WCH Bulletin

January 2014

DON'T LOSE YOUR 2015 YEAR INCENTIVE OF $21,250,00!

Be Smart, Use

iSmart EHR
ONE OF A KIND

- **FREE TO TRY**
- Enjoyable to Use
- Affordable
- Speeds You Up
- Brings You Money
- Cancel Anytime, Nothing to Lose

2,468 READERS

WCH Service Bureau is a proud member of the following professional organizations:

ACCREDITED BUSINESS
BBB Rating: A+

25th Anniversary

Health Care Compliance Association | HCCA

AHIMA
Quality Healthcare Through Quality Information

AAPC
Advancing the Business of Healthcare

CAMBRIDGE WHO'S WHO®

AMBA

CEU CREDITS

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Your Feedback is Important to Us
Please take a moment to provide feedback on **page 27**
Let us know what you want to see in upcoming issues and how we can improve.

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or by e-mail to: ilanak@wchsb.com

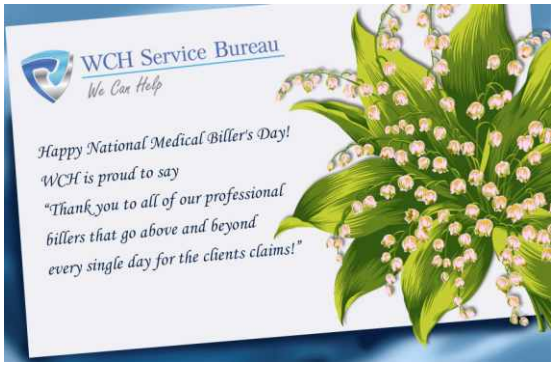
BE
SMART.
USE iSMART
iSmart
electronic health record

WCH Timeline

A LOOK BACK AT 2013

WCH Introduces New Brand Image

WCH Honors its Professional Medical Billing Staff on National Medical Billers Day



Mar

Veronika Mukhamedieva Added CFPC to Her Title

Achieved Certified Family Practice Coder (CFPC™) Credential from **AAPC**

2013 AAPC National Conference in Orlando

In effort to continue **ICD-10 education**, WCH attended educational sessions provided by **AAPC**

Apr

Seven Tips to Ensure a Smooth ICD-10 Practice Transition

By Aleksander Romanychev, CEO, WCH Service Bureau Inc.

Article was published in:

FOR THE RecorD

May

WCH Timeline

A LOOK BACK AT 2013

Credentialing and the New Graduate

With Guest Author Olga Khabinskay, General Manager, WCH Service Bureau Inc.

By Joy Hicks

Article was published in: About.com

Tips for Successful, Timely Provider Credentialing

Lessen frustration during the insurance credentialing process.

By Olga Khabinskay

Article was published in: AAPC

WCH Panthers in Pink are Ready to Go!!!

This September, WCH panthers contribute to the outstanding success of the Race for the Cure! WCH team members had a fantastic time on a beautiful Sunday sunny morning in central park.

susan g. komen race FOR THE cure

Jun | **Jul** | **Sep** | **Oct**

WCH Receives 2013 Best of Business Nomination

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

WCH Receives Best Billing Service in Brooklyn Award

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.

Brooklyn's First Certified Professioanl Biller

In the Spring of 2013 AAPC has launched its Certified Professional Biller credential. WCH Service Bureau is invested in the success of our staff and clients therefore nominated our first medical billing department expert Zukhra Kasimova to take the exam.

WCH Timeline

A LOOK BACK AT 2013

WCH Speaking at AMBA Conference

Olga Khabinskay the COO of WCH presented to AMBA members on the topic of credentialing in the annual National American Medical Billing Association conference in Las Vegas.

Oct

WCH on TV Bronxnet Channel

For the first time ever, WCH COO, Olga Khabinskay, made a TV appearance on a TV talk show, OPEN with Dr Bob Lee.

WCH First Educational Conference

WCH hosted a successful event 'How to overcome the occurring healthcare industry challenges'!

Dec

iSmart electronic health record

Drummond certified. 2014 EDITION EHR MODULAR

ONC Certified HIT 2014 EDITION

DrFirst

After 5 Years of Hard Work WCH Achieved Meaningful Use Certification for iSmart EHR

We never stop growing and improving. WCH Service Bureau is yet again announcing amazing and extraordinary news. On Monday December 2, 2013 WCH received meaningful use certification for iSmart EHR that was created by WCH programmers and with the support of the doctors.
This certification designates this software as capable for support health care providers with Stage 1 and Stage 2 meaningful use measures required to qualify for funding under the American Recovery and Reinvestment Act (ARRA). The testing and certification is provided by Drummond group, an Authorized Certification Body (ACB) and an Accredited Test Lab (ATL) within the Office of the National Coordinator HIT Certification Program.

