WCH BULLETIN

March 2013

MARCH IS RECOGNIZED AS A NATIONAL MEDICAL BILLERS AND DOCTORS HOLIDAY!

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

IN THIS ISSUE:

WCH BUZZ

WCH SERVICE BUREAU HONORS ITS PROFESSIONAL MEDICAL BILLING STAFF ON NATIONAL MEDICAL BILLERS DAY, MARCH 28, 2013

WCH Service Bureau, a global service provider for practitioners in the healthcare industry, will honor its highly trained and professional billing staff as well as its clients at practices nationwide in honor of National Medical Billers Day celebrated on March 28 this year.

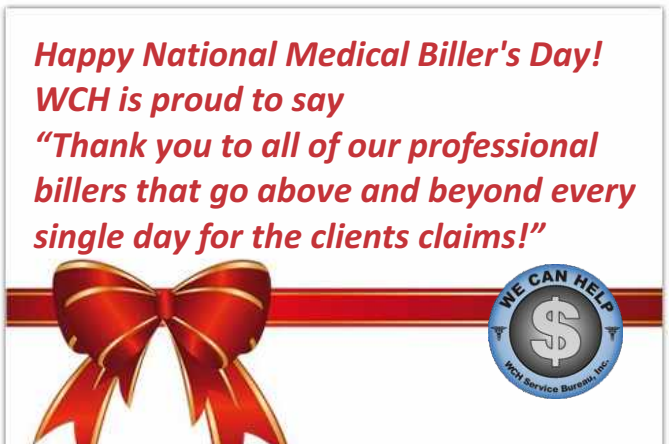
National Medical Billers Day was initiated by the AMBA (American Medical Biller's Association) beginning in 2008 in recognition of the importance and involvement of medical billers in the health care industry.

“This is a day to recognize and honor our highly trained and very professional medical billing staff,” explains CEO Aleksandr Romanychev. “This year is especially important given our current focus on helping clients upgrade to ICD-10 and significant industry changes it requires. Our health care providers are relying on us more than ever to help process claims that are timely, accurate and approved and we are consulting extensively on billing and reimbursement issues.”

Sponsor of the day, The American Medical Billing Association's (AMBA) goal is to provide the medical biller's association members with resources to enhance knowledge and skills to develop new ideas and technology collectively increase and realize true industry growth and leadership. It also offers the Certified Medical Reimbursement Specialists (CMRS), an exam which is a voluntary, national credential for the medical billing profession.

According to AMBA Director Cyndee Weston, “Medical Biller's Day is a great opportunity for doctors and billing companies to thank their billers for the hard work they do every day. Billing correctly and getting claims paid is no easy task. Rules change frequently, while insurers apply strict payment guidelines that often aren't communicated well – it's an often thankless job, so encouragement and appreciation for a job well done is welcomed by AMBA members and billers nationwide.”

Virtually all of our billing staff has this and other accreditations and as a result we have one of the experienced and best trained firms in the industry,” explains Olga Khabinskay, WCH general manager. “That's why our clients in physician and non-physician groups trust our opinion and services as well as receive the highest reimbursement level possible.”



Interview with our next CFPC Examinee - VERONIKA MUKHAMEDIEVA

Please, describe your career history in WCH.

- My work started from studying and learning new materials as a biller. While getting this new information, reading different policies and guidelines, I realized for myself that this is the work I want to do and that precisely, this is an area in which I want to develop as a qualified and skilled medical billing specialist. I knew that certifications through AAPC will be my next step.

Why did you decide to get your CFPC (Certified Professional Family Coder) certification from AAPC?

- I want to grow and do more for the company. To achieve this goal, I understood that I need to learn a lot of materials, to increase my field of knowledge in specificity of our work. So I decided for myself that I need to pass this CFPC exam, primarily to be confident in myself, in my experience and also in my knowledge base. At the time, WCH had a contest for the next CFPC nominee, I joined the group of 5 people that wanted to take the exam. Out of 5, I achieved the highest score on the pre-exam, and I was selected for the April 2013 exam to take in Florida. I am looking forward to grasping this certification and moving to the next chapter in my career in WCH - helping clients with their coding documentation and billing needs.

How is your exam preparation going?

- The main base of exam preparation is years of hands-on experience in medical billing and coding. I studied different manuals, guidelines, articles to receive more specific information regarding this huge medical billing sphere, and there is so much more to learn with all industry challenges is facing.

How do you feel, your CFPC certificate will help you in the future work?

- By having this certification, I know that I can help and protect WCH clients. I know how to work with the demands from the insurance companies, now I better understand insurance policies and their requirements from doctors. I will help my clients fight their audit requests and better organize their chart keeping.

What would you recommend to your colleagues that are planning to take the CFPC exam?

- Don't be afraid of huge piles of materials, books, manuals which should be studied… When you are just starting to prepare for the Exam, you think that it is impossible to learn all this information. But during this studying process, obtaining new information becomes very entertaining activity, and you want to get more and more useful information. Of course I couldn't stop to think of the benefits the CFPC will bring to me and WCH Billing Department.

WCH Service Bureau, Inc

3047 Avenue U, Brooklyn NY 11224 // Phone: 888 - WCHEXPERTS //
Fax: 347- 371- 9968 // wch@wchsb.com // www.wchsb.com

Dear Doctors and Office Managers,

Per request of WCH Billing Department Manager Oksana Pokoyeva, we are no longer submitting claims for ABI/PVR combination.

This decision is based on AMA and Medicare guidelines requirements.

93924 Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study.
(Do not report **93924** in conjunction with **93922**, **93923**)

Source: American Medical Association. CPT Book.

