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WCH Bulletin

Welcome back to the WCH Bulletin!

Therapy Cap Exception and Medicare Physician Fee Schedule News

On March 10, 2010 senate passed the H.R.4213, the Tax Extenders Act of 2009 by a vote of 62-36. This act includes the extension of therapy cap exception process until **December 31, 2010**, and leaving payments at the 2009 Medicare Physician Fee Schedule and preventing the 21.2% reduction until **September 30, 2010**. As of now the bill needs to be passed by the House of Representatives and signed by President Obama before coming into law.

Providers who charged their patients for services that exceeded caps, should refund the beneficiaries. If you have not yet provided WCH with superbills for the services you provided to the patients after they reached their therapy cap, please do so and we will submited them to Medicare for payment. If you already submitted the superbills to us we will make the necessary adjustments for payment. Claims with dates of service March 1 and later which were held by Medicare contractors, have been released for processing and payment; we are not expecting any payment delays.

WCH will keep you informed of all news updates, but if you feel you have any further questions, please do not hesitate and contact us.

Source of information optioned from: NGS Medicare Updates; APTA Information Bulletin March 10, 2010

Get Paid by Medicare for Diabetes Self-Management Education

In order for physicians to receive reimbursement from Medicare for Diabetes Self Management Education, providers must undergo specific training and receive Certificate of Recognition. The certificate must be submitted to Medicare enrollment unit to update the provider file, which will enable providers to receive payment for this service. WCH can help you obtain Certificate of Recognition Self Management and we will be able to update your Medicare Enrollment file. Our fee for the process is $200.00. Please contact our General Manager for more information at 718-934-6714 x 1201 or via email at olgak@wchsb.com.

Inside this issue:

WCH Service Bureau, Inc Is the proud member of the following professional organizations

Member of AHIMA
http://www.ahima.org/

National Association of Healthcare Consultants

Member of AMBA American Medical Billing Association

Member of NAMSS
http://www.namss.org/

Threshold Override Application Modified

Important changes have took effect in the Medicaid Utilization Threshold program. Each member was assigned specific service limits for physician/clinic, pharmacy and laboratory services; mental health and dental, remain as before. And each pharmacy refill is now counted within the service limits; a service authorization is now required for each refill on new and existing prescriptions.
Service limits are based on the member's diagnosis, procedures, prescription drugs, age, and gender. Giving the specific service limits for each member reduces the need for override requests. When an override request will necessary, the threshold override application (TOA) must include the medical assessment information to support the request for additional services. If the TOA is not received with the appropriate documents it will be returned to the provider. Forms 00101 and 00102 will not be accepted as of March 1, 2010, only EMEDNY 00103 will be accepted.
When submitting the TOA form you should:

- Know member's eligibility to the most up to date status.
- Include the provider's 10 digit NPI# if enrolled in MY Medicaid, if not space should be left blank.
- Have a description of medical condition that supports TOA request.
- Provide an original requesting provider's signature and date.
- Include provider information: printed name and telephone number.

To obtain SAs requests or TOA forms call: (800) 343-9000. Completed TOA forms should be sent to: Computer Science Corporation, P.O Box 4602, Rensselaer, NY 12144-4602.

Source of Information obtained from: February 2010 Medicaid Update

Overview of the Health Care Systems in Canada and the US

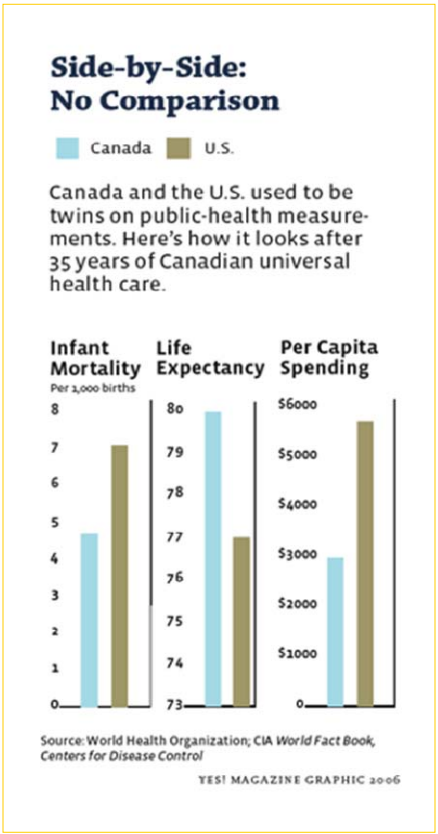
During one time Canada and the US had very similar health care systems; although in 1960s-70s, Canada began to reform their health care system. Today, there are many differences between the two health care systems; however, from what it seems President Obama is leaning toward implementing changes to the US health care system similarly to Canada's health care system.

Statics show that the US spends twice as much on health care than Canada (refer to graph); the funding in 2004 made by the Canadian government was around $1,893 per head of population, whereas the US government spend $2,728 per head of population. In 2006, 70% of health care expenditures was financed by the Canadian universal single-payer health care system (the government), while only 46% was financed by the US government. The Canadian government manages to spend less simultaneously have more involvement with their health care system.

