WCH TIMES

Winter 2009

Volume 07

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

American Academy of Professional Coders

Member of AHIMA

http://www.ahima.org/

National Association of Healthcare Consultants

Member of AMBA American Medical Billing Association

EMPIRE WHO'S WHO

Dear Doctors and Office Managers,

Happy New Year to you and your family!

WCH would like to welcome you to a first edition of WCH TIMES in 2009!

A newsletter that is designed to inform you about our company developments, insurance policies, community events, and provide ongoing support of current issues taken place in healthcare community.

WCH TIMES coeditor for this issue was our collection specialist Alena Lapshina.

Enjoy our Newsletter!

Inside this Issue

6814 18th Ave. 2 Fl. Brooklyn, NY 11204 / Phone: 718 934-6714 / Fax: 718 504-6072 / wch@wchsb.com / www.wchsb.com

Member of NAMSS

http://www.namss.org/

WCH DIRECTORY

Management—x 101
Billing Department— x115
Technical support—x 119
Credentialing—x 111
Patient Collection—x116

OUR EMAILS

Aleksandr Romanychev
alexr@wchsb.com

Olga Khabinskay
olgak@wchsb.com

Olya Lupu
olyal@wchsb.com

Stas Budnikov
stasb@wchsb.com

Oksana Pokoyeva
oksanap@wchsb.com

Darya Feklistova
daryaf@wchsb.com

Olga Lobizova
olgal@wchsb.com

Elizaveta Bannova
lizab@wchsb.com

Slava Kurdov
slavak@wchsb.com

Alena Lapshina
AlenaL@wchsb.com

Tatyana Zeygeril
TatyanaZ@wchsb.com

Ilya Kulidi
IlyaK@wchsb.com

Ilana Kozak
IlanaK@wchsb.com

Veronika Stefanishina
NikaS@wchsb.com

Andrey Slovesnik
AndreyS@wchsb.com

Visit our website
www.wchsb.com
for more updates.

WCH Corner

Wow, what a year! Not only did this year end with a historical election of a new president and economical melt down, WCH had also endured significant organizational changes and completed some of the set expectations for the year.

Recap of 2008:

√ Tested & Completed WCH Credentialing Program and uploaded for online use to the public: WCH application works similar to CAQH portal

√ Completed Testing for Electronic superbill infrastructure

√ Strengthen communication and daily work process of our offshore office & Registered WCH Service Bureau with proper authority to conduct business in Tashkent, Uzbekistan. Current staff consists of 15 full time employees

√ Completed design structure of the Electronic Health Record for the next phase of work in 2009

√ Added new feature to current billing to submit secondary Medicare claims electronically

√ Promoted the sale of WCH Patient Management Billing Operating System to billing vendors, doctor's offices and outpatient clinics

√ Become members of Certified Professional Medical Services Management

√ Changed the office routine process into paperless environment

Goals for 2009

- Complete testing and set up program for Durable Medical Equipment (DME) billing
- Finalize testing of Time Management Software
- Prepare Proposal to CMS and Local Medicaid for an exclusive use of WCH Credentialing program and receive offer to work together
- Test and Meet all requirements set by CCHIT for future WCH E H R and Patient Management Billing Operating System
- Pass the examination by American Academy of Professional Coders and become certified to perform Coding
- Install and train clients to use electronic superbill which will replace current paper superbills
- Complete all testing phases of Electronic Health Record and begin implementation process in client offices and sale of the program
- Build stronger marketing team to promote all WCH services
- ICD-10 Standards and Implementations: Taken the first plunge into the process

As all of us progress towards electronic movement which is rapidly taken over the healthcare community by storm. We are here to help you to overcome the headaches and challenges facing us in 2009. WCH would like to express a sincerely Thank You to everyone who has helped and supported us through out our journey together.

Thank you Everyone!

Signature on all super-bills

WCH would like to remind providers to sign their super-bills before submitting them for billing to WCH. By implementing signature on every super-bill we are protecting you and WCH from any fraud or mistakes that can occur during the billing process as well as validating the services rendered to the patient on the super-bill.

All super-bills received by WCH **without signature** of rendering/bill to provider **will be return to you not billed.** WCH **will not** accept any super-bills with **stamped signatures**, only original signature will be accepted. If there is a time filling period for claim submission, WCH will not be responsible for denials of such claims after signed super-bill will be received and filled to insurance. Moreover by signing WCH billing agreement you had agreed to submit all necessary information in order to process your claims. Please refer below to CMS requirements on provider signatures:

The use of stamped signatures is prohibited in ALL medical records and orders. This includes hospice orders and home health certification or other plans of care. These requirements are intended to apply all providers/suppliers. Hand written, electronic signatures or facsimiles of original written or electronic signatures are acceptable. Medicare contractors require a legible identifier for services provided/ordered. When documentation is for medical review purposes, the only acceptable method of documenting the provider signature are by written or an electronic signature. Again, stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

Changes in Coding Effective 01/2009

WCH had informed you in writing earlier this month about the changes affecting billing and coding on and after the date of service January 1, 2009. As reported by American Medical Association in 2009 all ECHO and drug administrations billing procedures and diagnoses codes will be changed. The current superbills provided by WCH will be edited to fit the new update and additional education resources will be available per request. All clients that use a superbill created by WCH will receive a new updated template reflecting the new codes. WCH will not return any bills starting with DOS 01/01/09 showing old codes, we will update the codes during the billing process.

