September 2010 Volume 1, Issue 6

WCH Bulletin

Welcome back our readers!

WCH NEWS

WCH Billing Department Vice Manager Becomes CPC

WCH is committed in providing our clients with professional and reliable services. Our staff is working hard to accomplish these results. We are proud to announce that our Billing Department Vice Manager, Vyacheslav Kurdov has joined an elite group of coders by passing the rigorous certification examination administered by the American Academy of Professional Coders.

Vyacheslav Kurdov, CPC

As a certified professional coder (CPC), Vyacheslav Kurdov has the skills to:

adjust claims for accurate medical coding for diagnoses, procedures, and services in physician-based settings; across a wide range of services, which include evaluation and management, anesthesia, surgical services, radiology, pathology and medicine. Has the knowledge of medical coding rules and regulations including compliance and reimbursement, how to integrate medical coding and reimbursement rule changes into a practice's reimbursement process, and the knowledge of anatomy, physiology, and medical terminology to correctly code provider diagnosis and services. A trained medical coding professional can better handle issues such as medical necessity, claims denials, bundling issues and charge capture.

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 NAMSS
http://www.namss.org/

Inside this issue:

Introducing WCH Service Bureau Real Time Eligibility Application

If you could be saving your practice time and money, would you? The best time to confirm a patient's eligibility is before they walk into your practice. But we all know that sometime it is virtually impossible to call each insurance company to obtain eligibility on each patient that walks through your doors; but good news is that WCH is here to help you!

WCH has created an application which eliminates the need for healthcare providers from calling insurance companies and searching insurance company's online portals for patient eligibility information. WCH Service Bureau Real Time Eligibility application allows you to check patient's eligibility faster and easier with most of the insurances you need, just by entering basic information you will receive real time eligibility information.

With WCH Service Bureau Real Time Eligibility application you will receive coverage status, health plan or group deductibles, and co-pay information for services within a second.

Key Features:

- Medicare CAP Amount for PT/OT/SLP Services
- Home Health Agency (HHA) Status

Benefits of the application include:

- Completely online – can be accessed 24 hrs, 7 days a week
- Predetermine the deductible and physical therapy CAP limits (especially for Medicare beneficiaries)
- Eliminate time-consuming phone calls
- Over 300 payers accessible through a single sign-on
- Print eligibility info directly from site
- Verify eligibility on every bill to prevent rejections and denials
- Improve your cash flow by correctly collecting co-payments and service fees up front
- Get the most correct and up to date insurance eligibility info

Contact WCH for a demonstration presentation and available packages for the service.

Is Your PECOS Up To Date? WCH Credentialing Can Help You

Every physician practice in the country is going to be required to complete new the Medicare enrollment forms. And the rules and forms have changed – again! Don't get left behind. There will be a short time limit on completing and returning these forms. Turn to WCH to prepare your enrollment forms today. Physicians must be listed in Medicare's Provider Enrollment Chain Ownership System (PECOS) by 2011 or will face unpaid claims and continued revalidation. **It only takes one mistake on your enrollment form to stop the entire approval process and that can cost you thousands of dollars.** Let WCH take the stress off your hands; contact Olga Khabinskay at (718) 934-6714 ext 1201 or email Olgak@wchsb.com now and save yourself a lot of headaches later.

WCH Changed Company for Patient Bills Collection

We would like to inform you that once again WCH has changed our third party collection company due to inadequate collections done by the previous collection company. In taking effort to provide our clients with best possible service, beginning September 2010, WCH has begun working with International Recovery Associates (IRA), a third party debt collection company to perform collection on your patient's delinquent accounts. We will be sending out an addendum to your contract with WCH, please sign and return back to your account representative. If you have any question please feel free to contact your account representative.

On the same note, WCH would like to inform you that as per request of our clients, we've modified the patient bill template.

MEDICARE NEWS

Medicare "Incident To" Billing

Services provided incident to a physician's service are covered when performed by a person qualified to perform them and permitted to do so under state law, and when provided under the direct supervision of the physician. There must be a physician service to which the service (s) of the nonphysician practitioner (NPP) or other ancillary staff relate. The physician must have initiated the service as part of a continuing plan of care in which he or she will be an ongoing participant. The physician must be present in the office suite and provide direct supervision. "Incident to" applies to the office/clinic setting, and is not applicable in the hospital or skilled nursing facility (SNF) setting. A new visit evaluation and management (E&M) service may not be performed "incident to", as well as an established patient visit may not be billed "incident to" when the patient presents with a new problem which requires a change in the plan of care. The visit must involve a face to face encounter and the physician must perform the initial patient visit.

