WCH TIMES

Fall 2009 **Volume 10**

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National Association of Healthcare Consultants

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EMPIRE WHO'S WHO

Dear Doctors and Office Managers,

Welcome to our Fall Edition of WCH Times! We hope everyone enjoyed the beautiful days of summer and are ready to face fast growing changes in healthcare industry.

On September 13, 2009, WCH has taken part in 2009 Komen New York City Race for the Cure in Central Park. As the world's leading breast cancer organization, Susan G. Komen for the Cure is committed to ending breast cancer. We were honored and privileged to take part of such an extraordinary event that not only benefited the foundation by helping them reach the goal of $6 million, but also to promote awareness of local breast cancer screening, education and outreach programs. WCH set goal to reach $1,000 with help of our clients and our dedicated staff we are getting closer to the goal. If you wish to support our team WCH Panthers and The Susan Komen Foundation please make the donation by following this link: http://www.komennyc.org/site/TR.

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WCH Corner

BBB Accreditation

WCH is joining the best in business! This past month we are working towards becoming accredited by Better Business Bureau of New York. It's a market place where buyers and sellers trust each other and practices upon the highest businesses standards. WCH is looking forward to partnering with BBB, and joining other business that take pride in their work. Once we are approved, we will be able to display the BBB accreditation logo on our website and in our company materials. We are looking forward to promoting your confidence and trust in WCH services.

E-Prescribing Project

As we had informed you in the previous newsletters we have been working on developing E– Prescribing Program that will transfer data related to medications, supplies and services within the prescribing healthcare system. At the present time we have applied to become vendors with NCPDP (National Council for Prescription Drug Programs) to implement well recognized national standards in our program. We still have a long way to go with the implementation of this project. We will need to become vendors with private and commercial pharmacies and establish connection with pharmaceutical companies for educational

and work related purposes. In mid 2010, we are planning to implement the testing phase of the program in our clients medical practices. We will continue to update you on the development of the E–Prescribing program.

YES! We Can Help with your credentialing headaches

Whether you are opening a new group, changing locations, updating your pay to address or adding members to your group - if you never had an experience with the credentialing process you will find yourself under piles of paperwork and struggling to comply with the required insurance guidelines. WCH has been successfully providing credentialing services for the past 8 years, not only we are able to enroll you with an insurance quicker but we also provide you with insurances standards, participation benefits, fee schedule and contract negotiations. WCH has credentialed:

- multi-specialty groups
- individual providers
- mental health clinics
- outpatient rehabilitation facilities
- durable medical supplies companies
- independent diagnostic testing facilities
- laboratories

Our credentialing department under Olga Khabinskay supervision, has developed business relationships with insurance company representatives, build up a network of communication and worked with lawyers to force insurances to follow established standards. Of course even for professionals like us, the process of credentialing can be difficult, but our strong experience have shown that by working with the local assembly offices and have legal back up from our attorney has helped to expedite the credentialing process for our clients. We are here to help you, call us for free consultation.

Please contact Olga Khabinskay at ext 1201 or via email at olgak@wchsb.com

Lets us take care of your front desk

Why should you loose money over inadequate performance of your front desk ? WCH receptionist services can help you check eligibility and obtain authorization directly from our office. We can inform patients of their upcoming appointments and provide you with scheduling list for each day. Several of our clients that work in private practice, nursing homes, hospitals and assisted living facility strongly rely on our receptionist service. Our experience in medical billing and credentialing provides strong back bone for the receptionist work. Knowing the meaning of patient benefits, providers participation and insurance policies eliminates the top denials for your claims. Our receptionist services are based on the hourly reimbursement and benefit package is not required. Let us help you to stop loosing money today!