If you have not received an updated superbill by the end of the January 2009, please contact our billing department manager at 718-934-6714 x1115.

Are there any difficulties with your superbill?

WCH would like you to take out a couple minutes and review your superbill and ask yourself these following questions:

- Are there any procedure and/or diagnosis codes you feel that are should be added?
- Are there any procedure and/or diagnosis code you feel should be removed?
- Is your superbill unorganized?
- Is you're your superbill causing you to loose time trying to find a procedure and/or diagnosis on the page?

If you answered yes to any of the questions, We Can Help!

WCH can help you edit your superbill in a way that best fits your practice needs.

Let's Stop The Blaming Game!

Many of the complaints we received, all traced back to the medical office where someone did not complete their job.

One of the biggest blames that is put on to WCH is "Why is this claim not paid? – What have you been doing wrong?"

90% of the time either the authorization has not been obtained or eligibly was not checked and patient is enrolled into a different insurance group. When the work has not been completed in the medical office, it is not appropriate to blame WCH billing department for the results. If we work together as a team we will achieve extraordinary results. You will no longer have to make extra phone calls, and worry about why claims are not being paid.

Verifying Patient Eligibility Saves Valuable Time

Just because you are on hold for an inordinate amount of time, does not mean you should not verify the patient's eligibility. You can always be doing some other type of work while waiting for a representative. If you do not check and confirm each patient's insurance coverage, you could be costing your practice much more time and money after all from all the denied claims and lost co-insurance.

Here are several tips you can use to set yourself a solid process that insurance verification will become a second nature:

1) Verify as soon as possible
2) Figure out how you will verify, make sure you have the patient's information
3) Copy the patient's insurance care every time

Credentialing Process Defined

What program we can use to assist us during the process of credentialing?

WCH Credentialing department uses all possible resources to complete applications. Here is the current method we recommend to use now.
WCH developed web-based credentialing program, which allows to populate available insurance application with doctor's information with one click. When we get a new client, we complete a profile which includes all information about the client, their education, experience, back group, associations, practice information and mandatory question about doctor's ethics, character and past crimes if any has been done by the provider. After the profile is complete, with one client we can populate any application and prepared the file for submission to the insurance company by email, fax or mail.

Updating/adding location and tax id

During a professional career a healthcare provider might want or will relocate or change their tax id number. If the provider chooses to make changes in the following:

- Tax Id Number and Corporation
- Billing Address
- Mailing address
- Service address
- Phone/fax number

All requests do not require for the doctor to go through the full credentialing process. Requests for updates take from 2 week to 1 month. In most cases WCH staff writes a standard letter requesting the necessary changes and attach W9 form showing new billing address or tax id. The request can be mailed, faxed or emailed to the credentialing department for process. Follow up is required once week from the time the confirmation of receipt of the original order was obtained. Once the request is processed, the new information will be reflected in the system following the effective date which was provided by the provider on the request. It is important to have the effective date for the change because this influences billing, payment received, and overall provider demographic information.

Working with WCH can expedite your overall credentialing process and reduce your headaches, call us We Can Help!

Healthcare News

Medical Records: What To Do with Old Charts

"Medical records shall be retained in their original or legally reproduced form for a period of at least six years", as stated by the NYS Department of Health. The department will not site those practices that did not maintain a paper and have transferred the file into electronic chart. In addition the department will not take any actions on those providers that have destroyed the paper chart. As long as the office is able to produce patients medical history and treatment that matter of keeping this information is not regulated by the New York State Department of Health.

Office of Inspector General (OIG) Gives away $10 Gift Cards

On July 25 2008, during and Advisory Opinion the OIG gave the "go-ahead" to an undisclosed heath care system to issue $10 gift cards to patients whose service expectations were not met. In hopes of that this will resolve service shortfall complaints from patients such as excessive wait times. These gift cards are just one component of the group's proposed program, whish would also allow managers know when and where, and how often services shortfalls occur.

Source: The Coding News, September 2008 (pg 13)

HMO Rates Are Sky High!

The Daily News reports on the rates of HMO plans. Two-thirds of the city's HMOs have rose at least 19% within the last year alone! All nine city HMOs have increased their rates starting August 2007, on many people who are just self-employed or insured by their job. The increase of HMOs was not small either, they rose by hundreds and even thousands of dollars per year. As the premiums "soared" many New York residents paying for there own health insurance decreased by 12,000 people, just about 34% from 2005.