During this holiday season WCH Team has volunteered with members of AAPC by joining God's Love We Deliver organization to give back to our community. We took time out of our busy schedules during this Holiday season to help our community Because We Care!

God's Love is the tri-state area's leading provider of nutritious, individually-tailored meals to people who are too sick to shop or cook for themselves. It's the only agency of its kind in New York, preparing every nutritious meal by hand and delivering them to people that really need the help.

With over 26,000 meals delivered each week, the kitchen staff relies on volunteers to help prepare meals for over 2,600 clients. Tasks usually include chopping onions, wrapping rolls, peeling potatoes, making meatballs, etc.

On December 22nd, 2013 WCH team has chopped and pealed carrots to make nutritious meals for people of our community. WE CAN HELP and this holiday season we did! It was a truly rewarding experience!

GOD'S LOVE
WE DELIVER ®

Health Care Compliance Association | HCCA

WCH Service Bureau
We Can Help

HCCA and WCH Web Conference
TOPIC:
CREDENTIAL WITH CONFIDENCE

This webinar will be held on

TUESDAY, FEBRUARY 25th, 2014

From 1:00 PM EST,

Olga Khabinskay has been invited by **HCCA (Health Care Compliance Association)** to speak at a National Web Conference.
Our goal is to provide insight and educate the healthcare community because we understand that knowledge is the key to success.

TOPIC: Credential with confidence

- Guidelines to successful insurance enrollment and the importance of credentialing process for medical practices.
- Tips on general rules that are applicable during the credentialing process and credentialing facts
- Key points demonstrating the strict requirements and regulations of the provider enrollment application process

to register, go to www.hcca-info.org

WCH Staff celebrating New Year

Happy New Year 2014

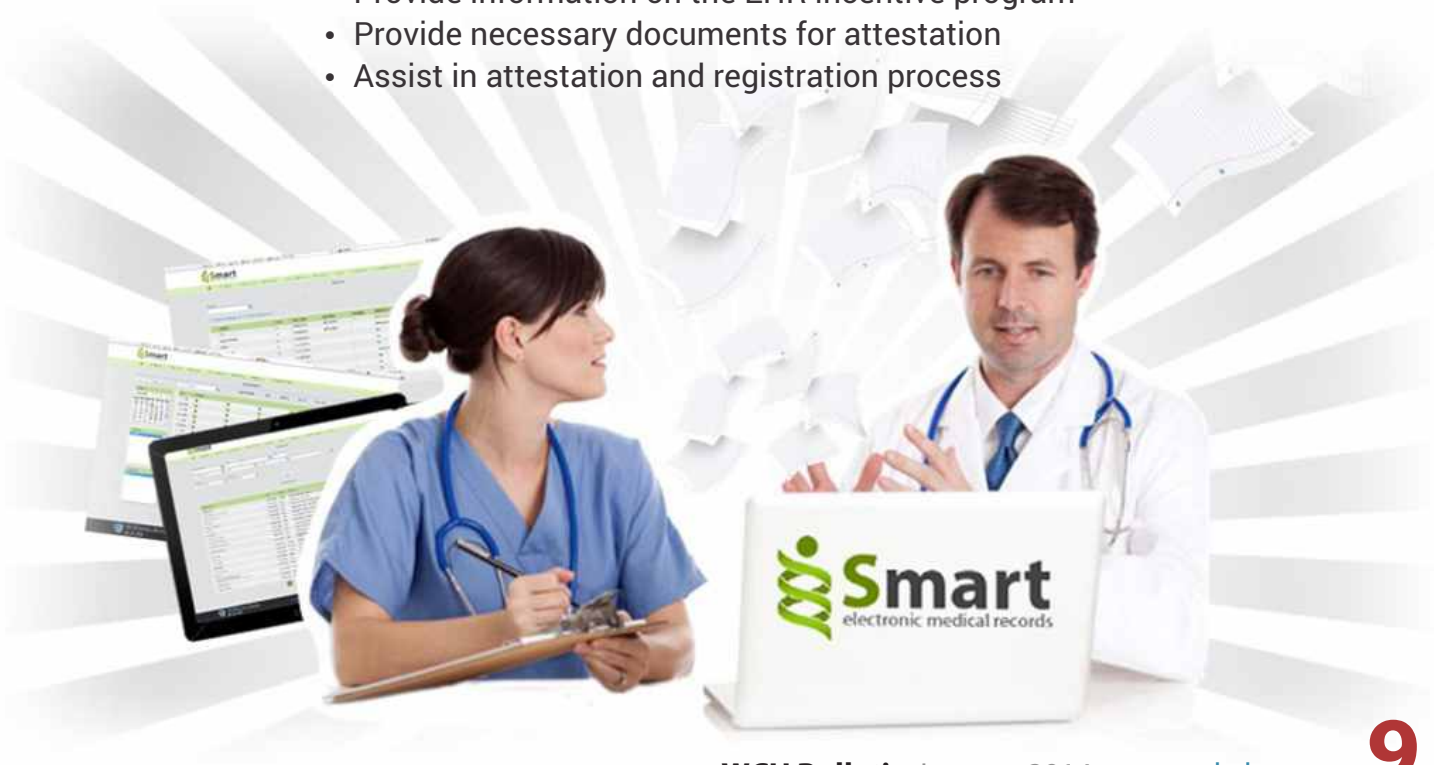
Get Thousands of Incentive Payments with iSmart EHR

