet the requirements in insuring their employees?

There are two situations where large employers may face a penalty for workers who get subsidized coverage in an Exchange:

1. Large employers that do not offer coverage and have at least one full-time employee receiving subsidized coverage are assessed an annual fee of $2,000 per full-time employee, but the first 30 employees are excluded in calculating the assessment.

2. Large employers who offer coverage that is either unaffordable or inadequate and who have at least one full-time employee receiving subsidized coverage in the Exchange must pay an annual fee of $3,000 for each full-time employee receiving a premium credit, with a maximum penalty equal to $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Coverage is considered unaffordable if the employee must contribute more than 9.5 percent of their household income for their premium. Coverage is considered inadequate if the plan’s does not coverage at least 60 percent of a person’s medical costs on average - referred to as actuarial values.)

Source: http://goo.gl/kjbk2r
Codes 99495 and 99496 are used to report transitional care management services (TCM).

These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days. 99495  Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge 99496  Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means.

Medication reconciliation and management must occur no later than the date of the face-to-face visit.

Source: http://www.ama-assn.org/ama
For more info contact your account representative today.

Documentation and audit + “Reviewed” Isn’t Enough to Meet E/M Documentation Requirements

When documenting elements of an evaluation and management (E/M) service, a notation of “Family History Reviewed,” for instance, is insufficient to satisfy the element. Guidelines require more than a simple note of “reviewed” to fulfill the documentation requirement.

Both the 1995 and 1997 documentation guidelines specify, “A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record [emphasis added].

Specifically, according to the documentation guidelines, the review and update may be documented by:

- Describing any new ROS and/or PFSH information, or noting there has been no change in the information. Noting the date and location of the earlier review of systems (ROS) and/or past, family, and social history (PFSH).

Source: www.news.aapc.com
The HIPAA omnibus September 23rd 2013 deadline is fast approaching!

On January 17th, 2013 The U.S. Department of Health and Human Services (HHS) moved to strengthen the privacy and security protections for health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The HIPAA omnibus rule greatly improves privacy protection of a patient, provides individuals new rights to their health information, and strengthens the government’s ability to enforce the law.

Providers now need to take the steps described below to ensure that they will be fully in compliance by the deadline:

**Updating internal policies.**

In order to comply with the Omnibus Rule, providers must update their internal privacy policies to reflect the changes to the HIPAA Privacy Rule, Security Rule and Breach Notification Rule. Below are certain key changes that a provider will likely need to make to its internal privacy policies.

Providers should assess whether it makes sense to take the opportunity to replace their policies or update existing policies. HHS has posted on its website the audit protocol derived from the recently completed audit pilot program. The audit protocol provides a helpful list of the items that an auditor will review when assessing whether a covered entity is in compliance with HIPAA. We recommend using the audit protocol provided by HHS to assess whether existing policies generally pass muster. If existing policies generally meet the requirements in the audit protocol, it likely makes sense to update existing forms. If however, existing policies are generally lacking, it may be more cost effective to replace existing policies with new, Omnibus Rule-compliant, policies.

After the policies are finalized, the provider should formally adopt and approve the policies pursuant to any procedural requirements in the provider’s governing documents or standard operating procedures.

**Staff training.**

It is important that a provider’s policies are both updated and implemented. Once a provider has updated its privacy policies, workforce members should receive training on any new and revised policies. In particular, management and higher-level employees should be fully trained on the new breach standard, so that, if necessary, they can correctly perform the required analysis.

Training is important both as a preventative measure and to ensure compliance with HIPAA and the HITECH Act. Training should be documented and maintained in the event training logs and program details are requested during an audit or investigation.

**Notice of privacy practices.**

The Omnibus Rule modifies and expands the content of the notice of privacy practices that a provider is required to maintain and distribute to its patients. After a provider has updated its NPP, the provider must make the NPP readily available to existing patients who request a copy on or after the effective date of the revisions; must post the revised notice on its website, if applicable; and must post the notice in a prominent location on its premises. New patients who receive services for the first time after modification of an NPP should be provided with a copy of the revised NPP. Consistent with the existing rules, providers should retain copies of previous versions of their NPPs and of any written acknowledgements by patients of receipt of NPPs.