Sincerely,
WCH Billing Department

Oksana Pokoyeva,
Billing Department Manager,
CPC, CPMA

NEW IT MANAGER IGOR SLOBODOV

To ensure that our clients continue to receive excellent support, we have expanded our IT department. We are happy to welcome Igor Slobodov to our team. The increasing investment in IT-enabled modernization and ways of working in WCH company requires the IT approach to be ever better integrated, managed, developed, focused and co-ordinate to achieve the very high standards required. Taking this forward will be a key part of Mr. Slobodov task.

Contact information:
email: igors@wchsb.com
skype: wchsb.igors
tel: **(718) 934-6714 ext 1225**

WCH PMBOS (Patient Management Billing Operating System)

Use unique medical practice Management software for your practice!

This software is unique because it was built on expertise of physicians, medical billers and collectors who use this program every day!
WCH's professionalism in medical billing, provider credentialing, CVO, office management combined with experience of our programmers has helped to create one of a kind distinctive program. WCH is a registered vendor with Medicare & Medicaid. PMBOS is recognized by most major insurance companies such as GHI, Blue Cross Blue Shield and Value Options, etc.
insurance companies such as GHI, Blue Cross Blue Shield and Value Options, etc.

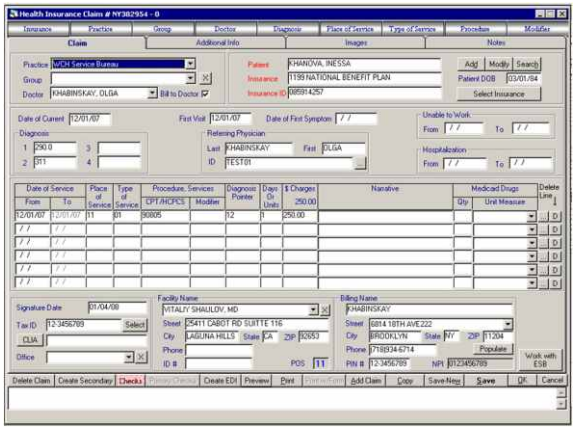
Major advantages of Patient Management Billing Operating System are:

- get paid faster;
- never lose a claim for a patient;
- the best front office management tool;
- robust billing fraud prevention.

APPOINTMENTS CAN BE MADE IN THE SAME SOFTWARE

Everything starts at front desk! The appointments screen is one of the common features that allow staff, office manager and doctor to schedule, maintain patient appointments, patient's data, ledger, authorization and much more:

- Flexibility to view, edit, and print any information related to patient profile or the visit;
- Patient profile contains ledger co-pay, authorization information and insurance coverage;
- Attach images;
- Color coded appointments;
- Multiple provider displaying options;
- Variety of comfortable features and different type of appointments – patients, business, meeting etc.;
- Create custom reports;
- Print Superbillls for appointment with patient information on the form.



BENEFITS OF USING PMBOS :

- Receive 98%-100% reimbursement;
- Save valuable time on claim (the process takes nearly 20);
- Attach images;
- Maintain accurate patient history from the first visit by matching claims billed with appointment schedule;
- Manage deadlines, tasks, claim follows ups, birthdays and credentialing dates by using task management system;
- Forget manual posting, start importing payments electronically;
- Helps to create paperless environment and keeps your front desk organized, scan your documents, attach to patients files, attached checks to claims payments in the program. Forget filling!

BILLING PROCESS INSIDE OF OUR SOFTWARE:

- Medical billing program conform regulations of CMS, LCD & HIPAA guidelines as well vital hand on experience of the medical billers and collectors;
- Maintain providers ids, tax id and network status with insurance;
- View history, resubmit claims, monitor payment and create follow up dates;
- Creating and Managing Authorization;
- Electronic submission of claims primary and secondary;
- Electronic submission of authorization to Medicaid;
- Automatically creating secondary claims;
- Generating outstanding report & export to excel for discussion during the next office meeting;
- Creating bills to patients;

Schedule a Demo Today!

Contact Ilya Mirolyubov via email: ilyam@wchsb.com or call **(718) 934-6714 ext 1111**

EVERYTHING STARTS AT THE FRONT DESK! KNOWLEDGEABLE RECEPTIONISTS SERVICES ARE VITAL TO A MEDICAL PRACTICE.

Take your business communication to the next level with WCH Receptionist Services!

As you are probably aware, everything starts at the front desk, from the moment the patient's walks and from the time they leave. If your practice has difficult time finding professional and knowledgeable medical receptionist allow WCH to take over your front desk! Our trained professional medical receptionists will schedule your office appointments, transportation, verify patient's eligibility, send out all types of communications to your patients, update your current superbills, collect missing information for billing and generate treatment reports to referring physicians, all from the convenience of our office.

We are currently helping healthcare providers with medical receptionist services in:

- Nursing Homes
- Home Care Practices
- Private Practices with in office and offsite receptionist
- Adult and Assisted Living Facilities
- Hospital Based Providers

If you need reliable remote front desk, contact us today!
888-924-3973 (x 1201), 718-934-6714

Due to upcoming holidays, WCH will be working with limited staff on the following days. Your dedicated account representative will provide you with their schedule. Our IT department will be available to assist you with any support questions.

Our Holiday schedule is below.

Passover (Tuesday)	March 26, 2013	closed
Passover (Wednesday)	March 27, 2013	closed
Easter (Sunday)	March 31, 2013	open with limited staff
Easter (Monday)	April 1, 2013	closed
Easter (Tuesday)	April 2, 2013	closed

HAPPY DOCTOR'S DAY!

We would like to thank all doctors for their hard work, patience and help they are providing everyday.
Thank you for making our lives healthier.
We also want to thank all of our clients for their loyalty and trust in our services.

CREDENTIALING NEWS

REVOCATION OF BILLING PRIVILEGES IN MEDICARE

Revocation 11 (42 CFR §424.535(a)(9))
The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.
Note the following with respect to Revocation 11:

This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not revoke the supplier's billing privileges on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR 424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may revoke the supplier's billing privileges.