Source: The Daily News | Monday, August 12, 2008 | pg 8

TOP 10 Targets of RAC (Medicare's Recovery Unit)and OIG

1) Incident-to Errors
2) Place of Service Errors
3) E/M Billed during Global Periods
4) Medical Necessity
5) Psychiatric Services
6) Social Workers Services in Facilities
7) Pharmaceutical Coding in Physician Offices
8) Stark Violation
9) Duplicate Billing
10) Debridement Coding

Source: American Academy of Professional Coders

What You Should Know About Leasing Office Space

Most medical practices lease their office space; the following list of items should be included into the lease:

- The lease should not be under the physician's name, but under the business entity
- The length of the lease
- Parking in an essential provision of the lease
- Maintenance and repairs of the demised premises should be clearly stated
- Janitorial services could be provided due to the large interchange in most medical offices
- Include the ability of the tenant to assign or sub-lease the demised premises
- The tenant should also be able to remove all medical equipment upon the end of the term, unless damage is made and the tenant is responsible for
- Typically the lease may include and insurance provision
- The lease may include the option to review for additional terms
- The tenant should also see several months of free rent from the landlord to allow the tenant to do the "fit-up" of the property, so that it is in condition to commerce business.

Source: Mandelbaum-Salsburg | Spring 2008 (pg 8-9)

Speak the Same Language With Your Patients

By speaking to your patients the way they understand can help increase satisfaction and reduce liability. Patient do not always understand what diagnosis they have and what the doctors plan is to treat them. Doctors often use terminally that patients do not understand, after all not everyone went to medical school. A study published by the *Journal of the American Medical Association* found that "physicians without a malpractice claim filed against them more often: laughed and used humor, asked patients their options, encourages patients to talk and interact, educated patients regarding expectations, and spent an average of over three minutes longer with patients, than physicians who previously had multiple claims filed against them."

Alan Williams, LD the author of the best selling medical malpractice prevention book "*Physician, Protect Thyself: 7 Simple Ways NOT to Get Sued for Medical Malpractice*" Recommends:

- Sit down, patients believe you have spend more time with them while sitting rather than standing throughout the visit.
- Listen to what your patients have to say, in average health care providers interrupt a patients just 17 seconds into the patients complaint, afterward patients feel that the doctors is not interested in hearing what the patient has to say.
- Face the patient, rotate you body to fully engage the patient when speaking to them. Studies have show that when a health care professional face the patient more that 45 degrees away, the patient has a negative impression of the visit.
- Look at the patient, research shows that when speaking to a patient, they look at you 80% of the time, and you must look at the patient 90%, so the patients fully comprehend what you are saying.
- Review the chart before entering the room, to refresh you memory from the last visit, and give a good impression of your entrance.
- The Physical Examination (PE), for most patients the PE is the most awkward and embarrassing aspect of receiving medical care. Health care professionals should do all they can to ensure privacy and dignity when performing an examination. If the patient may feel any negativity and degrading during the examination might file a malpractice claim.

Source: The Coding Edge | August 2008

Insurance News

Medicare Updates:

Medicare Premiums, Deductibles for 2009:

Medicare Part B premium is $ 96.40;

Deductible is $ 135.00;

Physical/speech therapy cap is $ 1810.00;

Occupational therapy cap is $ 1810.00.

Medicare Improvements for Patients and Providers Act (HR-6331)

HR6331: To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

This condition overrides the scheduled 10.6% reduction in payments under the Medicare physician fee schedule for the reminder of 2008 and an additional 5.0% cut for 2009. It also, extends to 18 months of therapy CAP exceptions process which will carry on until December 31, 2009.

Important: There are no exceptions to the therapy limits that would allow Medicare to pay for services above the limits. If your patient needs services that will go beyond the limits, the patient can be asked to sign the Advance Beneficiary Notice (ABN) that states Medicare will not cover the services above the $1810.00 therapy cap limit.

Options you may consider with your patients:

- Patients may consider out-of-pocket cost for the rendered services.
- If you may feel the patient needs therapy services and is not able to private pay, you may send the patient to an inpatient facility (hospital) - where therapy caps do not apply.

Highlights:

- Annually increases the amount covered by Medicare of health care cost associated with mental, psychoneurotic, and personality disorders until 100% of these costs are covered in 2014.
- Prohibits Medicare Advantage marketing from conducting direct soliciting via telemarketing, door to door marketing, in health care settings, at educational activities, and from attempting to sell non-health related products at events related to Medicare Advantage plans.
- $48.9 million is available for low income Medicare subsidies and Medicare Savings Program administrative costs.