Benefits of ERA & EFT

For the past several months WCH has been recommending for your practice to switch to Electronic Remittance Advise (ERA) and Electronic Fund Transfer (EFT) set up with the insurance offering this option. We cannot stress out enough the importance of having this option done with your insurance companies. Medicare and Medicaid were one of the first to offer this feature to their providers, than other insurances begun implementing electronic option in their network. The primary benefit of receiving electronic check and payment is that it will never be lost in the mail, secondary, checks will

always arrive on time within a 28-48 hour window from the date of issue. Moreover, based on the electronic statements your account representative in WCH can quicker send partiality paid or denied claims for reprocess and you will receive your money much faster. By 2010, its expected that major insurance companies will implement a requirement to have a set up for EFT and ERA simultaneously . Instead of waiting for the cut off day for compliance, start switching for the electronic feature now, contact your WCH account representative for the set up with the insurances.

Healthcare Industry Update

Malpractice Insurance Rates temporal lock down

Legislations has singed off on freezing medical malpractice insurance rates for New York for the second year in a row. The purpose of this bill is to give additional time for government representatives to develop a strong financial plan for the practicing healthcare providers. Lets hope the new quote will meet every providers financial situation.

Source of information obtained from LexisNexis Insurance Staff Center

NY Medicaid Providers prepare for Medicare Crossover

The August Medicaid Update newsletter informed providers about implementing a claims crossover system that will accept electronic secondary claims directly from Medicare Contractor (National Government Services). The implementation deadline is scheduled to take place in December 2009. The crossover will impact everyone in the billing business, especially the provider side. WCH has been submitting secondary claims to Medicaid electronically for the past seven years, since the creation of PMBOS. We understand how the process of transfer will simplify the exchange of data between two carriers, but we also realize the significant impact it will have on exact match of claim information with the providers demographic profile between the carriers.

What is the crossover process?

Once the system will be in effect, providers will no longer need to submit claims separately to Medicare and Medicaid. Once claim will follow a full cycle - Medicare will approve claim for payment then submit remaining patient responsibility forwarded to secondary carrier for payment, in this case it will be Medicaid.

How will crossover impact you?

Once the transfer of data will be in place, it will mean that Medicare's and Medicaid's information will have to cross-reference otherwise the claims will be rejected by the Medicaid system. It is crucial to have your practice billing /enrollment records in Medicare completely match the records with Medicaid system. Which means the NPI used on your Medicare claims must be the NPI enrolled with Medicaid. For example:If we are submitting a claim under a group NPI that is registered with Medicare, the claim will pass Medicare system and once it will get to Medicaid if the billing group NPI is not registered the claim will be denied. We strongly urge you to update your records in Medicaid especially if you are billing under group NPI to Medicare and under individual NPI to Medicaid.

WCH Credentialing service can help you with the update process.

Implementation of the Medicare crossover system is scheduled for December of this year, however in mid October Medicaid will release the implementation guidelines that will include the crossover process in more detail. As of today, Medicaid states they will only match the billing NPI with their records. As we will get closer to the deadline, we will keep you posted on the crossover process.

Law Reforms that Finally Benefit Providers

Governor Patterson recently signed a bill into law that changes managed care treatment of physicians claims and enrollment contracts. The bill states that providers that submit claims electronically must be paid under the prompt pay framework of 30 days instead of 45 days. Moreover, providers have 120 days to submit claim for process from the DOS opposed to 60-90 days allowed by insurance plans. However, I would double check this with the individual plans to avoid any denials. Because many insurances have rigorous requirements of the claim filling time line. Finally, credentialing applications by some health plan must be processed by the credentialing committee within the 90 days of the receipt of the application. We strongly encourage physicians to review the new bill in more detail, which can be found at http://open.nysenate.gov/openleg/api/html/bill/S5472A.