**Business associate agreements.**

Providers should revise their business associate agreement form to reflect the new requirements under the Omnibus Rule. Providers must enter into new BAAs or modify existing BAAs by September 23, 2013. However, existing BAAs that were entered into on or before January 25, 2013 and have not been modified after March 26, 2013 do not have to be updated until September 23, 2014.

Once the provider has updated its form BAA, we recommend conducting an inventory of all current BAAs (including BAAs in which the provider is the covered entity and BAAs in which the provider is a business associate or subcontractor). Each of these BAAs will need to be modified by an amendment or replaced with the provider’s revised form BAA. This may also be a good opportunity to consider whether the protections and restrictions in the form agreement go far enough in protecting patients and the provider.

Providers should review all business relationships to ensure they have a BAA in place where one is required under HIPAA.
may have relationships that did not previously require a BAA, but do now under the Omnibus Rule's expansion of the definition of “business associate.” One key change to the definition of business associate is the inclusion of subcontractors of business associates that deal with PHI. However, covered entities are not required to enter into BAAs with downstream subcontractors. Rather, the business associate who contracts with the subcontractor must enter into a BAA with the subcontractor.

For further details please go to: http://goo.gl/PBcsW2

Payers Targeting 80101 Abuse for Drug Testing

Per AMA instructions, when coding for drug testing by any method other than chromatography for multiple drugs or drug classes, you should report 80104 Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure. If qualitative methods other than chromatography are used to test for a single drug only, you should report 80101 Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class.

In recent years, there has been confusion on proper coding when using a “kit” containing multiple dipsticks (or cassettes, cups, etc.), each of which is used to detect a different analyte. AMA’s CPT Assistant, December 2010, explains, “Kits are commercially available for 12 or more analytes. These test kits are... effectively running multiple tests at once, in a single procedure, due to the test kit design.”

Proper coding when using such a “multiplex” test kit is a single unit of 80104—not multiple units of 80101. Payers in California and elsewhere have begun post-payment audits of provider claims, and are demanding repayment when multiple units of 80101 were reported, but where 80104 was appropriate. Improper payments have been substantial, in many cases equaling thousands of dollars, per claim.

Cutting the Confusion

Prior to 2011, qualitative testing of multiple drug classes in a single kit commonly was reported using multiple units of 80101. CPT® 2011 changed this with the introduction of 80104, which was created specifically “to describe a non chromatographic method wherein multiple drug classes were screened in a single procedure... more accurately reflecting the resources used in a multiplex test kit as compared to multiple runs using a single class methodology,” according to CPT Assistant (Dec. 2010).

The AMA’s CPT 2011 Changes: An Insider’s View further clarifies, “Code 80104 has been established to report a specific drug screen, qualitative analysis by multiplexed method for 2-15 drugs or drug classes (eg, multidrug screening kit).”

Be especially cautious when reporting multiple units of 80101, to be certain each unit represents (and documentation substantiates) a unique test, rather than the individual components of a single multiplex testing kit.

Finally, Medicare does not accept 80101 or 80104, and instead requires G0431 Drug screen, qualitative; multiple drug classes by high complexity test method (eg, immunoassay, enzyme assay) per patient encounter and G0434 Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter. Note that the Medicare codes specify “per patient encounter,” rather than per procedure or per analyte. For additional instructions, see MLN Matters® Number: SE1105 Revised.

Source: www.news.aapc.com
Get the Most Out of Locum Tenens Physicians

By Delly Parham, CPC

Using locum tenens physicians to fill in for regular physicians may cost your practice instead of helping it if you don’t understand how to bill for their services. To ensure you get paid and stay in compliance, you must adhere to Medicare and commercial payer guidelines.