- $100 million is available to aid states in giving assistance to low-income Medicare beneficiaries through September 30, 2008 and a total of $600 million through December 31, 2009.
- Eliminates life insurance policy values from being factored into determining an individual's income eligibility for Medicare low-income financial support.
- Distributes $7.5 million in federal funding for State Health Insurance Assistance Programs.
- Provides $210 million for the Secretary of Health and Human Services to give grants to states to increase mental health and other health services to veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas.
- Extends payments to physicians for treating Medicare patients at a higher rate than would otherwise be used until 2010.
- Delays the beginning of competitive acquisition programs for durable medical supplies until 2011.
- Extends the deadline for Medicare coverage of ambulance services until 2010
- Establishes the Medicare Improvement Fund to make improvements to Medicare fee-for-service programs and authorizes $19.9 billion during the fiscal years 2014 through 2017.

Source: http://www.apta.org ; 2. http://www.votesmart.org

Postpay Physical Therapy Medical Review Findings

The review of physical therapy services which was recently conducted resulted in many denials. The coverage guidelines for outpatient therapy services are published in the Centers for Medicare and Medicaid Services Internet-Only Manual, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220-230.

National Government Services has a local coverage determination for outpatient occupational and physical therapy. Medicare's requirement for documentation can be found in these documents. Some findings from this review may include the following:

- Medicare requires all physicians or non-physician practitioners, approve or certify the plan of treatment. Some denials were for the reason that no physician certification or re-certification of therapy services received. The approval of the plan of treatment is shown by a signature on the plan or some type of other documentation that indicated approval of the plan of care. It is important that the signature is dates. If the physician does not date the signature, the therapy provider should stamp the date the signature is received.
- All billed services should be documented. The records submitted without billed services are denied.
- All timed-code treatments, should have the amount of minutes recorded in the submitted documents, if this is not completed claims will result in denial
- Include the therapy evaluation; which is the most important document for supporting medical necessity of treatment.
- Submit daily treatment notes and exercise logs (if utilized) including the total treatment time.
- Documentation is legible.

Source: http://www.ngsmedicare.com/

CPT Finally Delivers a New Year's Gift to Physical Therapists.

Physical Therapist are granted with a new procedure code which describes canalith repositioning, 95992. Canalith repositioning, or "CRM," consists of specialized techniques to help relieve patients from Benign Paroxysmal Positional Vertigo (BPPV). Christopher T. Morrow, PT, NCS explains "when a person has a BPPV, small crystals, or otoconia, from the inner ear become dislodges and float into the canal system, inadvertently hitting sensory organs that, in response, send signals triggering eye movement to adjust for repositioning." Deanna Dye, PT, PhD feels that this procedure is very unique and has a clearly defined skill set. "The skill set for performing the procedure correctly should be valued greater than therapeutic exercise." Generally that there's considerable evidence that these techniques are both cost-effective and are effective to patients in relieving BPPV symptoms. Sadly, CMS just released its 2009 Medicare Physician Fee Schedule which considers the new code for CRM bundled into E/M services, plus it is not reimbursable for therapists for 2009. In spite of the current bundling status, there may be a chance for physical and occupational therapists to get reimbursed separately for this code in 2009. There will be a meeting the first week of December to urge CMS to unbundled this code. CMS does do quarterly updates, in which case may be changed the second quarter of the year.

Source: Part B Insider | Vol. 9, No 43 pg. 332

Participating Provider vs. Non-Participating Provider

When Medicare refers to a provider or supplier as "participating provider" or "non-participating", it refers to the way the provider or supplier is paid. Id has no effect whether the services they provide are covered.

Participating: The provider or supplier agrees to accept assignment, in other words he/she accepts the payment approved by Medicare as the payment in full.

Non-Participating: The provider or supplier does not accept assignment except in some individual cases. A provider or supplier who does not accept assignment can charge and additional amount above the Medicare approved amount. The extra amount is called the "limiting charge". The Federal limiting charge is 15% over the Medicare approved amount. The Federal limit applies to Connecticut, Delaware and New Jersey. In New York, state law sets the limit charge at 5% and in Massachusetts the law sets the limit at 0%.

Source: www.NGSmedicare.com

The Rumor of Physicians Performing Diagnostic Testing May Need to Enroll as IDTFs.

Medicare has decided to delay the enrollment as an IDTF, for the reason being the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") requires the Secretary of the Department of Health and Human Services to establish an accreditation program by January 12.

In the wished-for rule, CMS proposed to require physicians and non-physician practitioners providing diagnostic testing services, such as advanced diagnostic testing procedures, including MRI, CT, nuclear medicine (including PET) and other procedures (excluding mammography services, x-ray, ultrasound, and fluoroscopy) to enroll each practice locations furnishing these services with Medicare and to subject there locations to most of the performance standards for IDTFs (Independent Diagnostic Testing Facilities).

Ultimately, CMS may finalize a rule concerning quality and performance standards applicable to physicians, and any accreditation standards established by DHHS as requires by MIPPA will apply.