The Canadian Health Act requires that all insured people are fully insured; insurers do not create co-payments for hospital and physician care; they are funded by a public divisions. However, ophthalmic and dental services are out of pocket expenses. In the US with a public-private health care system 45 million people are uninsured.

On average American's spend $3,372 on health care expenses either through out of pocket expenses or private health insurances per year; Canadian's spend about $917.

Canada has less physician's then the US; according to the OECD there are 2.4 physicians for 1,000 people in the US, whereas there are 2.2 physicians for 1,000 people in Canada. Based on the OECD, in 1996 US physician's



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earned twice as much as Canadian physicians.

Drugs are covered by the US government under Medicare Part D; Canada's government does not have a program to cover drugs. Most employers provide Canadian's with private prescription drug coverage. While consumption of drugs is greater in Canada, drug cost is less. Canadian's spend about $509 per year, whereas American's spend about $728.

There are many other sufficient differences within the two health care systems, such as wait times, arguable discrepancies of the health services provided, and others. This overview is to provide an idea of what might yet come to the US.

Source obtained from: Wikipedia— http://en.wikipedia.org/wiki/Comparison_of_Canadian_and_American_health_care_systems

Seven Red Flags Which Can Be Found In Your Charts

Being able to recognize "red flags" can save you a lot of time, effort, and money. Here are seven red flags from the *Part B Insider* that can cause you potential risks.

1. The same diagnosis code for every visit— It can make the auditor suspicious.
2. Billing the same CPT code over and over— also causes suspicion.
3. Hospital admissions— Make sure you have a comprehensive history and examination to justify level one, two, or three hospital admission (one is usually missing).
4. Canned documentation— Instead of marking off checks that a patient has a head-ache or chest pain the physician should write out the patient's complaints.
5. Illegible documentation— If auditors cannot make out the physician's writing, they disregard the chart.
6. Blank documentation— Disregarding to put the number of views the physician preformed certain tests, can lose your practice money; the auditor will bring down that claim to two views (the minimum amount).
7. Tests documented but not done— Physicians must be able to prove that they provided services.

Source of information obtained from: Part B Insider | Vol. 11, No. 7, pg 51

OIG Is Requesting $41.5 Million From Federal Funding

According to Part B Insider, the OIG requested $41.5 million, to help summit fraud detection, from the 2011 federal budget. An increase of the OIG's budget can result in many practices in fear; although, you shouldn't stress "unless you are doing something wrong." "For every dollar they put into enforcement, the government receives multiple back, so it' just good business on the government's part to increase enforcement funding to stop fraud. Every practice should have appropriate compliance procedures in place and be careful what they do., explains Michael F. Schaff, Esq.," Schaff suggests that your staff is properly trained and do not over bill services that have not been done. Corroborate that you file the serviced you preformed correctly.

"it' just good business on the government's part to increase enforcement funding to stop fraud"

Source of information obtained from: Part B Insider | Vol. 11, No. 5

Medicare: PAR vs. Non-PAR Physicians

Participating Medicare physicians must accept the approved amounts as their payments in full (80% of Medicare pays and 20% made by the patient or the patient's secondary insurance). Par-physicians are not deemed to provide service to everyone who walks through their doors. Stimuli for physicians to participate usually include the 5% higher approval amount than for Non-par physicians; although, a non-participating provider may charge more than the Medicare approved amount. Other highlights of becoming a participating Medicare provider is that the process of claims is more quickly and directories of participating Medicare physicians are provided to senior citizens and individuals upon request. Even though non-participating physicians may charge more than the Medicare approved amount, they are set to a 115% limit, and Medicare's approved amounts are 95% of the rates for PAR physicians. The 15% limiting charge is equivalent to 9.25% above the PAR-physician's approved rates.

Due to the 21.2% cut in the physician fee schedule set to take effect on September 2010, the 9.25% sounds favorable; however "physicians should consider whether their total revenues from Medicare would exceed their total revenues as PAR physicians, particularly in light of collection cost, bad debts, and claims for which they do not accept assignment." Take note that 95% of the payment rate is based on whether PAR physicians accept assignment on the claim.

"Non-PAR physicians would need to collect the full limiting charge amount roughly 35% of the time they provide a given service in order for the revenues from the service to equal those of PAR physicians for the same service. If they collect full limiting charge for more that 35% of the service they provide, their Medicare revenues will exceed those of PAR physicians."

Source of information obtained from: AMA—American Medical Association
http://www.ama-assn.org/ama1/pub/upload/mm/399/med-par-options.pdf

WCH News: New Collection Company

WCH replaced the collection agency which we previously used to perform collection on your patient's delinquent accounts. As of March 12, 2010 WCH has been working with Access Credit Management (ACM). ACM is an international commercial debt recovery company, which offers a very reasonable percentage rate for account receivables.

WCH is always looking for new ways to save you money and increase your reimbursement; we believe that with this new collection agency you will receive a greater settlement than from the previous agency at a reduced percentage fee.

Comments, Feedback, or requests for future bulletins?
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