Practices usually use locum tenens (Latin for “lieutenant”) physicians when the regular physician is absent because of vacation, illness, childbirth, business, education, active duty, or having left the practice. The advantages of hiring a locum tenens physician versus using a physician in the same practice or in the same area are that it:

• Retains the regular physician’s existing patients
• Introduces new patients to the practice
• Maintains the patient level
• Keeps revenue with the regular physician

Most practices using the services of a locum tenens go through a recruiting agency, such as Comp Health. These companies handle the licensing requirements, professional liability insurance, and screening of the locum tenens, taking the liability and burden off practices. The practice or group pays the recruiting agency, and the agency pays the locum tenens physician. If your practice chooses to hire the locum tenens directly, you must:

• Check your state licensing laws for licensing requirements. Most – if not all – states require physicians to be licensed in that state.
• Check with your professional liability insurance carrier.
• Make sure the locum tenens is in good standing and get his or her professional liability insurance certificate, verifying it covers the services the locum tenens will be performing for the regular physician.

Whether you use a recruiting agency or hire the locum tenens physician directly, the practice must:

• Train staff with information about locum tenens physician to retain patients with the regular physician and give them incentive to see locum tenens without fear, for example:
  • The locum tenens is temporary and will only see them once or for a short period of time.
  • The locum tenens’ experience and expertise as a physician.

The period for which a single locum tenens physician may substitute cannot be more than 60 continuous days. The 60-day period begins the first day the locum tenens physician provides services for Medicare patients of the regular physician. An exception to this 60-day rule is for regular physicians who are called to active duty in the armed forces. The time is unlimited. See Social Security Act at section 1842(b)(6)(D.)

The regular physician:

• Must schedule appointments under his or her schedule.
• Is the only physician who can break the locum tenens’ 60-day period.
• May re-set the 60-day period by returning to practice and see patients only one day after the initial 60-days and use the same locum tenens.
• Must bill for the services of the locum tenens.
• Must put his or her National Provider Identification (NPI) number on all filed claims.
• May use more than one locum tenens to substitute for absences during the 60-day period.
• May reimburse the locum tenens a fixed amount per diem or similar fee for time.
• Must keep a record of each service furnished by the locum tenens physician and the NPI.

The regular physician bills and receives payment from Medicare and other payers who follow Medicare’s guidelines for the locum tenens physician’s services as though the regular physician performs the services.
The regular physician must put the regular physician NPI in box 24J and his or her name in box 31 of CMS 1500 and the regular physician or group name and NPI in box 33 of the CMS 1500. Other Medicare rules include:

- Use the name and NPI of the regular physician or group.
- Use modifier Q6 after the procedure code (Q6 identifies services by locum tenens physician).
- If the only service a locum tenens physician performs is post-operative for an operation within a global period, it cannot be billed with Q6 modifier because the regular physician is paid a global fee, and it’s not necessary to include the service on the claim.
- If a regular physician requires the locum tenens physician to provide services for longer than 60 continuous days without a break, the locum tenens physician must enroll with the practice.

Other payers have different rules. TRICARE requires that non-contracted locum tenens physicians complete a certificate or other document to be linked to the regular physician or group tax identification number. Some Medicaid programs (e.g., Florida Medicaid) require the locum tenens physician bill under his or her own name and NPI. Blue Cross Blue Shield adheres to the guidelines of Section 125b of the Social Security Act. (BCBS Manual for Physicians and Providers, May 2010).

Source: http://goo.gl/Jh3VbP

CMS Leaves ICD-10 Testing Up to the Industry

The Centers for Medicare & Medicaid Services (CMS) announced in April it will not perform end-to-end tests of ICD-10-CM and PCS fee-for-service (FFS) claims with providers before October 2014. This means providers, facilities, and EMR vendors must make sure they are ready for the mandatory implementation.

The federal agency explains end-to-end testing was already done when its 5010 data standard was implemented last year, and ICD-10-CM and PCS are code sets rather than mechanisms to manage the data. CMS says providers and payers are pretty much on their own to assure ICD-10 codes will be reportable and payable. End-to-end testing is a process-wide testing of electronic claims submission, adjudication, and “payment” to iron out bugs before a change is made to Medicare and commercial payment.

The agency is doing internal testing, but it won't be providing a lot of support to providers, Rhonda Buckholtz, vice president of ICD-10 education for AAPC, explained. She said this presents a challenge to both providers, who must assure their systems can handle ICD-10-related claims, and payers, who must retool and test their systems in time for the transition. The biggest worry is guaranteeing the process works from provider to payer and back.