Source:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R295PI.pdf

Feel free to contact our Credentialing Department specialist
Dora Mirkhasilova
at **(646) 434-5569** or via e-mail: doram@wchsb.com

UNITED HEALTHCARE WILL REPLACE THE CURRENT TRICARE WEST REGION CONTRACTOR ON APRIL 1, 2013

United Healthcare Awarded the TRICARE West Region Managed Care Support Contract and will replace the current TRICARE West Region contractor on April 1, 2013

- Will provide health care services for nearly 2.9 million active duty and retired military service members and their families
- Administrative services contract worth $1.4 billion over five years

United Healthcare, a UnitedHealth Group (NYSE: UNH) company, said its Military & Veterans Services business unit has been awarded the Department of Defense's TRICARE Managed Care Support contract to provide health care services for active duty and retired military service members and their families in the West Region.

UnitedHealth Military & Veterans Services will be the Managed Care Support contractor serving nearly 2.9 million TRICARE beneficiaries in Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding Rock Island Arsenal area), Kansas, Minnesota, Missouri (excluding the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, portions of Texas (including El Paso), Utah, Washington and Wyoming.

The contract includes a transition period and five one-year option periods for health care operations. The first year of operations is anticipated to begin April 1, 2013. The administrative services contract is worth $1.4 billion.

United Health Military & Veterans Services will provide contract and claims processing, as well as management support including cost trend risk management, fraud and abuse detection, and quality management services.

Note: Beneficiaries using TRICARE For Life (TFL) don't need to make any changes as the West Region transition to the new contractor will not affect your benefits. WPS-TFL will continue to provide you with customer service and claims processing services. Continuity of care remains a top TRICARE priority, and United Healthcare will make every effort to conduct a smooth transition. However, some TRICARE Prime and Prime Remote enrollees may have to change their primary care manager when the new contract begins. United Healthcare will have more information about the West Region provider network mid-February.

Source: https://www.optumhealth.com

Feel free to contact our Credentialing Department specialist
Julia Bondarenko
at **(646) 434-5569** or via e-mail: yuliyab@wchsb.com

MANDATORY PAYMENT REDUCTIONS IN THE MEDICARE FEE-FOR-SERVICE (FFS) PROGRAM - 'SEQUESTRATION'

The Budget Control Act of 2011 requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. The Administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

This listserv message is directed at the Medicare FFS program (i.e., Part A and Part B). In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a two percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by two percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the two percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the two percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor. As indicated above, we are hopeful that Congress will take action to eliminate the mandatory payment reductions.

Source: CMS Article PE201303-02

INCORRECT BILLING FOR CPT CODES 90471 AND 90472 WILL BE DENIED

Beginning **March 15, 2013**, National Government Services will deny current procedural terminology (CPT) codes 90471 and 90472 when billed as the administration codes for the flu vaccine. For Medicare billing, the only allowable administration code for the flu vaccine is G0008. CPT codes 90471 and 90472 are not valid for Part B Medicare flu administration billing. When providers use any other code for flu administration services, deductible and coinsurance amounts are applied to the claim incorrectly. When CPT codes 90471 and 90472 are billed for the administration of the flu vaccine it will be denied.

Source: http://www.ngsmedicare.com

MEDICARE PART B TO IMPLEMENT EDITS FOR SUSPECT DUPLICATE SERVICES

Beginning **March 4, 2012**, National Government Services will review claims for potential duplicate billing when a service or procedure is submitted by multiple providers on the same day. This review will affect providers of the same specialty within the same group practice, and duplicate billing by physicians and practitioners within the same practice.

If more than one claim for the same item or service is submitted, you can expect duplicate claims to be denied. One submission is all that is required. In addition, duplicate claims:

1. May delay payment;
2. Could cause you to be identified as an abusive biller; or
3. May generate an investigation for fraud if a pattern of duplicate billing is identified.

Some providers are submitting duplicate claims to Medicare for a single service encounter.

Medicare will pay the first claim that is approved and will deny subsequent claims for the same service as duplicates. A duplicate claim is a claim submitted from the same or different provider for the:

- Same beneficiary; for the
- Same item or service; for the
- Same date of service.

Although the Centers for Medicare & Medicaid Services (CMS) believes that most providers and suppliers are not deliberately trying to receive duplicate payment by submitting duplicate claims, CMS wants to remind providers and suppliers that submitting such duplicate claims for the same service encounter is inappropriate and asks you to discontinue this practice.

Source: National Government Services

CUTTING MEDICARE'S RED TAPE IS A WIN FOR RADIOLOGY

The Centers for Medicare & Medicaid Services proposed reforms of Medicare regulations it has identified as unnecessary, obsolete, or excessively burdensome on hospitals and healthcare providers–several of which will affect the radiology industry.
For instance, CMS recommended the elimination of a requirement that ambulatory surgical centers maintain a radiologist on staff. The Ambulatory Surgery Center Association has argued that the rule makes little sense since radiological services in an ASC usually are limited to intra-operative guidance and don't require radiologic interpretation.

The recommendation appears to be a win for radiologists, too, who often have liability concerns about having to review material not intended to be part of a diagnosis, but instead part of a procedure.
The new rule, which eliminates the term "direct," was based on the recommendation of the Society of Nuclear Medicine and Molecular Imaging with the idea that it will help speed services to patients.

Source: CMS.org

DIRECT ACCESS FOR THERAPY SERVICES VERSUS CERTIFICATION

In most states, physical therapists are now allowed to treat patients without a physician order. This change is referred to as 'direct access' as the patient does not need to see the physician prior to receiving therapy services. However, for Medicare payment, certification is still required. We have found some confusion exists in the provider community about this issue.