Documentation of "incident to" services should include:

- A clearly stated reason for visit
- Date of the service provided
- Signature of the person providing the service
- The patient's progress, response to, and changes/revisions in the plan of care
- While a co-signature of the supervising physician is not required, Medicare would expect to see evidence in the documentation that the supervising physician was involved in the care of the patient and was present and available during the visit

Source of information obtained from: The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60 (Link: http://ngsmedicare.com/Content.aspx?DOCID=22842&CatID=2)

Medicare Now Covers Tobacco Cessation Counseling

All smoking Medicare beneficiaries are now covered for tobacco cessation counseling. Tobacco cessation counseling is no longer only covered for patients with a tobacco-related disease or with signs or symptoms of one. On August 25, CMS announced that "under new coverage, any smoker covered by Medicare will be able to receive tobacco counseling from a qualified physician or other Medicare-recognized practitioner who can work with them to help them stop using tobacco." CMS indicates that the new benefit will cover two individual tobacco cessation counseling attempts per year, each attempt may include up to four sessions, with a total annual benefit of eight sessions per year.

CPT Codes:

99406— time counseling of patient is less than 10 minutes but more than 3 minutes ; Medicare fee schedule: $15.46
99407— time counseling of patient is greater than 10 minutes; Medicare fee schedule: $29.32

To read the complete coverage decision, visit www.cms.gov/center/coverage.asp, click on "NCAs", then scroll down to "Smoking & Tobacco Use Cessation Counseling."

Source of information obtained from: The Coding Institute, August 2010 – pg 234

$13 Million Overpaid to Providers

Based on a review of 100 non-facility Part B claims from 2007, the OIG found that only 10 of the sampled claims had correct place-of-service (POS) code assigned to it. The incorrectly coded POS claims have resulted in overpayments of over $4,700, estimating to an overpayment of $13.8 million of nationally. Higher payments are collected for services rendered in the physician's office, a patient's home, an ASC, a nursing facility or any other non-hospital facility versus those services performed in a facility setting (such as a hospital). Out of the 100 sampled claims, 90 of the services were coded as having been performed in a non-facilitly location, even though "60 were actually performed in a hospital outpatient department and 30 were ASC-approved procedures performed in ASCs," the report says. In regards to the findings, CSM indicated that it would institute safeguards to ensure that POS errors were better identified.

Source of information obtained from: The Coding Institute, August 2010 – pg 240

HEALTHCARE NEWS

New Jersey: Medical Marijuana Expected to be Available in October

Even though it is not yet available, medical marijuana is looking to become available in October in the state of New Jersey. The Department is establishing a process to register qualified patients, caregivers, and alternative treatment centers. A qualifying patient is one who has been diagnosed by a physician as having a debilitating medical condition, such as cancer, glaucoma, HIV/AIDS, or any chronic medical condition (or its treatment) that causes severe or chronic pain, nausea, seizures, and severe and persistent muscle spasms. Also eligible, would be those patients diagnosed by a physician with a terminal illness and a life expectancy of less than 2 months. The patient must apply for registration for medical marijuana use. Primary caregivers must have a registry identification card and are subject to a criminal background check. They also must sign an agreement that they will provide marijuana only to the patient who has named him or her as caregiver. The registration process and related fees have not yet been determined. Government medical assistance programs and private health insurance companies are not required to provide reimbursement for medical marijuana use. *Continued on next page.*

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To read the New Jersey Compassionate Use Medical Marijuana Act in its entirety , please visit: www.njlej.state.nj.us/2008/Bills/S05000/119 R3.PDF, You may also contact they're office at (609) 826-3962.

How To Do a Quality Chart Audit in 8 Steps

Step 1: Select a Topic

The focus of the audit must be clear and measurable using the data in the medical records. Choosing a topic: choose an area that interests you, one that also be of interest to your practice, could be a problem or aspect of care that the providers have identified as needing improvement.