Medicare administrative contractors (MACs) are encouraging providers to begin testing, but also won't be providing much support. Lack of a cohesive national effort means chaos, Buckholtz fears. “We can’t have another 5010,” she said, referring to the delayed and confusing implementation of the data standard now used for Medicare and commercial claims. She and others in the industry are working to change CMS’ mind before it becomes too late. Buckholtz said, “this is not just a technology issue, it’s how that code actually hits systems and if it can get paid.”

In the meantime, she advises, providers should communicate with their electronic health care system vendors and payers to assure claims and revenue will not be held up by systems not ready for the new code set’s implementation. Source: http://goo.gl/v9iHyY
Update on Medicare Demand Letters and Medicare Claim Cancellations Associated with an Item or Service Provided to Incarcerated Beneficiaries

CMS Article PE201307-05

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service. Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. A beneficiary may be "incarcerated" even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.

Medicare identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was apparently incarcerated based on information CMS receives from the Social Security Administration (SSA). As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

CMS is actively reviewing these data and will be taking action to improve the process used to identify periods of incarceration. As part of this effort, CMS is working to quickly identify claims that resulted in our recent recovery actions and take steps, as appropriate, to correct any inappropriate overpayment recoveries.

CMS will continue to issue messages about this topic, including timeframes for resolution, to keep the provider and supplier community informed. Information will also be posted on the All-Fee-For-Service-Providers page on the CMS Web site.

In the interim, providers and suppliers should no longer encourage beneficiaries to contact their local Social Security office in order to have their records updated as a result of this recent issue. Providers also should no longer fax information to their local CMS Regional Offices as CMS is currently working to develop processes to resolve this issue.

CMS regrets any inconvenience and is working to resolve these issues as quickly as possible.

Source: http://goo.gl/07CpwJ
CMS Authorizes 23 Databases to Disclose Medical Records to Health Plans:

Twenty-three databases operated by the Centers for Medicare & Medicaid Services (CMS) will be authorized to disclose identifiable provider and beneficiary information to health plans beginning June 27, pursuant to authority granted to the U.S. Department of Health & Human Services (HHS) and the U.S. Attorney General to arrange for the disclosure of data to health plans. According to CMS, disclosure will be permitted when it “is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse” in federal health programs. Disclosures will be coordinated by CMS’s Data Sharing and Partnership Group (DSPG), which became operational in December 2012. The DSPG focuses on developing data sharing for initiatives involving extensive external partnerships, such as the Healthcare Fraud Prevention Partnership and the Physician Payments Sunshine Act. See the announcement and list of databases affected at: [http://goo.gl/i06MKx](http://goo.gl/i06MKx). HHS’s own investigation reveals that key data from at least two of the databases may not be accurate (see below).

Inaccurate Medicare Enrollment Data in Two CMS Databases: A report [http://goo.gl/B8yhJu](http://goo.gl/B8yhJu) released by the HHS Office of Inspector General (OIG) revealed that Medicare provider data in the National Plan and Provider Enumeration System (NPPES) and the Provider Enrollment, Chain and Ownership System (PECOS) were often inaccurate, occasionally incomplete, generally inconsistent between the two databases, and often not verified by CMS. Addresses, which are essential for contacting enrolled physicians, as well as used by CMS to uncover fraud, waste, and abuse, were the source of most inaccuracies and inconsistencies. The OIG recommended that CMS require its contractors to implement better verification, oversight and program integrity safeguards.

CMS has already begun such efforts, including comprehensive enrollment revalidation, resulting in revocation and deactivation of billing privileges of thousands of physicians and other providers. One result of the inaccurate addresses is physicians not receiving enrollment queries and other communications from CMS, causing them to miss critical response deadlines. Physicians should verify the accuracy of their information in PECOS by going to: [http://goo.gl/nFVq1w](http://goo.gl/nFVq1w).