Government incentive payments are available during the beginning stages of implementation to EHR systems nationwide.
With the creation and certification of **iSmart EHR**, WCH now offers help in getting government incentive payments for eligible providers!!!!
If you are a Medicaid eligible provider, do not miss the opportunity to receive **$21,250** for the first year using the certified **iSmart EHR** system.
Earn up to **$63,750** in total incentive payments.
If you are a Medicare eligible provider, don't miss the opportunity to receive **$12,000** for the first year. Get up to **$24,000** in total incentive payments
The last year to begin participation in the Medicare EHR Incentive Program is 2014.

Beware! CMS Penalties will apply in 2015 for not adapting, implementing or upgrading to a certified EHR technology.
Get the incentive payment while you still can to avoid a reduction in Medicare payments.
iSmart EHR is a cost leader in the industry!
Save money and get **iSmart EHR** today to be eligible for incentive payments!
WCH will work with you to get the incentive payment!

WCH will:

- Provide access to a certified EHR system
- Provide information on the EHR incentive program
- Provide necessary documents for attestation
- Assist in attestation and registration process



Questions about EHR incentive program? We got the Answers for you.

Question:

Can EHR incentive payments potentially be recouped by Medicare?

Answer:

An eligible professional (EP), eligible hospital, or critical access hospital (CAH) attesting to receive an incentive payment for either the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program may be subject to an audit.

In addition to the pre-payment edit checks that have been built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment, CMS will begin pre-payment audits in 2013, starting with attestations submitted during and after January 2013. These pre-payment audits will be random and may target suspicious or anomalous data. Providers selected for pre-payment audits will have to present supporting documentation to validate submitted attestation data before CMS will release payment.

Jennifer Kirschenbaum, Esq.

Question:

How does the EHR incentive payment audit process work?

Answer:

Below is an overview of the EHR incentive payment audit process:

- Initial request letters will be sent to providers selected for an audit
  - o The request letter will be sent electronically by Figliozzi and Company from a CMS email address to the email address provided during registration for the EHR Incentive Program
    - o The letter will include contact information for Figliozzi and Company
- The initial review process will be conducted using information provided in response to the request letter:
  - o Additional information may be needed during or after the initial review process
- In some cases an on-site review at the provider's location may follow
  - o A demonstration of the EHR system may be required during the on-site review
- Figliozzi and Company will use a secure communication process to assist the provider in sending sensitive information
- Any questions pertaining to the information request should be directed to Figliozzi and Company.
- If the provider is found to be ineligible for an EHR incentive payment, the payment will be recouped