Source: www.g2reports.vom/webinars/1122.html

CMS - Medicare Enrollment Changes Effective January 1, 2009

As of 2009, Part B Healthcare Providers will lose 27 months in retroactive billing privileges. According to the new rule CMS will only allow a physician to bill back 30 days prior to the date the provider receives their Medicare approval. Medical community expressed its concern about the new proposed rule and asked to extended the 30 day rule but CMS overlooked their request and published the rule. At the present time all new providers to Medicare and those that are reactivating their provider file will be only to bill for the work performed during the last 30 days before becoming participating provider. It is important to submit enrollment application on time and with all appropriate documentation. For expedited credentialing process contact WCH, we can help you become participating providers within months.

NGS Medicare 1099 forms for 2008 Year

On January 30, 2009 Medicare will start issuing 1099 for calendar year 2008 to all line of business: Part A and B. All inquires about 1099 should be directed to 877-232-1099

Source: www.ngsmedicare.com

Medicare of NJ is now Highmark Medicare Services

As you are aware of the recent transition in Medicare Part B of New Jersey to, Highmark Medicare Services WCH would like to update you with the current contact information.

Provider IVR: 1-877-235-8073

The IVR provides quick and accurate responses to routine inquiries.

It is available Monday through Friday, 6:00am - 6:00pm, and on Saturdays from 6:00am - 2:30pm.

Part B IVR Options:

1) Eligibility
2) Claim Status
3) Checks and Earnings to Date
4) Pricing

5) Frequently Requested Numbers

6) Frequently Requested Addresses

7) Medicare News

8) Appeal Rights

9) FAX-on-Demand

Website: http://www.highmarkmedicareservices.com

Email: MACTransition@highmark.com

Highmark Medicare Services will process all claims regardless of date of service. Customer services and payments will be processed by Highmark Medicare Services. NGS has transferred all pending and in process operations to Highmark Medicare Services on November 14, 2008.

Issue Your Refunds on Overpayments, Or You May Just Be Asking For Trouble

Keeping overpayments may get you in a difficulty with your patients, payers, and even the law! If you haven't dealt with overpayments, consider yourself lucky. In just a matter of time you'll be a victim. Overpayments happen for several different reasons and it is important to deal with them right away to avoid any consequences such as fines and fraud allegations.

Refunds don't have to be difficult WCH can help you with these easy approaches:

1) Identify the Overpayment

2) Contact the Payer before Sending a Check

3) Use Letters to State Your Case

4) Know the Consequences of Non-Payment

Source: The Coding Institute 2008, Vol. 8, No.11 (pg 81-85)

Does Tax ID Affect Billing as New vs. Established?

If your group has a group NPI, the providers should still have individual NPI number. When the group NPI number is used to bill insurance on the claim form, it will not affect the "new versus established" unless the providers are from different specialties. The provider's subspecialties are designated on the application for the NPI. So even if you are billing under the same federal tax ID number, each physician is differentiated by his/her specialty with their NPI number. Therefore, keep in mind that the NPI does not replace the federal tax ID number of your claims. When a practice bills for several providers using the same federal tax ID number, then the providers are considered to be part of the same group practice.

Source: The Coding Institute 2008, Vol. 8, No.11 (pg 86)

Updated Physical Therapy Coding and Billing Rules

If you thought CMS' therapy billing requirements were scarce and complicated to find well now CMS can present you with a 53 page transmittal which provides just about all you need to bill for therapy services. CMS notes "the frequency or duration of the treatment may not be used alone to determines medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals."

Keep in mind that the updated regulations in the transmittal are just put into writing and that were already the requirements for many carriers.

Transmittal available at: www.cms.hhs.gov/transmittals/downloads/R88BP.pdf

Something you might have not known:

Under Medicare rules, physicians are privileged to report 97001-97549 procedure codes, not only physical and occupational therapists. The most important thing is to maintain a plan of care and document all services appropriately. Most areas require that physical therapy procedures be done exclusively by the doctor, non-physician practitioner or physical therapist. Services done by therapy assistant or aide as the primary care giver will not be covered. The therapy notes have to reflect who preformed the service.

<u>An effective PT patient file should include:</u>

· A full written treatment plan, including the patient's medical history, examination diagnosis, therapy goal and potential for achievement and any contraindications, functional assessment, type of treatments, areas of the body that need to be treated, date

the therapy was initiated, and expected frequency and duration of treatments.

- Prognosis for potential restoration of function in a given period of time

Source: The Coding Institute, Part B Insider

Signature Stamps Are Not Acceptable On Any Medical Record

CMS has take a step to ensure that the use of stamped signatures on any medical record is prohibited. These requirements are intended to apply all providers and suppliers. Medicare will accept hand written, electronic signatures, or facsimiles of original written or electronic signatures.

Source: CMS August E-Newsletter

Processing Medicare Secondary Payer Claims

Medicare has been receiving an "anticipated increased volume of Medicare Part B claims for services provided to Medicare beneficiaries who potentially have other insurance primary to Medicare, such as working aged, workers' compensation, etc." Medicare is saying that this is taking additional time to investigate, they are experiencing a "backlog". They have come up with a plan to speed up the process within the next two to six weeks, by adding additional staff to their team.