A certification is different than an order. A certification is usually demonstrated by a dated physician or nonphysician practitioner (NPP) signature on the plan of care but could be on some other document that indicates approval of the plan of care.

Requirements of a Plan of Care

If a signed order includes a complete plan of care, no further certification is required. The required elements for a plan of care include:

- Diagnoses,
- Long term treatment goals, and
- Type, amount, duration and frequency of therapy services.

The duration of the certification is for the longest duration in the plan of care, not to exceed 90 days. Often the plan of care will require treatment for less than 90 days. The format of all certifications is determined by the individual facility or practitioner. Sometimes a patient may present for evaluation but does not require treatment. Local Coverage Determination (LCD) L26884 for Outpatient Physical and Occupational Therapy provides this instruction for this issue:

"When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient."

Source: http://www.ngsmedicare.com

SLEEP TESTING AND THERAPY SERVICES

Empire will introduce a new specialty benefit management program for sleep testing and therapy services performed on or after **March 1, 2013**. This new program will consider the medical necessity of sleep testing and therapy services, including the need for use of a facility test versus doing the test in the home.
Prior Authorization for Sleep Testing and Therapy
Please contact AIM to obtain an order number for the following elective services or supplies scheduled on or after **March 1, 2013.**

- Home sleep test (HST)
- In-lab sleep study (PSG)
- Titration study

Initial treatment order (APAP, CPAP, BPAP and oral devices, appliances and related supplies)

Ongoing treatment order (APAP, CPAP, BPAP and oral devices, appliances and related supplies)

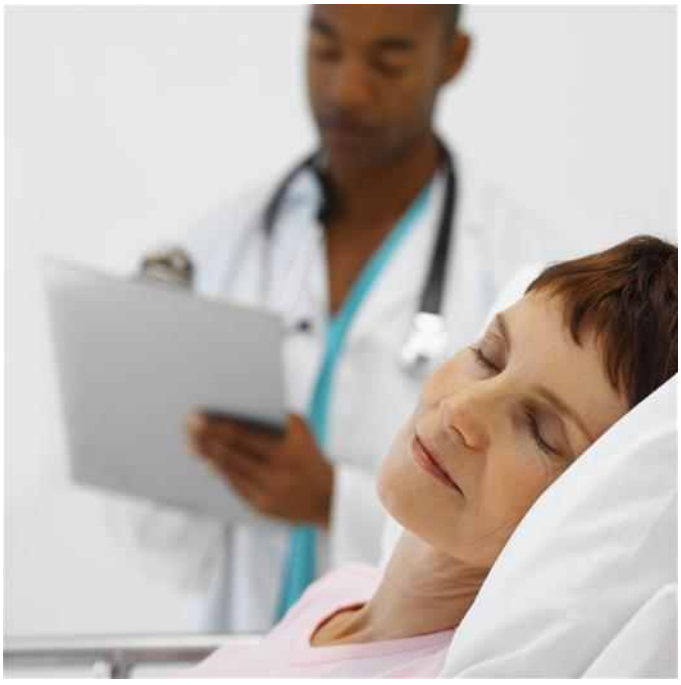
Services performed in conjunction with emergency room services, inpatient hospitalization, or urgent care facilities are excluded. For therapy services, members must meet usage criteria for the continued rental of equipment and replacement of supplies.

Prior authorization for sleep testing and therapy services applies to all Empire members except the following:

- Federal Employee Program (FEP)
- Empire BlueCross BlueShield secondary coverage, including those whose primary insurance carrier is Medicare
- Medicare Advantage - MediBlue
- Child Health Plus Members
- Plans that do not participate in High End Radiology programs

Please note that the prior authorization requirement will apply for Healthy New York members only for sleep studies.

Source: aimspecialtyhealth.com



AETNA PARTICIPATING PROVIDER PRECERTIFICATION LIST EFFECTIVE MARCH 1, 2013

Applies to: Aetna Choice POS, Aetna Choice POS II, Aetna Medicare Plan (PPO), Aetna Medicare Plan (HMO), all Aetna HealthFund products, Aetna Health Network Only, Aetna Health Network OptionSM, Aetna Open Access Elect Choice, Aetna Open Access HMO, Aetna Open Access Managed Choice, Open Access Aetna SelectSM, Elect Choice, HMO, Managed Choice POS, Open Choice, Quality Point-of-Service (QPOS), Choose and SaveSM, Aetna Performance Network, Savings Plus, and Aetna Select benefits plans and all products that may include the Aexcel networks and include the designation Aexcel or Aexcel Plus.

Precertification and notification are the processes of collecting information before elective inpatient admissions and/or selected ambulatory procedures and services take place. Therefore, requests for precertification and notification must be received before rendering services. Failure to contact Aetna for precertification will relieve Aetna or employers and members from any financial liability for the applicable service(s), if those services are rendered.

Polysomnography (attended sleep studies)

Precertification for all members with plans applicable to this precertification list when performed in any place of service except inpatient, emergency room and observation bed status

• Providers in all states where applicable, except Metro New York and Northern New Jersey, should contact MedSolutions to request preauthorization. You can reach MedSolutions:
--Online at www.medsolutionsonline.com
--By phone at **1-888-693-3211** between 7 a.m. and 8 p.m. ET
--By fax at **1-888-693-3210** Monday through Friday during normal business hours or as required by federal or state regulations
• Providers in Metro New York and Northern New Jersey should contact CareCore National to request preauthorization. You can reach CareCore National:
--Online at www.carecorenational.com
--By phone at 1-888-622-7329

Radiology imaging

Precertification for all members with plans applicable to this precertification list when performed in any place of service except inpatient, emergency room and observation bed status

• Through regional specific vendor (MedSolutions or CareCore National) where applicable for computed tomographic (CT) studies, coronary CT angiography, MRI/MRA, nuclear cardiology, PET scans, diagnostic left and right heart catheterizations and echo stress tests

Source: http://www.aetna.com/healthcare-professionals/assets/documents/2013_Precert_List.pdf

NOVITAS ISSUES LCD LIMITING CHIROPRACTIC VISITS

MAC Part A&B Novitas Solutions, Inc has published LCD L32718 that imposes diagnosis limitations that support diagnosis to procedure code automated denials. Medicare will allow up to 12 chiropractic manipulations per month and 30 chiropractic manipulation services per beneficiary per year. Despite allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment, and Medicare does not expect that patients will routinely require the maximum allowable number of services. Additionally, Medicare requires the medical necessity for each service to be clearly demonstrated in the patient's medical record.