Source: www.cms.gov

Electronic Health Record (EHR) COMPARISON TOOL

Pricing Information
COST PER PROVIDER

	iSmart	Amazing Charts	Practice Fusion
	$175 per month Free 7 Day Trial	$1,995 (one time fee) + $ 995 per year	Free
CERTIFICATION			
Stage 1	Will be available in 2nd quarter of 2014	Complete EHR	Complete EHR
Stage 2	Modular EHR	✗	Complete EHR
EHR FEATURES			
Patient registration	✓	✓	✓
e-Prescribing	✓	✓	✓
Mobile Version	Will be available in 3rd quarter of 2014	✗	✓
Patient portal	✓	✗	✓
Immunization	✓	✓	✓
Laboratory Tests orders and results	✓	✓	✓
Radiology/imaging orders and results	✓	✓	✓
Referrals	✓	✓	✓
Patient Examination (E&M Guide 95 & 97)	✓	✗	✗
Visit Level Calculation	✓	✗	✗
Progress notes	Will be available in 2nd quarter of 2014	✓	✓
Amendments	✓	✓	✓
Vital Signs and Growth Charts	✓	✓	✓
Problems list	✓	✓	✓
Medications list	✓	✓	✓
Medication allergies list	✓	✓	✓
Exchange health information	✓	✗	✗
Clinical Decision Support alerts	✓	✓	✓
Patient education resources	✓	✓	✓
PRACTICE MANAGEMENT FEATURES			
Scheduling	✓	✓	✓
Task list	✓	✓	✓
COMMUNICATIONS			
Secure Messaging	✓	✓	✗
Direct Project Compliance Mail	✓	✗	✗
SECURITY FEATURES			
Automatic logoff	✓	✓	✓
Emergency access	✓	✓	✓
Encrypted data transfer	✓	✓	✓
Password protection	✓	✓	✓
Activity Log	✓	✓	✓
Automatic backup	✓	✓	✓
REPORTS			
Patient List	✓	✓	✓
Automated measure calculation	✓	✓	✓
Clinical Quality Measures	CMS068v3; CMS075v2; CMS125v2; CMS126v2; CMS134v2; CMS155v2; CMS156v2; CMS161v2; CMS165v2	CMS146v1,NQF 0013,CMS165v1,CMS155v1, NQF 0027, CMS138v1,CMS125v1,CMS124v1, CMS130v1,CMS117v1,CMS147v1,CMS127v1, CMS166v2,CMS123v1,CMS131v1,CMS122v1, NQF 0061,CMS134v1,CMS163v1,NQF 0067, NQF 0074,NQF 0084, CMS69v1, NQF 0575	NQF 0013, CMS155v1, CMS138v1, CMS117v1,CMS147v1, CMS131v1, CMS123v1, NQF 0061, CMS69v1

ObamaCare for Your Patients

Health insurance was always a major issue in the US. As of January 1, 2014 more than 1million people, that never had insurance before, are now covered by health insurance plans.

The Affordable Care Act, also known as Obamacare allows everyone to enroll into a health insurance plan of their choice. The NY State of Health website, also known as the "Health Marketplace," where eligible New Yorkers will be able to look for health insurance options, calculate premiums and purchase insurance. Open Enrollment started on October 1, 2013 and is still running untill March 31, 2014. Your eligible patients could have health insurance starting as soon as February 1, 2014.

Penalties for not having insurance will apply once tax season comes around. The Affordable Care Act (ACA) requires that everyone enroll into a health insurance plan beginning in 2014 or pay a penalties when doing their taxes. Although there are some exceptions, there are very few exemptions to this rule.

In 2014 for the first year, an adult could face a penalty of $95
or 1% of income, whichever is higher.

Source: www.cms.gov

SAMPLER

Postviral fatigue syndrome (benign myalgic encephalomyelitis)

G93.3

Important News: Doctors! Don't lose your 2015 year **Medicaid incentive of $21,250,00**! You must sign up with Certified EHR Vendor and obtain special ID (ID will be provided by our IT Department). **WCH is offering Special Pre-Market Price** for **iSmart EHR**, get your access today with possibilities for free customization.

COUNTDOWN TO ICD-10, WCH IS READY, ARE YOU?

This year the health care industry will adopt and use International Classification of Disease, Tenth Revision (ICD-10) codes. The Department of Health and Human Services mandates the use of ICD-10 codes for dates of service on or after **October 1, 2014**.

Ever wondered Why is the United States moving from ICD-9 to ICD-10-CM?

ICD-9-CM has several problems. Foremost, it is out of room. Because the classification is organized scientifically, each three-digit category can have only 10 subcategories. Most numbers in most categories have been assigned diagnoses. Medical science keeps making new discoveries, and there are no numbers to assign these diagnoses.

Computer science, combined with new, more detailed codes of ICD-10-CM, will allow for better analysis of disease patterns and treatment outcomes that can advance medical care.

These same details will streamline claims submissions, since these details will make the initial claim much easier for payers to understand.

REMEMBER:

- **October 1, 2014** – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)
  - No delays
  - No grace period
- CMS Myth and Fact Sheet

Implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the **October 1, 2014** compliance date.

HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required in order to implement ICD-10-CM/PCS on **October 1, 2014**.