Source: NGSmedicare.com

Split/Shared Visit Policy

"A split shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer." As defined by the CMS Internet Only Manual (IOM): Medicare Claims Processing Manual Publication 100-4, chapter 12, section 30.6.1.H Split/Shared E/M visit.

When an office E/M visit is split or shared between a physician and a NNP, the E/M encounter can be billed under the physician's name and provider number but only if the patient is an established patient and the incident-to rules are met.

Incident-to Rules—CMS IOM: Medicare Benefits Policy Manual Publication 1002-02, chapter 15:

- The service or supplies are an integral, although incidental, part of the physician's or practitioner's professional services
- The services or supplies are of a type that are commonly furnished in a physician's office or clinic
- The services or supplies are of a type that are commonly furnished under the physician's/practitioner's direct supervision.
- The services or supplies are furnished by an individual who qualifies as an employee of the physician, NPP or professional association or group that furnishes the services or supplies
- The service is part of the patient's normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the course of the treatment

New patients have to be established first, a treatment plan has to be created by the physician. Incident-to regulations do not apply and new patient office or other out-patient visits (99201-99205) can be billed.

Required Documentation of Split/Shared Visits

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit.
- The physician's documentation must clearly indicate that a face-to-face visit took place.
- Must support the combined service level report on the claim.
- Auxiliary staff document the review of systems, past family history, and social history. The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record.

If the physician does not clearly document that there was a face-to-face with the patient, the claim cannot be billed under the physician's name and provider number. It would have to be billed under the NPP's name and provider number.

Scribing is not a billable service, and its not always straightforward.

Understanding Differences with Private Payers

Medicare rules do not mean rules for all. Some payers may defer to state law, so it is important to understand your states law on split/shared visits. Most private payers to do issue numbers to NPP's and do request that services are rendered with the physician's supervision.

-Medicaid also has a different way of handling split/share visits. To find out your states rules, log on to Medicaid's website.

Source: AAPC Coding Edge | August 2008 (pg 14-18)

CIGNA

ePrescribing is Now Available

ePrescribing in now available for your patients who are covered by CIGNA Pharmacy. ePrescribing offers access to prescription eligibility, drug list and medication history, and allows you to send prescriptions electronically to the patients choice of pharmacy.

ePrescribing Provides:

- Patient safety advantages
- Check for drug allergies
- Conflict with another medication the patient is prescribed
- Allows to discuss medication efficacy and dosage with your patient at the time of care
- Access to CIGNA drug list allows you to help prescribed the best possible medicine and review cost-effectiveness medications
- Eliminates the need for a written prescription, telephone or fax delivery
- Eliminates phone calls explaining handwritten prescriptions or renewal of a prescription

For more information visit the CIGNA website at www.cignaforhcp.com

Save Your Time with Online Pre-certification Approval

Depending on your specialty, procedures that require pre-certification may be automatically approved online. This function provides you with an up-to-date status of a request, whether it was submitted online, by phone or fax. Using this option of pre-certification approval can easily save you time. You can keep track of all your submissions.

Log on to www.cignaforhcp.com for more information about online pre-certification.

New CPT Code For Patients Who Utilize Alcohol and Drugs in Harmful Ways

People who may be using alcohol or drugs in harmful ways: A technique used to help identify and intervene with these people is screening and brief intervention for alcohol and substance abuse. A brief intervention seeks to motivate the patient to decrease to even discontinue use of alcohol or other substances. Intervention can include feedback, advice, motivation enhancement strategies, and plans for follow up.

99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT and brief intervention services; 15 to 30 minutes
99409	Greater than 30 minutes

When using these codes, the intervention activity should be documented in the clinical record.

CIGNA source: Network New | November 2008

Transparency Web-Site for Members is Now Available

CIGNA has launched a website for its 10 million members to help then be aware of different health decisions for themselves and their family.— myCIGNA.com Care Connections delivers a self-contained and interactive, step-by-step, logical progression of information and decision support tools designed to lead to effective and efficient healthcare. This approach allows CIGNA members to:

- Recognize potential care needs
- Identify, learn about, and evaluate treatment options
- Understand available benefits

Source: For The Record | July 7, 2008 (pg. 30)

Insurance Fraud

Waiving co-pays and deductibles violates the Stark and anti-kickback rules. Even if you are a non-participating provider, do not waive co-pays and deductibles to your patients this is interpreted as insurance fraud.

Source: The Coding Institute 2008, Vol. 8, No.11 (pg 87)

Aetna

Treatment Record Criteria Introduced

According to Aetna's policy, participating behavioral health practitioners must maintain administrative, technical and physical safeguards to protect the privacy of members' protected health information (PHI). In addition, participating practitioners agree, by contract, to keep their treatment notes "in a current, detailed, organized and comprehensive matter in accordance with customary clinical practice, applicable laws and accreditation standards". Aetna will have every right to access the treatment records, including secure patient information for claim reimbursement. The insurance company will "maintain a performance goal, access for opportunities to improve treatment record keeping and implement actions to improve medical record-keeping practices."