In this policy, the primary diagnoses remain as 739.0- 739.5 however the "Secondary Diagnosis codes are now displayed in four groups in ascending specificity. Medicare does not expect that substantially more than the following numbers of treatments will usually be required:

• Twelve (12) chiropractic manipulation treatments for Group A diagnoses.
• Eighteen (18) chiropractic manipulation treatments for Group B diagnoses.
• Twenty-four (24) chiropractic manipulation treatments for Group C diagnoses.
• Thirty (30) chiropractic manipulation treatments for Group D diagnoses.

Utilization Guidelines

Medicare covers the following numbers of chiropractic manipulation services per beneficiary:

• Twelve (12) chiropractic manipulation treatments per month.
• And,Thirty (30) chiropractic manipulation treatments per year.

Source: novitas-solutions.com/policy

UPDATE TO THE CY 2013 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)

In the American Taxpayer Relief Act of 2012, Congress increased the therapy multiple procedure payment reduction (MPPR) to 50% of the practice expense component of "always therapy" services (in all settings) when furnished to a single beneficiary in a single day, effective **April 1, 2013**. (Currently, this reduction is 25% in the facility setting and 20% in the office setting.)

Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services Effective **January 1, 2011**, Medicare applied an MPPR to the Practice Expense (PE) payment of select therapy services paid under the physician fee schedule or paid at the physician fee schedule rate. Currently, the reduction is 20 percent for therapy services furnished in office and other non-institutional settings, and 25 percent for therapy services furnished in institutional settings. Effective for claims with dates of service **April 1, 2013**, and after, Section 633 of the American Taxpayer Relief Act of 2012 revised the reduction to 50 percent for all settings.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. Effective for claims with dates of service on or after **April 1, 2013**, full payment is made for work and malpractice and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day.

For therapy services furnished by a group practice or “incident to” a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, e.g., Physical Therapy (PT), Occupational Therapy (OT), or Speech-Language Pathology (SLP).

The reduction applies to the Healthcare Common Procedure Coding System (HCPCS) codes contained on the list of “always therapy” services that are paid under the physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g., hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.) For professional claims, the MPPR applies to the procedures with a Multiple Procedure (Field 21) value of “5” on the Medicare Fee Schedule Database (MFSDB). For institutional claims, the MPPR apples to procedures with a Multiple Services Indicator (field labeled MULTSURG) value of “5” on the therapy abstract file. Note that these services are paid with a non-facility PE

Recovery of Annual Wellness Visit (AWV) Overpayments Providers may provide an initial AWV visit (HCPCS code G0438) to a beneficiary once in a lifetime. In addition, providers may provide a subsequent AWV (HCPCS code G0439) if the beneficiary has not received an Initial Preventive Physical Examination (IPPE) or an AWV within the past 12 months.

For claims with dates of service on and after **January 1, 2011**, and processed on and after **April 4, 2011** through **March 31, 2013**, the business requirements of CR7079 allowed an AWV visit (HCPCS G0438 and G0439) on an institutional claim and a professional claim for the same patient on the same day.

In some cases, this resulted in double billing of the same service, since institutional and professional claims may be submitted for the same service. In other instances, both a professional and an institutional claims have been received for the same patient with different dates of service exceeding the allowed services under coverage guidelines.

As a response to double billing of AWV services, the Centers for Medicare & Medicaid Services (CMS) issued CR8107 to provide instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV. CR8107 will be implemented on **April 1, 2013**. In the interim period from **April 4, 2011**, through **March 31, 2013**, double billings have occurred and may continue to occur. CR8153 provides instructions to contractors to initiate a recovery process for these overpayments of AWV services.

Source: ngsmedicare.com

THERAPY LIMITATION AND MANUAL MEDICAL REVIEW PROCESS FOR THERAPY THRESHOLD FOR 2013

On **January 3, 2013** President Obama extended the American Taxpayer Relief Act of 2012 (ATRA) which impacted outpatient therapy caps and mandated 100 percent (100%) manual medical review prior to allowing Medicare payment for services that exceed the $3700 threshold in 2013.

Providers who render and bill outpatient therapy services should expect to receive an additional development request (ADR) whenever a claim is billed to Medicare for a beneficiary that has exceeded either the physical therapy (PT)/speech-language pathology (SLP) $3700 threshold or the outpatient therapy (OT) $3700 threshold. There is no preapproval process at this time for 2013 as there was in 2012.

Source: www.NGSMedicare.com

DOCUMENTATION REQUIRED TO SUPPORT THE NEED FOR HOME VISITS (CPT CODES 99341-99350)

National Government Services Part B Medical Review Department is conducting a service-specific prepayment audit of current procedural terminology (CPT) code 99350, home visit for the evaluation and management of an established patient. One issue found during the review of the medical records is that documentation

frequently does not include information to support the necessity of the home visit. The Centers for Medicare & Medicaid

Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.14.1 (1.31 MB) states:

Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary's home. In addition to supporting the over-all medical necessity for the visit, the medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

It is very important that you consider the following points when documenting in support of home visits:

• Home visits are not covered when provided simply for the convenience of the patient. While the patient is not required to be home bound to receive home visits, the CMS IOM Publication 100-04, Medicare Claims Processing Manual emphasizes that documentation must support the need for the home visits. Because chronic conditions are not static and symptoms and/or circumstances can vary, it is very important that the reasons why the patient was seen in the home instead of the office are well documented. For example, an elderly, frail patient may not be able to travel to a physician office in February with ice and snow on the ground and below freezing temperatures, but may easily do so in May or June. Patients who are able to go to offices/hospitals for tests or elsewhere for recreational activities might be expected to do the same for their physician visits.

