January 2010 Volume 1, Issue 1

WCH Bulletin

Welcome to the first monthly WCH bulletin! The purpose of our bulletin is to keep you updated with news even sooner than before. We hope you will enjoy this issue!

Grand Opening of Our New Location
February 8, 2010!
3047 Ave U Brooklyn NY 11229
Visit our website for more information
www.wchsb.com

WCH Introduces the New Credentialing and IT Department Managers

We are happy to announce the promotion of Alexander Ivanov, manager of our technical department and Olga Lupu, manager of our credentialing department. WCH is always working on ways to improve our company that would be best for our clients. With motivated managers like Alexander and Olga we know that your work with WCH will become even easier than before!

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Inside this issue:

Nurse Practitioner Q&A

1. **Q:** Can a NP run and operate private practice and bill Medicare, Medicaid and private insurance carriers?
A: Yes, a NP can run and operate a private practice, billing Medicare etc so long as it is within the scope of her collaborative agreement and for billing each insurer's regulations & procedures will need to be complied with.

2. **Q:** Can NP services be rendered under the umbrella of incident to service? For example NP is hired by physician specialist to provide primary care services as an employee in the physician base practice, can these services be billed under the owner of the practice (physician)?
A: Within the rules of "incident to" billing a NP may provide services. However, the rules MUST be complied with exactly. (for the best information on this you should speak with your office billing/coding expert)

3. **Q:** Are there any practice limitations for NP?
A: NP practice is limited to the scope of the specialty the NP is certified in together with any additional limitations that may be contained within the collaborative agreement between the NP and the MD/DO. Scope is broadly determined to be acting within the specialty according to the NP education, training and experience. The State Education Department does not provide a specific listing or limitation generally for a specialty, with the exception of certain age limits of patients for certain specialties or the type of patient e.g. in an area such as psychiatry.

Source: *Director of Membership & Public Affairs Nurse Practitioner Association New York State*

Top 10 DME Claim Submission Denials

National Government Services conducts a regularly analysis of top claim submission denials for each month. These reports provide details about the claim submission errors and information on how to avoid the possible denials.

Top 10 DME claim submission denials for December 2009:

1. CO-18 Duplicate claims
2. CO-151 Equipment is the same or similar to equipment already being used
3. CO-109 Claim not covered by payer/contractor. You must sent claim to the correct payer/contractor
4. CO-176 Payment denied because the prescription is not current
5. OA-24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
6. CO-173 Payment adjusted because this service was not prescribed by the physician
7. CO-13 The date of death precedes the date of service
8. CO-22 Payment adjusted because this care may be covered by another payer per coordination of benefits
9. PR-31 Claim denied as patient cannot be identified as our insured
10. CO-189 Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service

To review full analysis of this report and reports for previous months please visit: http://www.ngsmedicare.com/content.aspx?CatID=380OCID=187

Medicare Outpatient Therapy CAP

Effective January 1, 2010 the financial limits on outpatient therapy services are: $1,860 for combined physical therapy and speech-language pathology services; and $1,860 for occupational therapy services.

Congress made a decision for exceptions to outpatient therapy caps be expired on 12/21/09. Claims can no longer be submitted with the KX modifier, for service rendered on and after 01/01/10. Services billed in excess will not be covered, unless for those patients who reside in a Medicare-certified part of a

The following table shows the financial limits on outpatient therapy services for the last three years.

Year	PT and Speech Therapy Combined	Occupational Therapy
2010	$1,860	$1,860
2009	$1,840	$1,840
2008	$1,810	$1,810

skilled nursing facility,

WCH is continuing to monitor Congressional activity and stay apprised of the status of potential legislation.

Source of information obtained from: http://www.ngsmedicare.com/content.aspx?CatID=26&DOCID=3527

Medicare-Medicaid Crossover Claims Update

CMS announced that they will discontinue to send letters to providers whose Medicare and Medicaid enrolled NPI do not match. Because of the large amount of claims not being accepted in by NYS Medicaid for crossover benefits, NGS will suspend sending letters advising providers of the news.