Aetna's medical record will be measured against the following performance ranges:

90-100	Performance goal
80-89	Minimal deficiencies
70-79	Moderate deficiencies – corrective action plan
69 – Below	Serious deficiencies – corrective action plan, re-audit within six months

If you are furthermore interested in a complete description of the ne Practitioner Treatment Record Criteria, please see Aetna's Behavioral Health Manual at www.aetnabehavioralhealth.com on the Health Care Professionals page.

HIP/GHI

As you already know, during the summer of 2008 HIP and GHI merged together as one and are operating under a common parent, EmblemHealth. HIP and GHI say they are "committed to working with you to make it as easy as possible for your patients to see you and receive the care you deem appropriate and that they deserve." HIP and GHI's contract terms remain intact with each company and your participation status with each remains unchanged. Please continue to contact each company for any medical management, customer service, claims submissions and other inquiries, using the same channels you have in the past.

Over time, HIP and GHI will introduce new health care benefits choices for members and new tools for providers. There first step will be to launch new products under the EmblemHealth brand. Staring this fall you and your patients may begin to notice advertising for these new products. HIP and GHI will communicate with you about future developments and the process goes on.

Source: HIP—GHI Summer 2008 Newsletter

GHI | EmblemHealth

Introduces New Products

The parent of GHI and HIP, EmblemHealth has already launched new products. Two new products are avalible through their national network of participating practitioners and facilities (National Network): EmblemHealth EPO and EmblemHealth PPO. You may treat EmblemHealth EPO and EmblemHealth PPO members as patients, if you already are in the National Network, there have been no changes to your current contract, or relationship with GHI.

Effective January 1, 2009 you can begin treating EmblemHealth members.

"EmblemHealth PPO offers members care from virtually an doctor or an specialist (in or out of network) without a referral. The EPO product offers members open access to all *network* providers without a referral. Both plans offer our National Network of physicians and other health care providers."

To learn more about EmblemHealth you can visit their website @ www.eblemhealth.com, or call (212-501-4444) for NYC and outside of NYC (800) 624-2414

Source: http://www.ghi.com/GHIPractionersAlert_2008_Dec.html

United Behavioral Health

UBH New Brand Name

We would like to let you know that United Behavioral Health will soon be operating under a new company brand name: OptumHealth Behavioral Solutions. This migration to the new brand name is a phased process; it had began two years ago in 2007, lead through 2008, and now stretches out into 2009. Their first transition is the change of the change and several email addresses. THERE ARE NOT OPERATIONAL OR CONTRACTUAL CHANGES AT THIS TIME. OptumHealth Behavioral Solutions assures, "should there be any changes that impact you or your patients, be assured that they will be communicated well in advance."

If you have any questions regarding this change in the brand name, you can contact:

- ubhonline web portal: www.ubhonline.com
- Email: UBHrebrandingQuestions2009@optumhealth.com
- Provider Helpline: (800) 711-6089 option 4, option 4

Medicaid

National Drug Code (NDC) Requirement on Medicaid Claims

Effective January 1, 2008 Medicaid requires 11-digit NDC, dispensing quality and unit of measure to be submitted for physician-administered drugs. National Drug Code is number maintained by the Food and Drug Administration which identifies the drug labeler/vendor, product and product package size. It is a provider's responsibility to give this information for each drug that they want to be reimbursed for. Otherwise drug is not going to be paid by Medicaid. **It is important that you provide us with the NDC of each drug for Medicaid reimbursement.**

Medicaid Will Pay for Smoking Cessation Counseling for Pregnant Women

Effective January 1, 2009, Medicaid will reimburse providers for smoking cessation counseling. Reimbursement for these services will be available to free-standing diagnostic and treatment centers effective March 1, 2009. A Federally Qualified Health Center (FQHC) may bill for this service only if it has elected to be reimbursed under Ambulatory Patient Groups (APGs).

Medicaid managed care and Family Health Plus plans will also be responsible for covering smoking cessation counseling services for pregnant women effective January 1, 2009. This coverage will include up to six counseling sessions within a twelve month period.

Smoking cessation counseling must include the following criteria:

- Services must be provided face-to-face
- Services are only available for Medicaid-eligible pregnant women who smoke. Diagnosis of pregnancy (ICD-9-CM: 630-677, V22, V23, V28) must be shown
- The smoking cessation counseling can only be provided by a physician , registered physician's assistant, registered nurse practitioner, or licensed midwife during a medical visit (no group sessions)
- Payable in a clinic setting with a diagnosis of pregnancy , an E&M code, and a SCC CPT procedure code
- CPT Procedure as follows: 99406—Smoking cessation counseling 3 to 10 minutes ; 99407—Smoking cessation counseling greater than 10 minutes

Fee-Schedule for SCC will be posted shortly online @ www.emedny.org

NON-Pregnant, and other patients have an option of smoking cessation *medication* coverage.