• A stand-alone statement indicating the reasons why the patient requires home visits would be ideal, but not required. In lieu of that, medical reviewers should be able to easily infer such a need from the submitted documentation.

• If the necessity of the home visits is not clearly indicated, these visits will be recoded to the Office or Other Outpatient Services Established Evaluation and Management Service code (CPT 99211-99215) at a level supported by the documentation.

Source: http://www.ngsmedicare.com

MEDICAL NUTRITION THERAPY

1) What conditions are necessary for Medical Nutrition Services?
According to CMS Manual Medicare provides coverage of MNT services when the following general coverage conditions are met:
- The beneficiary has diabetes or renal disease;
- The treating physician provides a referral and indicates a diagnosis of diabetes or renal disease;
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;
- The services provided are either on an individual or group basis without restrictions;
- The services are provided by a registered dietitian, or a nutrition professional who meets the provider qualification requirements, or a "grandfathered" dietitian or nutritionist who was licensed as of **December 21, 2000**;
- The services are provided within the same time period and for the maximum number of hours allowed under each benefit;
- The beneficiary, with a diagnosis of diabetes, has received DSMT and is also diagnosed with renal disease in the same episode of care; and
- The beneficiary has a change in medical condition, diagnosis or treatment

2) What codes need to be billed for MNT services according to Medicare guidelines?
The codes are used by Medicare

97802: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803: re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804: group (2 or more individual(s)), each 30 minutes Healthcare
G0270: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.
G0271: Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

3) What places of services are appropriate for MNT services?
•**Included:** private practice, physician offices, ambulatory clinics; hospital outpatient departments; other outpatient settings.
But never at: inpatient hospital setting; skilled nursing facilities.

4) How often MNT services can be provided in a year?
Initial MNT: 3 hours per calendar year in the first year.

(MNT services covered by Medicare include: an initial nutrition and lifestyle assessment, nutrition counseling, diet management, follow-up sessions to monitor progress)

Follow- up MNT: 2 hours per calendar year in subsequent year.
Hours can be spread over any number of visits during the year (1 visit = 15 min.)

5) What patient's conditions are required for MNT services?
Following listed ICD-9 codes describe conditions when MNT services are necessary. The service must be reasonable and necessary in the specific case and must meet all criterias.

250.00	250.01	250.02	250.03	250.10
250.11	250.12	250.13	250.20	250.21
250.22	250.23	250.30	250.31	250.32
250.33	250.40	250.41	250.42	250.43
250.50	250.51	250.52	250.53	250.60
250.61	250.62	250.63	250.70	250.71
250.72	250.73	250.80	250.81	250.82
250.83	250.90	250.91	250.92	250.93
403.01	403.11	403.91	404.02	404.03
404.12	404.13	404.92	404.93	585.1
585.2	585.3	585.4	585.5	585.6
585.9	593.9	648.00	648.01	648.02
648.03	648.04	648.80	648.81	648.82
648.83	648.84	V42.0		

NY MEDICAID REIMBURSEMENT NOW AVAILABLE FOR MEDICAL LANGUAGE INTERPRETING SERVICES

Providers of outpatient health services who utilize medical interpreting services are now eligible for reimbursement through Medicaid Managed Care and Family Health Plus Plans. This reimbursement became available October 1 last year and retroactive billing is acceptable. Many providers across NY State are still not fully aware of this. The new reimbursement can be a tremendous help to providers who utilize the services of professional Medical Interpreters in order to abide by regulations from the ADA and Title VI of the Civil Rights Act. Previously, providers have had to bear the cost of Medical Interpreting as a business expense. Among the facilities eligible for reimbursement are hospital clinics, private practice practitioners, substance abuse centers, emergency/urgent care locations, mental health offices, dentists and centers that care for individuals with developmental disabilities.

Source: ambanet.net

EDIT 02165 - DELAY REASON 10 (ADMINISTRATION DELAY IN THE PRIOR APPROVAL PROCESS) INVALID WILL DENY CLAIMS BEGINNING MARCH 7, 2013

New York State Medicaid continues to work to increase provider compliance with delay reason reporting on claims aged more than 90 days. As published in the **March 2012** Medicaid Update, eMedNY editing will verify the validity of Delay Reason Codes reported on claims.

Effective **March 7, 2013**, claims with dates of service over 90 days old may be denied with edit 02165 - Delay Reason Code 10 (Administration Delay in the Prior Approval Process) Invalid. The associated HIPAA reason code will be 29-THE TIME LIMIT FOR FILING HAS EXPIRED and for Pharmacy claims NCPDP Reject code NV-M/I DELAY REASON CODE.

Delay reason 10, “Administration Delay in the Prior Approval Process”, applies only to services and supplies requiring prior approval where prior approval is granted after the date of service due to administrative appeals, fair hearings or litigation and is only valid if the claim ages over 90 days during this process. Claims must be submitted within 30 days from the time of notification of the determination.

Source: eMedNY General Updates

OVERPAYMENT IDENTIFIED FOR OUTPATIENT PSYCHIATRIC SERVICES

National Government Services has identified a situation in which psychiatric services were processed and paid incorrectly during the period of **January 1, 2013** through **January 24, 2013**. The new 2013 current procedural terminology (CPT) codes 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, and 90840 were processed without applying the 2013 outpatient psychiatric limitation of 81.25%, causing an overpayment. Overpayment adjustments will be made to approximately 14,000 claims.