Source: www.aapc.com

Reflux Guard

A revolutionary, non-invasive solution

As you already know lifting the head of the bed is very helpful in treating Acid Reflux, therefore Reflux Guard© is the best option.

The recommendation of lifting the head off of the bed can be a game changer, yet has a low compliance rate for the following reasons:

1. Doctor's recommend using blocks, which is very hard to do.
2. Blocks need many logistically steps.
3. With blocks you can't move the bed without disassembling the bed or damaging the floor.
4. Lifting the head off of the bed compromises the front legs. If a heavy and/or elderly patient quickly drops themselves on a corner of the bed, they might collapse the leg, fall, and get injured.
5. You can't travel with blocks.
6. Can't easily move blocks from bed to bed.

COMPETITOR PRODUCTS:

Many patients use multiple pillows and wedges. They do not realize that in many cases these methods of bending the abdomen may cause internal pressure which can propel stomach content into the esophagus.

The **Reflux Guard**© method promotes better sleep over pillows and wedges, for the following reasons;

1. On a **Reflux Guard**©, the patient is sleeping on their own mattress rather then some cheap wedge therefore utilizing the full surface area of the mattress.
2. The above discussed pillows and wedges are small with drastically reduced sleeping surface area.
3. You could roll off of the wedge.
4. The wedge could end up on the floor.
5. Wedges need to be replaced every year or so since pressure is being put on one area.
6. While deciding whether a new wedge is needed, the patient sleeps on a deformed wedge.
7. We are so confident in our product we give a 10 year limited warrantee.

DOCTORS SAVE TIME ON SEEING PATIENTS, EASY TO USE REFLUX GUARD PAD, IN A FORM OF A HEALTH JOURNAL, SO THAT YOU GIVE THEM BETTER MEDICAL TREATMENTS:

If you agree to display our brochure in the waiting area and give them to your patients we will supply you with one easy to use **Reflux Guard**© pad, so that you can give them a few sheets. The pad is beautifully designed to quickly spot problems and for the healthcare provider to quickly look at the possible sources of activity, mostly food, that may be the underlying cause of their symptoms.

Give your patients the best care and we will support them with a **Reflux Guard**©. If this is something you feel that can help your patients check us out at www.RefluxGuard.com or call us at 1-888-RefluxG(uard)©.

Healthcare practice financing

You'll find it here – and much more.

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.

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- **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.
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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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Practice Solutions

Bank of America

Credentialing News

How to Identify Provider Enrollment Revalidation Letters in the Mail

Several providers have asked how they will be able to identify the provider enrollment revalidation letters when they arrive. Specifically, providers have asked if the letters will be mailed in a bright colored envelope so they stand out from ordinary mail. We are mailing our provider enrollment revalidation letters in optic yellow envelopes. A sample of what these envelopes look like has been posted to our Web site at the following link: Revalidations–Required CMS-855 Form and Helpful Hints.
This page also includes a sample of the provider enrollment revalidation letter. We recommend sharing this information with your mail & distribution office, so they can easily recognize this important correspondence.

How will you know if and when your organization is receiving a revalidation letter?
The CMS has posted a list of all providers and suppliers who were mailed a revalidation letter during phase 1 on their Web site. CMS will update this list every 60 days with a new group of providers and suppliers who will receive the revalidation letter. We recommend checking this Web site every 60 days to determine when your revalidation letter has been mailed.scales, based upon ability to pay, have subordinated financial ability to pay in favor of the higher duty to care for the patient's need. federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

Source: www.cms.gov

It is important that you respond to the request within 60 days of the date on the request!
For more information on how to successfully process revalidation enrollment application contact WCH credentialing department specialists
Dora Mirkhasilova by phone at (718) 934-6714 x 1310 or email: doram@wchsb.com

Healthcare News

President Obama Signs the Pathway for SGR Reform Act of 2013

New Law Includes Physician Update Fix through March 2014.

On December 26, 2013, President Obama signed into law the Pathway for SGR Reform Act of 2013. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014. President Obama remains committed to a permanent solution to eliminating the Sustainable Growth Rate (SGR) reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal. The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies have been extended. We also have included Medicare billing and claims processing information associated with the new legislation.