Patients with High Deductible Plans

Patients with high deductibles can be found in every practice, mishandling these plans can cause drop in office revenue and unnecessary confrontations with the patient. In order to avoid these problems, priority must be given to education and training of office staff. Patients with high deductible are aware of the deductible amount during the signing with the health plan contract provided either by the employer or purchased privately. Some studies indicate that employers and employees prefer to take high deductibles plans due to low monthly premiums. The problem with providers is that the front desk is not always able to identify and collect payment from the patient. The first reason is that the members card reads “Co-Payment $0”.The office assumes that that co-pay is not due because the plan will reimburse the physician for the full cost of the service. Second reason is that during eligibility verification process office staff neglects to ask about patients full and remaining deductible amount. This is where management has to step in and educate their staff to properly handle such health plans. From our experience we can add that collecting payment from the patient after the services was rendered can be strenuous and conflicting. Patient blame doctors office for their negligence to check the eligibility prior to taking in the patient for service. Of course with time and use of collection agencies the doctors will receive their payment. However, a lot of time can be saved with proper training of the office staff: to check eligibility, speak with insurance representative, and primary to ask right questions and inform the patient of their responsibility before providing care.

Source of information obtained from Healthcare Consultant

Version 5010 Coming Soon

The implementation of ICD –10 codes its on the way but before we can begin using the new codes, providers, billers, and software vendors will have to get used to the new HIPPA 5010 form. The new version of the claim form will include the structural component of the previous form 4010 but it will also have new changes. The implementation date is set for January 1, 2012 and CMS will begin the testing phase in early 2011 for the software vendors other submitting providers. Moreover, the new claim version also will impact the formats currently used to bill Medicare, they will be also changed. If you are using a billing company you are worry free, but if you are billing independently its time to start reviewing the standards and preparing for upcoming changes.

Highlights of Version 5010:

- Introduce ICD-10 codes - The form will have increase in the diagnose field from 5 to 7 characters and increase number of diagnoses allowed on the claim
- Improve claim receipt and balancing of procedures

Source of information obtained from Part B Insider Vol. 10 No. 21

Minnesota First State to make E–Billing Mandatory

Minnesota is the first state that is going to transform exchange of information between payers and healthcare providers. On December 15, 2009 Minnesota state providers will be obligated to submit all claims in one and only format, which is electronic. Moreover, payers will be mandated to sent to providers all type of forms of communication via electronic format. This will include, payments, remittances, rejections, and provider updates. Minnesota is one of the first states to eliminate paper claims completely. This change is going to impact every type of practice and setting. Clearing houses and software vendor companies are working hard to update their current systems, educate their clients and establish a secure bridge between the payer / provider.

Source of information obtained from Advance for Health Information Professionals

Imaging Tests under Care Core National Umbrella

Earlier in Spring of this year, providers participating with Aetna, GHI, Health Net , Well Care, Oxford and HIP received letters advising them that Care Core National will be taking over the payment and authorization process for imaging services. This change had a big impact on the authorization process since Care Core has specific guidelines for physicians specialty concerning the type of imaging test being ordered. Care Core identifies the provider eligible only if they are accredited by a specific program for the imaging service. The real headache of not knowing the requirements prior to switch started aggravating the medical community. Before the change the individual plan set up a list of procedures and contracted providers based on their specialty to perform. Care Core has never presented such list, in fact doctors offices had to call to insurance to obtain this information. For example, Well Care transferred radiology services in March but only in August of 2009 they had officially posted the authorization process for each imaging service. Our recommendation is that before scheduling a patient for imaging test, confirm with their insurance your doctors eligibility to perform the test.

Source of information obtained from Care Core National & Well Care Imaging

DME Updates !!!

Medicare DME Deadlines

Upcoming month is going to completely reshape Medicare DME network due to accreditation and surety bond deadlines. Those that in the DME industry understand that this past year has been the most anticipated year for the preparation and spending for the Medicare participation requirements. About 14 months ago, National Supplier Clearinghouse (Medicare DME Jurisdictions) had announced two participation requirements that must be met by October 2009. In case these requirements are not met, DME providers will be revoked from the network and billing privileges will be terminated. It is expected that by October 2, 2009, all DME providers would have received accreditation and purchased surety bond for each location. If the provider fails to comply with any of the two requirements, they must voluntarily terminate from network and reapply upon completing the designated requirement. In case the provider is revoked by Medicare, they can only reapply in one year from the termination date. There are conferences, NSC customer service and of course WCH credentialing team that can help you with the process.