For additional information, please review the Local Coverage Determination (LCD) at LCD for Psychiatry and Psychology Services (L26895).

Source: ngsmedicare.com

AMA JOINS BRIEF OPPOSING 'PAY-FOR-DELAY' DEALS

The American Medical Association joined healthcare and consumer groups calling on the U.S. Supreme Court to limit the ability of drugmakers to enter agreements that keep generic competition off the market.

The Federal Trade Commission has been battling what it calls “pay-for-delay” agreements in court with limited success for several years, arguing they illegally deny consumers the benefits of competition.

Source: ama-assn.org

AUDITING SERVICES, WE CARE ABOUT YOUR CHARTS.

It may seem simple, but with today's ever-changing medical codes, guidelines, and regulations the task of properly putting together your medical charts requires more time and experience than ever before. Selecting the appropriate codes and level of care requirements can be challenging. With the implementation of Medicare and other payer audit projects, these problems, if not addressed, **could cost medical professionals excessive charge-backs and penalties. We have an experience and Certification! Let us help you today!**

Benefits of auditing your charts with WCH:

- Get your records evaluated by AAPC staff Certified Professional Coders, and Medical Auditors
- Ensure that your charts are error free
- Prevent losing money to prepayment or post payment reviews
- Stay focused on your patient's health, while we take care of your charts

Don't risk losing money, take advantage of our chart auditing services

Contact us today to schedule a consultation to assess your needs and determine how we can help your practice.

Oksana Pokoyeva,
Billing Department Manager,
CPC, CPMA,
(718) 934-6714 ext 1215,
oksanap@wchsb.com

FIDELIS CARE'S QARR/HEDIS 2013 MEDICAL RECORD REQUEST LETTER AND MEMBER LISTS ARE NOW POSTED ON PROVIDER ACCESS ONLINE

The Fidelis Care QARR/HEDIS 2013 medical record request information has been posted to your account on Provider Access Online. As in previous years, an incentive is offered to providers who send in records or schedule and complete an onsite review within 2 weeks of the posting. Please go to "File Downloads" to access the request, just as you would access Remittance Advices or your Provider Report Card. Please review the entire package for instructions on what records are needed, where they are to be sent, and what is required to receive the incentive. Please contact your organization's Provider Access Online account administrator if you do not currently have access to this application. If you do not know who your administrator is, please call the Fidelis Care Provider Call Center at 1-888-FIDELIS (1-888-343-3547). If you are no longer the person responsible for these reports, please contact your account administrator to update your organization's access.

Source: Fidelis

DUE TO THE HIPAA FINAL RULE, YOU MAY NEED TO UPDATE YOUR POLICIES, PROCEDURES, AND CONTRACTS. DON'T BE CAUGHT UNPREPARED!

Practices Must Comply with New Medical Record Transfer Rules

You should be aware, patients have a right to have their entire medical record transferred (subject to some exceptions, such as for mental health records) to any provider they choose. This process should be easy for patients once the appropriate paperwork is executed. Practices must be sure not to allow patient records to get caught in a dispute among providers, which can arise when a physician leaves a medical practice. Additionally, medical records cannot be held hostage in exchange for a patient's payment of medical bills.

The HIPAA final rule provides some specific guidance on transfer of medical records:
(a) If your practice maintains EHR, you must provide a copy of the medical record in at least one readable electronic format. The record can, for example, be provided on a disc, by sending a secure email, or through a secure Web-based portal. Although a

(c) Be sure you are prepared to transmit an electronic copy of a patient's medical record directly to a third person if designated by the patient in writing. Policies and procedures must exist within the practice to verify the identity of any such person.

(d) While practices can charge patients for copying medical records, every practice should be familiar with the limitations set by the final rule. Labor costs for copying PHI, whether in paper or electronic form, are one factor that may be included in the reasonable, cost-based fees charged to individuals. This might include time the staff spent creating or copying electronic files, scanning, and burning PHI to media. Reasonable, cost-based fees may also include the costs of supplies (e.g., discs, flash drives) or postage, depending on how the patient asks for the record to be transferred. Be aware that under the final rule, a practice cannot charge a retrieval fee for electronic copies or for any costs related to new technology, maintaining systems for electronic PHI, data access or storage infrastructure. Each practice should also determine the state law requirements on patient record copying, since state law will preempt HIPAA if the state law imposes a lower copying charge.

Finally, the final rule decreased the time a practice has to respond to requests for a medical record. A practice now only has 30 days to respond to a record request but may obtain a one-time extension of 30 days if the practice provides a written explanation to the patient explaining the reason for the delay and the expected date of completion.

Make sure your record transfer policies are compliant with the final rule and your staff is trained accordingly.

Source: http://www.physicianspractice.com/blog

THE NEW YORK HEALTH BENEFIT EXCHANGE: WHAT YOU NEED TO KNOW

One of the provisions of the Affordable Care Act (ACA) is the establishment of statewide Health Insurance Exchanges. These organized online marketplaces will enable consumers and small businesses to shop for coverage in a way that allows them to easily compare health plan options on benefits, services, price and quality.

What the Exchange Means for New Yorkers
Nearly 2.7 million New Yorkers under age 65 — about 16 percent — do not have health insurance coverage. It is estimated that over one million New Yorkers will gain health insurance coverage once the Exchange and the other provisions of the ACA have been fully implemented. Here are some important facts about the Exchange:

- The Exchange will take the form of a Web site where individuals, families and small businesses can compare and enroll in plans that best meet their needs and budgets.
- Every plan sold on the Exchange must offer a comprehensive package of services known as "essential health benefits" that include preventive, diagnostic and therapeutic services representing 10 different categories of care.
- Consumers shopping for insurance on the Exchange will choose from four standardized coverage levels — bronze, silver, gold and platinum — each based on cost and the level of benefits offered.
- Health plans offered on the Exchange will be required to accept all applicants, meaning they may not deny insurance to anyone who applies.
- The ACA requires that the Exchange establish a Navigators program to help individuals and families with the information necessary to determine which health insurance option best fits their needs, and then help them enroll in their plan of choice.