Section 1101 – Medicare Physician Payment Update – As indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014. CMS is currently revising the 2014 Medicare Physician Fee Schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

Section 1102 - Extension of Medicare Physician Work Geographic Adjustment Floor - The existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

Section 1103 - Extension Related to Payments for Medicare Outpatient Therapy Services - Section 1103 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3. The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit for a beneficiary on incurred expenses is $1,920. There is a separate cap for occupational therapy services which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Source: www.cms.gov

Request an Informal Review of 2014 eRx Payment Adjustment

Eligible professionals and group practices (who self-nominated for the 2012 and/or 2013 Electronic Prescribing (eRx) group practice reporting option) who were not successful electronic prescribers under the 2012 or 2013 eRx Incentive Program will be subject to a payment adjustment in 2014. CMS will notify those eligible professionals and group practices who will be subject to the 2014 eRx payment adjustment. The 2014 eRx payment adjustment will result in an eligible professional or group practice receiving 98.0% of his or her Medicare Part B physician fee schedule (PFS) allowed charges amount that would otherwise apply to such services for all charges with dates of service from January 1 through December 31, 2014.

Request an Informal Review

CMS has implemented an informal review process for the 2014 eRx payment adjustment. An informal review may be requested if the eligible professional or group practice receives notification from CMS confirming they will be subject to the 2014 eRx payment adjustment or they did not meet the requirements to avoid the 2014 eRx payment adjustment. Informal review requests will be accepted through February 28, 2014.

Eligible professionals and group practices should submit their eRx informal review request via email to the informal review mailbox at eRxInformalReview@cms.hhs.gov. Complete instructions on how to request an informal review are available in the 2014 eRx Payment Adjustment Informal Review Made Simple educational document.

Questions

For all other questions related to the eRx Incentive Program, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Source: www.cms.gov

I10

SAMPLER

Essential (primary) hypertension
(High bllod pressure includes hypertension
(arterial) (bening) (essential) (malignant)
(primary) (systemic)

National Government Services℠

Healthcare Professionals Eligbile to Furnishe IPPE or AWV

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

The Initial Preventive Physical Examination (IPPE) (also known as the "Welcome to Medicare" Preventive Visit); and The Annual Wellness Visit (AWV). These preventive benefits allow you to assess your patients' health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers. These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. The average reimbursement level for the AWV is about $107 and about $150 for the IPPE with no patient deductible or co-pay. Medicare covers an IPPE for all patients who have newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their
- Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following:
  - o Review the patient's medical and social history;
  - o Review potential risk factors for depression and other mood disorders;
  - o Review functional ability and level of safety;
  - o Measurement of height, weight, body mass index (BMI), and visual acuity screening.
  - o End-of-life planning (upon agreement of the individual);
  - o Education, counseling and referral based on the review of previous 5 components;

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period; and
- Who have not gotten either an IPPE or AWV within the previous 12 months. Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient
- annually. Note: The elements in first and subsequent AWVs, and the codes to bill them, are different.
- The first AWV includes the following elements:
  - o A health risk assessment;
  - o Establishment of a current list of provider and suppliers;
  - o Review of medical and family history;
  - o Measurement of height, weight, BMI, and blood pressure;
  - o Review of potential risk factors for depression and other mood disorders;
  - o Review of functional ability and level of safety;
  - o Detection of any cognitive impairment the patient may have;
  - o Establishment of a written screening schedule (such as a checklist);
  - o Establishment of a list of risk factors; and
  - o Provision of personalized health advice and referral to appropriate health education or other preventive services.

Subsequent AWVs include the following elements:

- o Review of updated health risk assessment;
- o Update medical and family history;
- o Update of list of current providers and suppliers;
- o Measurement of weight and blood pressure;
- o Detection of cognitive impairment the patient may have;
- o Update of the written screening schedule (such as a checklist);

Source: www.ngsmedicare.com

Expansion of Medicare Telehealth Services for CY 2014

In the calendar year 2014 physician fee schedule final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) added 2 codes to the list of Medicare telehealth services. Additionally, CMS modified regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of metropolitan statistical areas effective January 1, 2014. This definition is consistent with the determinations made by the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA). Finally, CMS modified regulations in order to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Background

CMS is adding the following services to the list of Medicare telehealth services for CY 2014:

- CPT code 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.
- CPT Code 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.

This policy will allow the required face-to-face visit component of both services to be furnished through telehealth.

CMS is finalizing the regulatory definition of "rural HPSA" for purposes of determining eligibility for Medicare telehealth originating sites to include HPSAs located in rural census tracts, consistent with ORHP's definition of "rural." HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services.