WCH has been working hard to prevent any delay and denial in your payment cycle with the crossover system in effect, and will continue to do so. We will continue to follow up and collect payment for each claim submitted to Medicare and crossed over to Medicaid.

Development of an Integrated System for Claims and Data

In struggle to grab hold of "wasteful and illegal claims" CMS is developing an integrated database to target waste and fraud. The comprehensive repository will collect claims and payment data from all federal health programs. Because the current government system is fragmented it is more likely for scams to go through undetected and gives the opportunity for criminals to submit false claims, government officials said in a *Modern Healthcare* article. By integrating claims and data into one system "will allow government officials to run analytics on hundreds of millions of data points to detect trends in fraud and root out wasteful claims." By the end of 2009 the Senate Judiciary Committee directed all hospital, physician, and prescription drug claims into a single data repository. By 2014 CMS hopes to have all claim data going through the combined system.

Source of information obtained from: Journal of AHIMA | January 10, pg 17

What to do to Better Improve your Reimbursement

You expect to be paid for the services you provided, but with all the work there needs to be done, a full team effort is required to ensure all deserved reimbursement is recouped.

Some things to keep in mind:

Contracting:

- Know your market when negotiating contracts. Contract with those companies who insure the most members in your region.
- Complete all credentialing, with an experienced person handling your contracts.

"Having an experienced person negotiate your contract, can be the difference between outstanding, fair, or poor reimbursement."

Front Deck:

- Educate your staff.
- Verify patient eligibility before rendering services to the patient.
- Collect all accurate information from the patients
- Collect co-pays right away.

Coding:

- Timely completion of all records is important
- Documentation should be clear for accurate coding
- Communication with physicians and coder is crucial

Business Department:

- Forward denials and payments to account representatives promptly

Source of information obtained from: AAPC Magazine | February 2010, pg 43

Medicare Effective Billing Date for New Physicians

Previously, Medicare has been lenient with the 18 month period to bill claims for all new physicians, non-physician practitioners, and physicians, non-physician practitioners organizations. But effective 04/01/09, there is a 30 day policy to submit the CMS-855 application.

Example 1: A physician opens a new practice location on August 15, 2009 and files for enrollment on September 1, 2009, the effective date of filing is August 15, 2009, but the filing date for billing purposed is 30 days prior to September 1, 2009. The physician will be reimbursed for services provided on and after August 1, 2009.

Example 2: A physician started working on January 2, 2009 and files for enrollment on March 1, 2009, the effective date of filing is March 1, 2009 but the filling date for billing purposes is limit to the 30 day prior to March 1, 2009. In this case the physicians effective billing date is January 31, 2009 and will not be reimbursed for the service provided before January 31, 2009.

Source of information obtained from: CMS Manual: 6.1.4—Effective Billing Date for Physicians, Non-Physicians Practitioners, and Physicians.

Initial Chiropractic Services

Did you know, there are specific guidelines Medicare wants Chiropractors to follow? There are eight items which must be documented in the Medicare patient's clinical record during the initial visit whether the visit is demonstrated by X-ray or physical examination.

1. History, a chief complaint which includes symptoms present 2. Present illness 3. Family history

4. Past health history 5. Physical Examination—evaluation of musculoskeletal/nervous system through physical examination to identify: P = Pain/tenderness evaluated in terms of location, quality, and intensity; A = Asymmetry/misalignment identified on a sectional or segmental level; R = Range of motion abnormality; and T—Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

Two of the four criteria mentioned are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Source of information obtained from: AAPC Coding Edge | February 2010, pg 18

AmeriChoice Authorization Requirements

Effective, January 25, 2010 prior authorization will be required for outpatient radiology services.

AmeriChoice will require physicians to obtain prior authorization for the following procedures for dates of service on or after January 25, 2010:

- MRI, MRA, CT, PET, Nuclear medicine, and Nuclear Cardiology

This requirement is for all NYS AmeriChoice Medicaid, Family Health Plus, Child Health Plus, and Medicare members.

Source of information obtained from: AmeriChoice News update | December 21, 2009

Comments, Feedback, or requests for future bulletins?
Please e-mail them to Alenal@wchsb.com

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