Average Cost of Accreditation Process:

Per Location $2,500 — $6,000

Average Cost of Surety Bond:

Per Location $ 500 - $8,000

Source of information obtained from National Supplier Clearing House DME Jurisdiction

Medicare's New System will Lead to Big Headache for All Providers

Medicare is preparing for the implantation of the new system that will reject any claim that has ordering/referring provider that is not enrolled with Medicare. This rule will impact all type of service claims and providers. The process is starting in two phases. The first phase begins October 5th 2009, providers who are submitting claims with non-enrolled Medicare referring /ordering provider will receive payment for services rendered but on the remittance will receive a notice that referring/ordering is not participating. This stage is considered a warning stage.

During the second and last stage of the implementation which expected to begin on January 4, 2010, the claims with non participating providers on claims will be simply denied. It is important that all suppliers/providers take action and educate front desk to be aware that any services being referred for care requires that the referred or ordered provider is participating with Medicare Program. Billing department will not be able to appeal these claims and unfortunately providers/suppliers will loose money.

Providers with the following specialties can order or refer services:

- MD/DO
- Podiatric Medicine
- Chiropractic
- Certified Clinical Nurse Specialist
- Clinical Psychologist
- DDS
- Optometrist
- Physician Assistant
- Nurse Practitioner
- Clinical Social Worker

Everything begins at the front desk; let your office staff know how important and expensive the mishandling of this information can get for your practice revenue.

Message from Medicare bulletin on this issue: Medicare implementation of system edits to assure that provider/ suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact all claims received and processed on or after October 5, 2009.

Source of information obtained from MLN Matters # MM6421

WCH Opinion on the Issue

We are glad that at least Medicare is doing the implementation in stages, this will allow time for providers to adjust to the new system and educate their staff. However, by implementing a rule that only Medicare participating providers can act as ordering/referring is unfair and completely abolishes provider's freedom of choice. Medicare always gave providers freedom to choose their participation status and allowed to treat Medicare beneficiaries under separate agreement set by doctor and patient. As the stage one will begin shortly, all specialist providers will have to double check that the ordering/referring practitioner is enrolled with Medicare. We can only imagine what kind of mess this implementation will create at the front desk and at the billing department side. Lets hope the set implementation date will be extended!

Upcoming Events

Medicare University 2009 Virtual Convention

No travel cost to attend this years Medicare convention, because its virtual!

For the past few years Medicare had conducted face to face conventions for providers and suppliers. Well, this year with increase demand for online training, Medicare has created a virtual convention that will take place November 16-20, 2009. Participants will be able to choose a training course and schedule other classes for the remainder of the conference.

Convention Offers:

- Earn CEUs
- $150 per provider/supplier
- No Travel costs

To register and view information about this event visit:

www.ngsmedicareconvention.com

61st Institute on Psychiatrist Services

WCH is attending this years Psychiatric Conferences, which will take place on October 8th to 11th at Sheraton New York Hotel and Towers. We are looking forward to joining mental health professionals and other healthcare vendors to learn about innovating new technologies and discuss practice management issues in the area of electronic record keeping. In addition, the conference will also have exhibits, prize drawings and offer brochures about different mental health illnesses.

For more information about the conference and to register, please visit http://www.psych.org/ips

Public Town Hall Meeting

Congressman Michael E. McMahon will be hosting a open public town hall meeting on Monday October 5th. The meeting will focus on the healthcare reform pending before the House and Senate. We encourage providers and office managers to attend this meeting to learn about the healthcare bill details and express your concerns about the bill.

The event will be held at October 5, 2009 at 7-9 pm

@ P.S . 80, Michael J. Petrides School Auditorium 715 Ocean Terrace Staten Island, NY

WCH Feedback Form

Please use this form for your suggestions and comments.

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