If you have any questions please contact Mathew J. Levy, Esq., Principal/Partner, Kern Augustine Conroy & Schoppmann, P.C. at 516 -294-5432 or MLevy@drlaw.com
New Requirements for All Billing Providers to Begin on August 22, 2013

IMPORTANT: Billing Providers are urged to read the following notice. Failure to follow the new requirements outlined below will result in claim rejection and jeopardize payments. As previously announced the NYS Department of Health will soon require all billing providers to sign up for EFT payments and either ERA or PDF remittances.

Existing Enrolled Providers
Beginning on August 22, 2013, and for the following 12 months, as your Electronic Transmitter Identification Number (ETIN) approaches its yearly expiration date, providers will be sent notifications instructing them to complete either or both of the application forms (EFT and ERA or PDF). If you are already signed up for both EFT and ERA or PDF remittances, you need only return the signed/notarized certification form. Complete instructions will be included with the certification renewal notification.
Note: Failure to return the appropriate form(s) with the required Certification form will cause claims to be rejected.

New Non-enrolled Providers
As of August 22, 2013 providers enrolling in the NY Medicaid Program will be required to submit a Certification Statement and an EFT Application form with their enrollment applications. Failure to submit the required forms will result in rejection of the enrollment application. Once enrolled, providers will be notified of the assigned ETIN and will be given 60 days to submit the ERA/PDF application. The notification will provide complete instructions on where to find and send the form. If the forms are not received within 60 days, the ETIN will expire and claims will be rejected. The required forms will be available on www.emedny.org on the Provider Maintenance page and on each Provider Enrollment page prior to the August 22 implementation date.

Contact WCH credentialing team if you not set up for eft.

Source: http://goo.gl/6oZm2F
Dear Provider,

Please read this important announcement pertaining to podiatric services.

Medicaid fee-for-service policy provides coverage for medically necessary podiatric services provided in a podiatrist’s private practice office for enrollees who are under 21 years of age. Coverage for these individuals is not based on diagnoses. However, for Medicaid eligible individuals age 21 and older, Medicaid fee-for-service provides coverage for medically necessary podiatric services provided in a podiatrist’s private practice office ONLY when such members have a diagnosis of Diabetes mellitus. Podiatric services provided in a podiatrist’s private practice office to members age 21 and older who do not have a diagnosis of Diabetes mellitus are not covered.

Effective August 15, 2013 and consistent with the above-referenced policy, Fidelis Care will no longer grant authorizations for podiatric services for Medicaid and Family Health Plus members who are 21 years of age or older who do not have a diagnosis of Diabetes mellitus. Effective September 1, 2013, Fidelis Care will no longer cover such services, unless a valid authorization was obtained prior to August 15, 2013.

In addition, Fidelis Care has modified its authorization requirements as follows:

Medicaid and Family Health Plus: Medically necessary podiatric services provided to Fidelis Care members age 21 and older with diagnosis of Diabetes Mellitus will no longer require prior authorization, when such services are rendered in the podiatrist’s private practice office (place of service 11).

Medically necessary podiatric services provided in a podiatrist’s private office (place of service 11) to Medicaid Managed Care enrollees who are under 21 years of age will no longer require prior authorization.

Podiatric services rendered to Fidelis Care Child Health Plus and Medicare members in the podiatrist’s private practice office (place of service 11) will continue to require authorization.

Please refer to the authorization grid available on the Fidelis Care website for complete information on the authorization requirements (http://goo.gl/RmpZEG).

If you have any questions, please call the Provider Call Center at 1-888-FIDELIS (1-888-343-3547).
Cardiology

**Question:**
What is the best way to code the placement of an Impella® left ventricular assist device? It is inserted retrograde through femoral artery access, no transseptal approach. The catheter is placed in the left ventricle through aortic valve.

**Answer:**
As of January 1, 2013, there are a series of CPT codes specifically for percutaneous ventricular assist devices. Code 33990 was created to report the physician work associated with placement of the Impella device. Code 33991 was designed to describe the physician work associated with the TandemHeart device, and the removal and repositioning codes (33992 and 33993, respectively) were designed to be reported as applicable for either device.