Source: www.healthcarereform.ny.gov

NEWS BY SPECIALTY

CARDIOLOGY

Code 93653 would be correct since atrial flutter is a type of supraventricular tachycardia.

93653 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry. If atrial flutter was found and treated after a primary ablation of a different kind of arrhythmia, you would assign 93655.

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)

RADIOLOGY

For claims with dates of service of **January 1, 2013**, and after, the American Medical Association (AMA) created four new codes to report thoracentesis, revised 32551, and deleted formerly used codes 32421 and 32422. Two of the new codes listed below will be assigned if no imaging guidance is used, and the other two will be assigned if guidance is used.

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
32555 with imaging guidance
32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
32557 with imaging guidance

According to the American College of Radiology (ACR) Committee on Coding and Nomenclature, it is appropriate to code for a unilateral diagnostic mammogram (77055 or G0206) for verification of clip placement after biopsy when it is performed on a separate piece of equipment, if it is a different modality from the primary procedure or if separate physicians are involved.
However, according to the Centers for Medicare & Medicaid Services (CMS) in the NCCI Policy Manual(chapters 3 and 9), guidance codes for breast biopsy, needle localization, localization clip or other breast procedures include all imaging, and a post-procedure mammogram should not be coded.

Source: panaceahealthsolutions.com

STATES UPDATES

ILLINOIS DOC SOCIETY BACKS 67% HIKE IN LICENSE FEES

The Illinois State Medical Society is supporting a bill that would raise physician license fees 67% to stabilize operations of the Illinois Department of Financial and Professional Regulation's medical unit.

The unit, which handles doctor discipline and processes medical licenses, has had 18 of its 26 employees reassigned elsewhere because of budget issues that the medical society argues were caused by the state redirecting medical license fees for other purposes. With the reassignment of staff, it was feared that processing of license renewals and applications would be delayed—causing hardship for the 2,500 medical school graduates expected to train at the state's residency programs this year.

TEXAS SYSTEMS LATEST TO LAUNCH ACOS

Two large Texas health systems with Medicare accountable care contracts are among the latest to enter into commercial ACOs in deals that suggest a growing willingness to adopt the largely untested payment model amid increasing pressure on providers and payers to curb health spending.

Memorial Hermann Healthcare System announced plans to launch an ACO on April 1 with Aetna, one of the nation's largest insurers. Last July, Memorial Hermann was among nearly 90 named Medicare ACOs under a provision of the Patient Protection and Affordable Care Act.

Under the Aetna contract, Memorial Hermann will be eligible for bonus payments tied to measures of quality and cost control, but will not immediately be at risk for losses based on performance.

The Texas Health Resources' ACO with Aetna will initially cover 5,000 individuals and is expected to expand to 15,000 to 30,000 enrollees. The rate of expansion will depend on the speed with which Aetna identifies patients for the ACO and distributes patient data to providers. Providers will not be at risk for financial losses under the deal, but are eligible for bonuses based on quality and cost-control measures.

Source: Modernhealthnes.com

QUESTIONS AND ANSWERS

Question:

♦ What DOS (Date Of Service) should be on the claim according to Medicare policy for PC when billing for professional component only by physician?

Answer:

♦ CMS does not have written confirmations, but according to CMS regulations date of radiology service interpretation should be reported as a date of service on the claim. In another words if TC and PC are rendered on different days, they should be reported at the factual date of the service.

Separate Billing of Professional Interpretation

The professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician, if the same physician or other supplier entity does not furnish both the TC and PC of the diagnostic service. This also applies if the same physician or other supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished.

When the physician's interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier -26, the interpreting physician (or his or her billing agent) must report the address and ZIP code of the interpreting physician's location on the claim form. If the professional interpretation was furnished at an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices. The address and ZIP code of this practice location is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent).

Susanna Bekirova,
Billing Department
susannab@wchsb.com

Source: http://www.ngsmedicare.com

Question:

♦ What is Medicare Timeframes for processing provider enrollment applications?

Answer:

♦ Submitting your completed enrollment form(s) is the first step to what we hope will be a positive relationship between you and Medicare. It is also an important process for ensuring proper claims payment, deterring

criminal activity, and protecting the Medicare trust fund. It does take time to process your enrollment forms, so your patience in refraining from contacting us during that processing time is greatly appreciated.

Timeframes for processing provider enrollment forms are as follows:
Initial Enrollments and Reactivations
Paper Applications: 60 – 180 calendar days from receipt
Paper Applications IDTF: 90 – 180 calendar days from receipt

*Processing times will vary contingent upon the number of development requests.
Internet-based (Web) PECOS Applications: 45 – 90 calendar days from receipt

Reassignments/Change Requests
Paper Applications: 60 – 120 calendar days from receipt

*Processing times will vary contingent upon developmental requests.

Internet-based (Web) PECOS Applications: 45 - 90 calendar days from receipt

How Does an Application Get Processed?
You have completed and submitted the appropriate provider enrollment forms to Medicare. There are several different steps that must take place in order to process your enrollment or change application. Please review the following information in order to better understand the progression of work required to complete your request.

Julia Mouravyova,
Credentialing Specialist
juliam@wchsb.com

FEEDBACK

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.

Give us your feedback and receive free glass name plate.

_____

_____

_____

_____

_____

_____

Name_____

E-Mail_____

Thank you for your support!