Source: Policy and Billing Guidance | Medicaid Newletter | October 2008 Volume 24, Issue 12

Diabetes & Asthma Self-Management Training Offered to Medicaid Beneficiaries Effective January 1, 2009

Medicaid will cover diabetes and asthmas self-management training services for beneficiaries effective January 1, 2009. The DSMT and ASMT, respectively services have to be ordered by physician, registered physician's assistant, registered nurse practitioner, or licensed midwife. On March 1, 2009 a FQHC may bill for this service only if it has elected to be reimbursed under Ambulatory Patient Groups (APGs). These services can only be provided by a NYS licensed, registered, or certified health care professional , who is also certified as an educator by the National Asthma Educator Certification (CAE) or the National Certification Board for Diabetes Educators (CDE). Self-management training service will be billed by physicians, RNPs, LMs, OPDs, D&TCs, and FQHCs who employ, or contract with certified educators, themselves, can also bill for these services.

<u>Asthma Self-Management Training (ASMT)</u>

- A beneficiary with newly diagnosed asthma or a beneficiary with asthma who has a medically complex condition (such as: an exacerbation of asthma, poor asthma control, diagnosis of complication, etc.) will be allowed up to 10 hours od ASMT during a continous 6-

month period.

- Beneficiaries with asthma who are medically stable may receive up to 1 hour of ASMT in a continuous 6-month period.
- Self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

ASMT CPT Codes: 98960– Individual education for 30 minutes

98961– Groups education, for a 30 minute session, 2-4 patients

98962– Group education, for a 30 minute session, 5-8 patients

Diabetes Self-Management Training (DSMT)

- A beneficiary with newly diagnosed diabetes or a beneficiary with diabetes who has a medically complex condition (such as: poor diabetes control, diagnosis of a co-morbidity, post-surgery, prescription for new equipment such as an insulin pump, etc.) will be allowed up to 10 hours of DSMT during a continuous 6-month period.
- Beneficiaries with diabetes who are medically stable may receive up to 1 hour of DSMT in a continuous 6-month period.
- Self-management training services can be provided in individual sessions, or in group sessions of no more than eight patients.

DSMT HCPCS Codes: G0108– Diabetes outpatient self-management training services, individual, per 30 minutes

G0109– Diabetes outpatient self-management training services, group (2-8 patients), per 30 minutes

Fee schedules for these services will be posted in January 2009. Source: Policy and Billing Guidance | Medicaid Newletter | October 2008 Volume 24, Issue 12

Coding News

The Next Generation of Coding Has Finally Reached the United States:

The International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (IDC-10-CM/PCS)

The new classification system provided significant improvement through the greater detailed information and the ability to expand in order to capture additional advancements in clinical medicine. Countries all over the world have already begun using the ICD-10 coding system, The United Kingdom (1995), France (1997), Australia (1998), Germany (2000), and Canada (2001).

ICD-10 consists of two parts:

ICD-10-CM – The diagnosis classification which was developed by the Centers for Disease Control and Prevention for the use in all of U.S medical care treatment facilities. Contains 68,000 diagnosis codes, while ICD-9-CM contains on 13,500

ICD-10-PCS – The procedure classification which was developed by CMS, this system uses 7 alpha or numeric digits while the ICD-9 coding system uses 3 or 4 numeric digits.

Below are some samples which show the difference between ICD-10-CM/PCS and ICD-9-CM

ICD-9-CM Mechanical complication of other vascular device, implant and graft: (996.1)

VS

ICD-10-CM Mechanical complication of other vascular grafts:

T82.310- Breakdown (mechanical) of aortic (bifurcation) graft (replacement)

T82.311- Breakdown (mechanical) of carotid arterial graft (bypass)

T82.312- Breakdown (mechanical) of femoral arterial graft (bypass)

T82.318- Breakdown (mechanical) of other vascular grafts

T82.319- Breakdown (mechanical) of unspecified vascular grafts

T82.320- Displacement of aortic (bifurcation) graft (replacement)

Source: Centers for Medicare and Medicaid; The Coding Edge July 2008Source: For The Record | Vol. 20 No. 14 | July 7,2008

Upcoming Issue Discussions:

- **Medicare Enrollment 2009 Rule and Providers Reaction to the requirements**
- **WCH Electronic Superbill Implementation**
- **WCH Electronic Medical Record Testing**
- **DME Billing and Vendor Certification**
- **ICD 10 Around the corner**
- **On our way to becoming Certified Coders: Preparation and Testing**

Please use next page for any suggestions, your feedback specific topics you would like us to discuss in the next issue in Spring 2009.

You can send your requests by email

OLGAK@WCHSB.COM

We hope you had enjoyed WCH TIMES Winter 2009 Edition!

WCH Feedback Form

Please use this form for your suggestions and comments.

Your Name

Email Address