Step 2: Identify Measures

Once you're set on a topic, you need to define what you will measure. Criteria must be outlined precisely with specific guidelines as to what should be counted as "criteria met" and what should be counted as "criteria not met". Once the measures have been chosen, it is suggested to conduct a pilot audit. Just going through a few charts will help to identify issues that need to be clarified before starting a full audit.

Step 3: Identify the Patient Population

To determine which records to review, you need to define the population you want to assess. Characteristics to consider may include age, gender, disease status and treatment status.

Step 4: Determine Sample Size

Because a manual audit of charts meeting your inclusion criteria will not be possible in most situations, sampling is called for. For an informal audit designed to give you a sense of whether a more sophisticated audit is required, you may find it useful to sample a minimum of 20 charts. For better results, a common rule of thumb is to try for 10 percent of the eligible charts.

Step 5: Create Audit Tools

Structure is key; data should be collected in a format that keeps all individual records separate but allows for easy compiling. Many chart audits involve the calculation of a rate, percentage, mean or other statistical measurement. An electronic spreadsheet format can be customized to do these calculations for you. Creating clear, simple audit tools will make it possible for nonclinical staff to perform audits effectively.

Step 6: Collect Data

Select the date or dates on which you will collect data. Be sure to use coordinate the specifics (date, time, and number of charts pulled) with the medical records staff. Review each chart to determine if the patient meets the selection criteria. The reviewer should complete one audit tool for each patient that meets the criteria. To protect patient confidentiality, patient names should not be included on the review forms.

Step 7: Summarize Results

You must consider how the data will be used and make sure the information is presented in a way that will make in meaningful. Inconsistencies here can produce data that can't be interpreted.

Step 8: Analyze and Apply Results

Once you have compiled your data and calculated the results, you can compare them to local or nation benchmarks. There may be multiple benchmarks, depending on your topic and the performance measure you calculated. You should take into account the differences between your population and those you're comparing it with, as appropriate. If the measure is truly important to the group, you may wish to set a performance goal based on what the group feels is appropriate and reasonable and make it the focus of a quality improvement.

Source of information obtained from: www.medscape.com/viewarticle/579287_2

Questions You've Asked

Topic: Medicare imaging services interpretation date on the claim

Q: When it comes to imaging services: when the physician is performing the interpretation, which date should be billed: the date of the actual test or the date when the interpretation was done?
A: The appropriate DOS for the professional component is the actual calendar date that the interpretation was performed. For example, if the test or technical component was performed on April 30th and the interpretation was read on May 2nd, the actual calendar date or DOS for the performance of the test is April 30th and the actual calendar date or DOS for the interpretation or read of the test is May 2nd.
Source: CMS Provides Guidance Regarding Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation Professional Component (PC) and Technical Component (TC) of Diagnostic Tests (Transmittal 1823, Change Request 6375)

Topic: Medicare OT & PT Services

Q: Can you be paid for Occupational and Physical therapy for the same patient?
A: Services provided to the same patient by physical therapy and occupational therapy may be covered if separate and distinct goals are documented in the treatment plans and there is no duplication of services.
Source: LCD for OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY Services (L26884)

Topic: No-Fault insurances imaging services billed

Q: Are No-Fault insurances able to process professional and technical component separately?
A: Yes, No-Fault insurances are able to process professional and technical component claims separately

Q: Do No-Fault insurances recognize and process medical bills submitted by IDFT, non-physician owned facilities?
A: Yes, No-Fault insurances recognize and process medical bills submitted by non-physician owned IDTF facilities, but only for Technical Component (TC modifier). However, we do recommend contacting each individual no-fault insurance to confirm the type of test being preformed.
Source: Elizabeth – GEICO Representative Supervisor

Topic: Highmark Medicare IDTF

Q: For Independent Diagnostic Testing Facility (IDTF) services rendered in New Jersey, can one physician perform both supervising and interpreting services?
A: The supervising physician and the interpreting physician can be the same for an IDTF.

Q: Can an IDTF which is owned by a non-physician, bill for IDTF services globally if there is a reassignment of benefits from the interpreting physician?
A: If the professional and technical components of the procedure are to be performed by the IDTF and there is a reassignment of benefits then you can bill globally.

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

WCH Service Bureau, Inc

Our Services

- Medical Billing
- Credentialing
- Software & Website Development
- Chart Auditing
- Real Time Eligibility

Transcription

Remote Receptionist

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