CMS is also finalizing a change in policy so that geographic eligibility for an originating site is established and maintained on an annual basis, consistent with other telehealth payment policies. Absent this proposed change, the status of a geographic area's eligibility for telehealth originating site payment is effective at the same time as the effective date for changes in designations that are made outside of CMS. Accordingly, CMS is revising regulations at 42 Code of Federal Regulations (CFR) section 410.78(b)(4) to conform to both of these policies. For dates of service on or after January 1, 2014, MACs will accept CPT Codes 99495 and 99496 submitted on professional claims. In addition, for dates of service on or after January 1, 2014, MACs will accept and pay CPT Codes 99495 and 99496 when submitted with a GQ or GT modifier. For Critical Access Hospitals (CAHs), MACs will accept and pay according to the appropriate physician or practitioner fee schedule amount when electing Method II on Type of Bill 85X.

Source: www.ngsmedicare.com

SAMPLER

Type 2 diabetes mellitus with hyperglycemia

E11.65

ValueOptions and Oscar Partnership

Effective January 1, 2014, ValueOptions will begin to manage the Oscar Health Insurance Mental Health and Substance Abuse benefit.
ValueOptions will provide Mental Health and Substance Abuse services to members enrolled in Oscar Health Insurance.
Service areas include Manhattan, Brooklyn, Bronx, Queens, Staten Island, Rockland County, Westchester County, Nassau County and Suffolk County

Provider Credentialing

- Completion of Credentialing Application required for network participation

Provider Recredentialing (every three years)

Notifications

- 4 months prior to due date (telephonic), 1 week later (email/fax), 15 and 30 days prior to due date Failure to respond to requests will result in disenrollment from the network.

Provider Contracting

- ValueOptions Provider Agreements

Source: www.valueoptions.com

SAMPLER
Postviral fatigue syndrome (benign myalgic encephalomyelitis)
G93.3

ValueOptions to Administer the Empire Plan Mental Health and Substance Abuse Program

Effective January 1, 2014, the Empire Plan Mental Health and Substance Abuse Program will be administered by ValueOptions.
As a ValueOptions in-network provider, you are eligible to receive referrals and provider services for this population. Providers should confirm network participation prior to seeing an Empire Plan member. If you are concerned about your participation status, contact the Provider Services Line at 800.235.3149

Providers with Empire Plan members in active treatment should continue to submit authorization requests to the current carrier through December 31, 2013. After January 1, 2014, providers will be required to submit continued authorization requests to ValueOptions.

Source: www.valueoptions.com

News by Specialty

Speech-Language Pathology New and Revised CPT Codes For 2014

The following are changes to CPT codes that are effective January 1, 2014. We are including comments from the Centers for Medicare and Medicaid Services (CMS) regarding the CPT coding changes because health plans may adopt Medicare coding rules.

New Codes

- 92521 Evaluation of speech fluency (eg, stuttering, cluttering)
- 92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
- 92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
- 92524 Behavioral and qualitative analysis of voice and resonance

Deleted Codes

- 92506 Evaluation of speech, language, voice, communication, and/or auditory processing
- CPT 92506 has been replaced with four new evaluation codes related to speech sound

Revised Codes

No speech-language pathology codes have been revised for 2014.

Source: www.asha.org

CARDIOLOGY NEWS: Service-Specific Prepay Audit of CPT 93042 for Jurisdiction K Part B Providers in Connecticut and New York for Specialty 06

National Government Services will be conducting service-specific prepayment audits on Rhythm ECGs, One to Three Leads; Interpretation and Report Only (current procedural terminology [CPT] code 93042) reported by cardiologists (specialty 06) for Jurisdiction K Part B Providers in Connecticut and New York.

Medical review data has recently identified a large volume of claims being billed for CPT 93042 reported in an in-patient place of service (21).

A review of medical documentation supports beneficiaries were receiving telemetry monitoring. ***It is not appropriate to bill this procedure code for reviewing monitor strips taken from a telemetry monitoring system.***

The Coding Tip in the CPT Manual for reporting electrocardiographic recordings states: "Codes 93040-93042 are appropriate when an order for the test is triggered by an event, the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, and a report is generated. There must be a specific order for an electrocardiogram or rhythm strip followed by a separate, signed, written, and retrievable report. It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system. The need for an electrocardiogram or rhythm strip should be supported by documentation in the patient medical record."

A prepayment review consists of a medical review of claims prior to payment. Request for records are most frequently electronically generated and referred to as additional development requests (ADRs).

The primary focus of the audits will be to better identify common billing errors, develop educational efforts, and prevent improper payments. Providers will be receiving ADRs asking for documentation to support the service billed. Medical Review encourages providers to respond with the requested documentation in a timely manner to expedite adjudication of these claims.