- 33990 Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
- 33991 both arterial and venous access, with transseptal puncture
- 33992 Removal of percutaneous ventricular assist device at separate and distinct session from insertion
- 33993 Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion

**Source:** http://goo.gl/A2sDR5

Radiology

**Question:**
If a practitioner orders a complete abdominal echo (76700) and the patient’s gallbladder has been removed, would we charge for a limited (76705)?

**Answer:**
For complete ultrasound exams, each required element must be imaged and documented, or the radiologist must document why an element cannot be seen.

In the case of a complete abdominal ultrasound, if the radiologist dictates within his report that the gallbladder was removed, you can count the gallbladder and, assuming all other required elements were imaged and documented, assign code 76700. If the radiologist does not say anything about the gallbladder because it has been removed, then you must code 76705. Within the report, the radiologist can say “patient is status post cholecystectomy” or “gallbladder has been removed” etc.

**Source:** http://goo.gl/jkTqQE
**Question:** Do you know if Medicare sets a limit on the number of times a patient can be seen for outpatient psychotherapy?

**Answer:**

Frequency and Duration of Services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1).

When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the outpatient psychiatric services are no longer considered reasonable or medically necessary.

Medicare LCD for Psychiatry and Psychology Services (L26895) answered by

Vyacheslav Kurdov  
Account Representative, CPC  
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e-mail: slavak@wchsb.com

**Question:** What is included in an appropriately documented patient medical record?

**Answer:**

An appropriately documented medical record should be complete and legible; it should reflect the reason for the encounter, appropriate history, physical examination findings. The reasons for and results of x-rays, lab tests and other ancillary services should be included.

Also, relevant health risk factors should be identified. Further, the patient progress, response to treatment, change in treatment and change in diagnosis should be documented. A plan of care should be included with specific treatments and medications. All should be dated and signed by the provider.

For small practices, chart auditing is an often overlooked compliance effort – one that should be performed at least annually or semi-annually. Source AMBA

Answered by

Zukhra Kasimova  
Supervisor, CPC  
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e-mail: zukhrak@wchsb.com

**Question:** How does the self-referral law translate to providers?

**Answer:**

For Medicare cases (and potentially other payers on the state level), Stark prohibits physicians from making a referral to a "designated health service" (DHS) in which the physician or a direct family member of the physician has a financial relationship. There are exceptions to the rule, however.

Section 1877 of the Social Security Act, also known as the physician self-referral law and commonly referred to as the "Stark Law" specifies that it:

1. Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.
2. Prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services.

3. Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse. According to the CMS FAQ section on the CMS website, “No Medicare payment may be made for DHS rendered as a result of a prohibited referral, and an entity must timely refund any amounts collected for DHS performed under a prohibited referral. Civil money penalties and other remedies may also apply under some circumstances.”

Source: http://goo.gl/wrxhGv

Question: What qualified a physician to participate in the Medicaid EHR incentive program?

Answer: The following are considered “eligible professionals” who can participate in the Medicaid EHR Incentive Program: Physicians (primarily doctors of medicine and doctors of osteopathy), nurse practitioners, Certified nurse-midwives, Dentists and Physician assistants who furnish services in a Federally qualified Health Center or Rural Health Clinic that is led by a physician assistant. Hospital-based practitioners, are defined by CMS as those practitioners who furnish 90% or more of their covered professional services in the hospital inpatient and emergency department, are not eligible. To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must also meet one of the following criteria:

Have a minimum 30% Medicaid patient volume, Have a minimum 20% Medicaid patient volume, and is a pediatrician (reduced incentive payment) Or Practice predominantly in a Federally Qualified Health Center or Rural Health Clinic and have a minimum 30% patient volume attributable to needy individuals.

The last year that an eligible professional can begin participation in the Medicaid EHR Incentive Program is 2016.

Source: http://goo.gl/gg3YUn
In observance of the Jewish Holidays WCH will be closed on the following days:

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<th>Date</th>
<th>Day</th>
<th>Holiday</th>
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<tr>
<td>September, 2</td>
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<td>Thursday</td>
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<td>Shmini Atzeret &amp; Simchat Torah</td>
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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 mariannash@wchsb.com or send it by mail to our office address
3047 Avenue U Brooklyn, NY 11229

Message:

Name:

E-mail:

Thank you for your support!