Source: www.ngsmedicare.com

SAMPLER

Postviral fatigue syndrome (benign myalgic encephalomyelitis)

G93.3

Service-Specific Prepay Audit of Multiple Noninvasive Diagnostic Vascular Studies for Jurisdiction K Part B Providers in Connecticut and New York

National Government Services will be conducting service-specific prepayment audits on the following current procedural terminology (CPT) codes targeting noninvasive diagnostic vascular studies for Jurisdiction K Part B Providers in Connecticut and New York. corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

The CPT codes to be reviewed are as follows:

- 93880 or 93882 when reported on the same day as 93970, 93971, 93925, and/or 93926
- 93970 or 93971 when reported on the same day as 93880, 93882, 93925, and/or 93926
- 93925 or 93926 when reported on the same day as 93880, 93882, 93970, and/or 93971

A prepayment review consists of a medical review of claims prior to payment. Request for records are most frequently electronically generated and referred to as additional development requests (ADRs)

The primary focus of the audits will be to better identify common billing errors, develop educational efforts, and prevent improper payments. Providers will be receiving ADRs asking for documentation to support the service billed. Medical Review encourages providers to respond with the requested documentation in a timely manner to expedite adjudication of these claims.

Providers can assist in this process by:

- Reviewing all contractor provider publication and local coverage determinations (LCDs)
- Understanding Medicare coverage requirements
- Ensuring office staff and billing vendors are familiar with claim filing requirements
- Performing self-audits of medical records against billed claims using coverage criteria, LCD, and coding guidelines
- Responding to request(s) for records in a timely manner (the Centers for Medicare & Medicaid Services [CMS]) requires that providers respond to an ADR within 30 days of the request)
- Ensuring documentation is legible and demonstrates that the patient's condition warrants the services being reported and billed

Source: www.ngsmedicare.com

Questions & Answers

Question:

Is there a contract that I must sign in order to start using iSmart EHR?

Answer:

Yes there is a contract with 2 year membership but it can be canceled any time.

Question:

If I want to check out the trial to use the iSmart EHR how can I start?

Answer:

We offer 7 day free trial to all providers, you must contact Olga Khabinskay at olgak@wchsb.com or by calling 718-934-6714 x 1201

Question:

What features iSmart EHR offers compared to other EHR?

Answer:

With iSmart EHR, you can fully document a patient visit, complete E/M coding, write a new prescription and refill two old prescriptions for the same patient, in an average time of 3 minutes!
iSmart EHR is comparatively usable system with a relatively short learning curve.

Question:

What are some iSmart EHR features?

Answer:

SMART FEATURES:

- **e-Prescribing**
- **Appointments**
- **Visit Level Calculation**
- **Task List**
- **Laboratory Tests**
- **Immunization**
- **Patient Panel**
- **Referrals**
- **(CPOE) and visit information**

Question:

When reporting codes 94644 and 94645, can 94645 be assigned with 94644?

Answer:

As indicated in the parenthetical note following 94644, if the service is performed for less than one hour, code 94640 is reported. For a total treatment time of less than one hour, neither code 94644 nor 94645 is reported. Code 94640 describes a treatment administered several times a day at short intervals (e.g., 10 minutes), whereas continuous inhalation treatment (94644, 94645) is administered for longer periods and then discontinued.

Source: www.panaceahealthsolutions.com

Question:

How long do I have to keep patient records? What is least the length of time I need to keep charts - 6 yr, 7yr- ?

Answer:

In NY and many other jurisdictions the rule is a record must be maintained the greater of 6 years or until one year after the minor patient reaches the age of 21 years. According to TITLE 8. EDUCATION DEPARTMENT CHAPTER I. RULES OF THE BOARD OF REGENTS PART 29. UNPROFESSIONAL CONDUCT 8 NYCRR § 29.2 (2011) (3) Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years.

Jennifer Kirschenbaum, Esq.

Question:

For Speech Therapy Can code 92522 and 92523 be billed together on the same day?

Answer:

No, you may only bill one or the other. A speech sound production evaluation (CPT 92522) is already included as a part of CPT 92523 (speech sound production evaluation with language evaluation).

Source: www.asha.org

Question:

Since ValueOptions now Administers Empire Plan Mental Health and Substance Abuse Program. Are all ValueOptions in-network providers eligible to see Empire Plan enrollee?

Answer:

Providers should confirm network participation status prior to seeing an Empire Plan enrollee. If you are concerned about your participation status, contact the Provider Services line at 800.235.3149.

Source: www.valueoptions.com

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 ilanak@wchsb.com or send it by mail to our office address 3047 Avenue U Brooklyn, NY 11229

Message:

Name:

E-mail: