WCH BULLETIN

October 2012
VOLUME 3
ISSUE 9

Dear Providers and Office Administrators, Welcome to our October '12 Bulletin!

Introducing WCH Referral Program

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2013 CPT Coding Changes for Psychiatrists

Important note to physicians ordering DME

2013 eRx Hardship Exemption

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INSIDE THIS ISSUE:

WCH Referral Program for our clients

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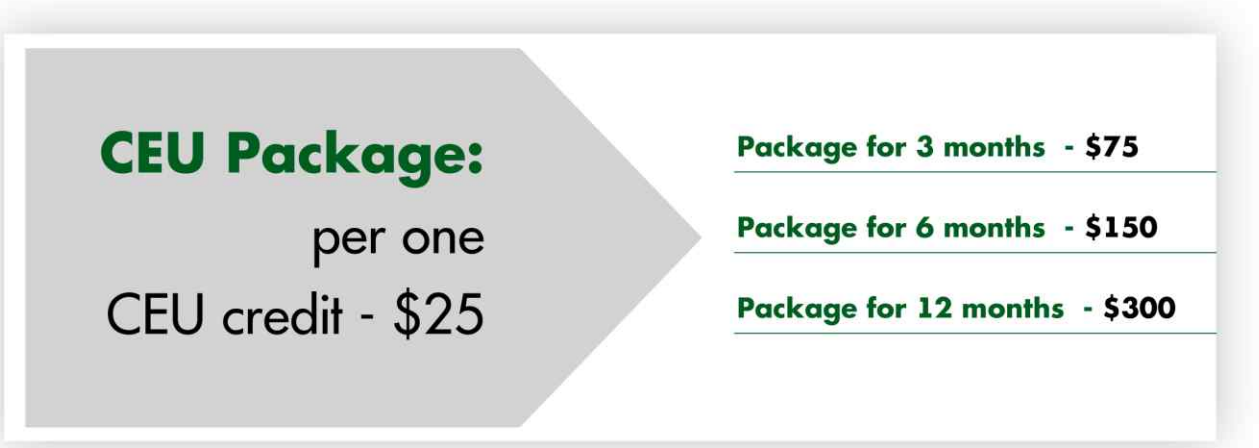

Accountable Care Organizations

Special for our clients we prepared article about main information of Accountable Care Organizations.

In light of the high and rapidly growing cost of healthcare in the U.S., there has been growing interest both in the federal government and in states and regions across the country in finding ways to encourage health care providers to take greater accountability for the overall cost as well as the quality of healthcare delivered to patients. A healthcare provider or group of providers that accepts accountability for the total cost of care received by a population of patients has been termed an "Accountable Care Organization."

An **accountable care organization** (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness and efficiency of the health care provided. According to the Centers for Medicare and Medicaid Services (CMS), an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

Using Partial Capitation to Support Accountable Care Organizations in Medicare

The federal Patient Protection and Affordable Care Act created a new Medicare payment program to support Accountable Care Organizations (ACOs). Although the program is titled the "Shared Savings Program," and most discussions have focused on using "shared savings" to pay ACOs, the Act allows CMS to use payment models other than shared savings to support ACOs. One of these payment models is "partial capitation." The law states that under partial capitation payment, an ACO would be at financial risk for some, but not all, of the items and services Medicare covers.

Source: CMS.org

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Olesya Petrenko, Marketing Manager
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FedEx small business grant contest

http://emails.fedex.com/r/c/r?2.1.3Jd.2Ww.12R04q.D49wM6..N.LNyw.2qyY.cnNzaXRlQ2F0YWx5c3Q9RU1DLTEwMDA5NjgtMi0xLTIwMC0xMTEwMDAwLVVTLVVTLUVOLUdSQU5UQ09OVEVTVDAwMCZtbz0xBeSEMVT0

DEAR CLIENTS, IT IS TIME TO GET YOUR OWN WEBSITE!

Hurricane Sandy's passage through the northeastern United States has impacted many homes and businesses. The Situation with hurricane has shown that medical practices need websites more than ever. Since all of the phones have been cut off, patients have not able to reach their doctors, and there is no information available about the status of the office. This is the perfect time to have your free website, its benefits are limitless:

- A website is like a 24 hours a day, 7 days a week secretary who never goes to sleep. Easy contacts directly from the website: email, skype, etc
- When your practice closes for the day, the website continues to work by providing support of clinic details, and provides critical information needed by your patients.
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It's fast 2
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Enjoy your website, domain name and hosting free for an entire year.

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Benefits of auditing your charts with WCH:

- Get your records evaluated by AAPC staff

Know the Rules About Collecting Deductibles Up-Front

Navigate your way when carriers give you conflicting advice about deductibles, but use business sense as well as compliance know-how.

Collecting deductibles from patients has never been more difficult — between determining whether the patient has secondary coverage and seeking answers on whether they've already met their deductible, you could lose an hour of your time. Payer confusion only adds more difficulty to the process. One subscriber wrote to the *Insider* and explained that her carrier told her it was illegal to collect a deductible from a patient before receiving an EOB from the insurer.

Is this accurate? No, says J**oan Gilhooly, CPC, CHCC**, president of **Medical Business Resources, LLC**.

Compliant point of view: "From a compliance standpoint, if the practice knew without a doubt that the patient's deductible had not been met, there is nothing that prohibits the practice from collecting it at the time of service prior to sending the claim to Medicare," Gilhooly says.

Business point of view: Even if it's legal to collect a patient's deductible at the time of service, however, it may not be a good business practice.

"In the distant past, people may not have had secondary payers and it may have made good sense to collect the deductible in January," Gilhooly says. "But now that Medicare pays so promptly and so many people have secondary plans, it's very uncommon to find someone whose deductible you need to collect up-front."

Secondary payers will usually pay you the cost of the patient's deductible, and the secondary payment often arrives at your office before you even receive your Part B reimbursement, Gilhooly says.

Refunds: "Some practices collect the deductible up-front as a rule, especially if they see the patient early in January, and then figure they'll just issue a refund later if necessary," says Jay Neal, a coding consultant in Atlanta. "But generating all of those refunds can be a headache when February rolls around," Neal adds.

Not to mention costly: What you collect from the patient up-front probably isn't as much as you'd spend processing a refund, Gilhooly says. "Given the extraordinary expense of processing refunds, I generally recommend that practices don't collect the deductibles, and instead, they should simply wait the two weeks (assuming electronic claims filing) to find out if the patient really does owe any money," she advises. Even if you can predict what the Medicare EOB will say (which is nearly impossible), the odds of knowing whether the patient will owe you his deductible get worse and worse every day after January first, "and that's before you start to factor in the implications of the patient having a Medigap policy you weren't aware of that would have picked up the deductible for the patient in the first place," Gilhooly advises.

Example: Suppose you see a patient on January 15. She tells you that she hasn't seen any other physicians yet during the year. She also mentions during the history portion of the E/M visit that she performs her glucose test daily and that she just received a new box of glucometer strips the day before, so she is prepared to continue testing her blood sugar.

Reality: Although this patient has not seen a Medicare physician, she probably did pay some money toward her deductible when she ordered the glucometer strips. “The eductible accounts for all services, including durable medical equipment (DME),” Gilhooly says. “I once did the billing for a practice that collected a deductible from every single patient they saw from Jan. 1 through Feb. 1,” Neal says. “It was their policy and they had no intention of changing it — until we had to bring in a temp. for a month to help us process all of the refunds.”

Bottom line: Determine whether collecting that deductible is really worth your while from a business standpoint before you ask the patient to pay it at the time of service.

Source: Kaern Augustine Conroy & Schoppmann, P.C.

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CREDENTIALING NEWS

Bank of America's Practice Solutions Group now offers business lending specifically for Urgent Care Centers- 100% financing on startup loans, practice expansions

Bank of America, Practice Solutions has provided unique financing opportunities to the medical industry for several years. Bank of America is endorsed by more dental, veterinary, and medical associations than any other lending institution.

They are now offering this same great lending program to Urgent Care Centers and Pain Management Clinics.

Practice loans from $10,000 to $5 million
Fixed loan terms up to 20 years
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Call WCH Credentialing Department with any of your question about insurance contracts.

Source:
http://www.bankofamerica.com/small_business solutions/index.cfm?template=overview_pr statecheck=NY

Space-sharing and Leasing for IDTFs: A Clarification of the Rules

By Alicia B. Chandler and Christopher J. Laney, Wachler & Associates, P.C.

Independent Diagnostic Testing Facilities ("IDTFs") are subject to fairly onerous certification standards governing both what they must do and what they cannot do. One standard that has been in need of clarification is under what circumstances an IDTF can share space with another Medicare provider. IDTF certification standards explicitly state that IDTFs are prohibited from "sharing a practice location with another Medicareenrolled individual or organization," but the standard exempts two categories of providers from this rule: hospital-based IDTFs and mobile IDTFs. However, since the Centers for Medicare and Medicaid Services ("CMS") had never defined what it meant to be a "mobile IDTF", IDTFs sharing space with another Medicare provider risked the revocation of Medicare billing privileges. There has been recently been some clarification of this issue by the Departmental Appeals Board ("DAB") of the Department of Health and Human Services, which is the entity that hears appeals in CMS enforcement cases.

A CMS Medicare contractor revoked billing privileges of an IDTF based on the allegation that the IDTF was a fixedbase IDTF “sharing a practice location and subleasing space from another Medicareenrolled organization” in violation of the certification standards.

In addressing whether the IDTF was mobile or fixed-base, the DAB made clear that the manner in which an IDTF provides services is the determining factor in whether an IDTF is mobile, and thus not subject to the space-sharing prohibition. The DAB referenced the preamble to the applicable Medicare regulation indicating that a fixed-base IDTF is one that performs *all* of its testing at its home office In this case, the IDTF performed ultrasound procedures at its home office, but also provided vascular diagnostic testing at multiple locations using portable equipment.

CMS argued that because the IDTF did not have a “mobile facility,” such as a mobile trailer where testing is performed, that the IDTF was actually a fixed-base IDTF. The DAB ruled that an IDTF having a mobile facility is irrelevant when making a determination whether or not an IDTF is “mobile.” Rather, as long as an IDTF is using portable equipment to provide services at locations other than its home office, an IDTF may be considered mobile.

Relying on language in the Program Integrity Manual, the DAB recognized two types of mobile IDTFs, a mobile-facility IDTF and a portable-unit IDTF. A provider is a mobilefacility IDTF when a trailer or mobile home has been converted and equipped to provide health care services to patients inside the vehicle. A provider is a portable-unit IDTF when its equipment is transported to another location, such as a physician office or nursing home, and the patients are seen at that location. The significance of the DAB's decision is that both of these types of providers, a mobile-facility IDTF and a portableunit IDTF, are considered mobile IDTFs and are therefore exempted from the spacesharing prohibition contained in the certification standards. This decision provided needed clarification to allow IDTFs to structure their business models while having some degree of certainty as to whether they are a fixed-base or mobile.

Also addressed in the DAB's decision was the prohibition on IDTFs leasing space to another Medicare provider. In this case, the IDTF shared a waiting room/reception area with a physician from whom the IDTF leased its office. The decision reaffirms that the regulations only ban IDTFs and providers from sharing “practice locations,” and not waiting rooms, hallways or parking lots. This language allows IDTFs and other providers to share nonclinical spaces as long as they are careful not to share anything that may be considered clinical space. Moreover, all IDTFs that lease space from another provider should verify that their leases explicitly state that the IDTF has exclusive use of all such clinical spaces in case this issue is ever raised by their Medicare contractor.

While the DAB did not state that a contractual agreement between an IDTF and another Medicare provider that does not give an IDTF exclusive use of the practice space violates Medicare regulations as a matter of law, the fact that the IDTF's lease unambiguously stated that the IDTF had exclusive use of the suite clearly was an important factor in the DAB's decision to overturn the revocation of the IDTF's billing privileges.

Lastly, the DAB addressed the issue of whether an IDTF may lease space from a Medicare-

-enrolled individual without violating Medicare regulations. CMS argued that regulations barring an IDTF from leasing space *to* a Medicare-participating provider also meant that an IDTF could not lease space *from* a Medicare provider. The DAB rejected that argument, reasoning that the plain language of the regulation only banned an IDTF leasing to another Medicare provider, so the IDTF's lease from a doctor enrolled in Medicare did not implicate the prohibition. This ruling provides support for IDTFs who lease space from other providers, though IDTFs must be cautioned that they still cannot lease to other providers or they may face sanctions including the revocation of billing privileges.

This recent DAB decision sheds some light for providers on several issues including when an IDTF is considered a mobile, what space IDTFs may share with another provider without violating the IDTF space-sharing prohibitions, and clarifying that the prohibition on IDTFs leasing space to another provider does not impact an IDTF's ability to lease space from another provider. While there remains some open questions in the area of IDTF certification standards, this decision was an important step. Based on this ruling, IDTFs should contact their counsel to ensure that their business structure and leases are compliant and minimize the risk of revocation of billing privileges by CMS.

Bios Alicia Chandler is an attorney with Wachler & Associates, P.C. Ms. Chandler's healthcare practice focuses on Stark, fraud and abuse, and the Anti-Kickback statute. She also has significant experience in medical staff privileging, board certification disputes and commercial litigation.

Christopher J. Laney is an attorney with Wachler and Associates, P.C. Mr. Laney has experience defending Medicare audits, representing professionals in licensing disputes, and defending civil False Claims actions.

Source
http://www.wachler.com/CM/Custom/20110218%20IDTF%20space%20sharing%20FINAL%20doc.pdfenrolled individual

Call WCH your IDTF specialist

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George Osipyants,
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HEALTHCARE UPDATES

Medicare is considering removing the SSN from their ID

Congress has asked CMS to explore options for removing the Social Security Number from Medicare cards to reduce the risk of identity theft for Medicare beneficiaries. To protect beneficiaries from identity theft, the Medicare program needs to end the long delay in removing Social Security numbers from member ID cards, a new Government Accountability Office report urges. The subject of dropping Social Security numbers from Medicare cards isn't exactly new. For at least eight years, the Centers for Medicare and Medicaid Services has been toying with the idea, notes the GAO in its report, **CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards.**

Source: CMS.org

Medicare Advantage Plans

Delay in Standardization of the Prior Authorization List for UnitedHealthcare Medicare Advantage Plans and UnitedHealthcare West Medicare Advantage Plans - Now effective **Jan. 1, 2013**
Medicare Advantage Cardiology Prior Authorization Program, Medicare Advantage Part B Specialty Drug Prior Authorization Program and the Standardization of the Prior Authorization List for UnitedHealthcare West Commercial Plans proceed according to the previously communicated **Oct. 1, 2012** effective date.
As previously communicated in the July and September 2012 Network Bulletins, UnitedHealthcare is working to standardize its Prior Authorization programs in the coming months in support of improved administrative consistency and transparency. After **Oct. 1, 2012**, UnitedHealthcare will require Prior Authorization for a standardized list of procedures for UnitedHealthcare Medicare Advantage Plans, UnitedHealthcare West Medicare Advantage Plans and UnitedHealthcare West Commercial Plans. Standardization of the Prior Authorization Lists for UnitedHealthcare Medicare Advantage Plans and UnitedHealthcare West Medicare Advantage Plans will be effective **Jan. 1, 2013**. Please continue to request prior authorizations. Please continue to request

prior authorizations for UnitedHealthcare Medicare Advantage plans for the current list of services outlined in the 2012 Provider Administrative Guide until **Jan. 1, 2013**. Please note, the changes to the following programs and lists as described in the July and September 2012 Network Bulletins will proceed according to their original schedule and, therefore, those changes will still be effective on Oct. 1, 2012:

- Medicare Advantage Cardiology Prior Authorization Program
- Medicare Advantage Part B Specialty Drug Prior Authorization Program
- Standardization of the Prior Authorization List for UnitedHealthcare West Commercial Plans

Source: UnitedHealthcare

2013 CPT Coding Changes for Psychiatrists and Behavioral Health Providers

2013 brings big coding changes for prescribers and non-prescribers alike. On the psychiatry front, perhaps the most notable change is the elimination of the med-management code 90862. The 2013 CPT code book explicitly directs providers to report pharmacologic management in the absence of therapy with an evaluation and management (E&M) code. For the busy psychopharmacology provider or group practice, knowing your plan for transition from using 90862 to the equivalent evaluation and management code will help ensure your revenue cycle does not suffer disruption. The 908XX psychiatric code series (90807 and 90817, for example) which covered therapy with medical management for prescribers has been eliminated. Again, prescribers are directed to report medical management including therapy with an appropriate E&M code and one of the new 2013, prescriber-only, psychotherapy add-on codes based on the time spent in therapy. E&M codes, a territory where some psychiatrists might once have feared to tread, will now be an integral part of the billing required in the course of the psychiatric practice.

Other changes for behavioral healthcare CPT coding include the elimination and replacement of therapy codes in the 908XX series used by non-prescribers. The new psychotherapy codes have specific times rather than time ranges attached to their descriptions, but will follow the 15 minute CPT time rule ~ an important detail which will also require your investigation if you are not familiar with it. Historically, the time described in previous years was designated as *face-to-face* patient time. Time spent is now described

as time spent with the *patient and family/caregivers*. 90801 has been eliminated and replaced with two initial psychiatric diagnostic codes, one for prescribers (90791) and an initial evaluation code specifically for non-prescribers (90792). A new add-on code has been created for interactive complexity, to be used in tandem with the new therapy codes as appropriate. All other interactive psychotherapy codes have been eliminated from the 2013 CPT codes. A completely new code series has been added for crisis psychotherapy, primarily intended for non-prescribers, based on 60 and 30 minute increments of time spent in crisis therapy.

Source: valant.com

Important note to physicians ordering ancillary services and supplies

The claims filing requirements for certain ancillary services and supplies changed, effective **October 14, 2012**. On that date, Empire will implement Blue Cross and Blue Shield Association (BCBSA) claim filing requirements, based on ancillary provider type. This means that some independent lab, specialty pharmacy and DME ancillary providers, whose claims currently process in-network, have started to process out of network on **October 14, 2012**.

If you are an ordering physician, please be aware that Empire members' out of pocket liabilities could change for the specialty pharmaceutical, ancillary services and/or supplies that have been ordered. To avoid a negative impact on your Empire patients, and make sure that you are referring your patients to the correct ancillary provider, based on location; and then direct them to Empire's contracted provider networks.

Note: Other ancillary provider types, including Home Infusion Therapy providers, are not subject to this requirement. The mandate applies to all lines of Empire business except FEP.

Source: empireblue.com

An important tip for completing and submitting claims for newborns

When submitting newborn claims for your Empire patients:

- Newborn claims should be submitted with the baby's actual name.

Claims submitted with temporary names such as Baby, Baby boy, Twin A, etc. could result in denial. A new EOB message will be implemented shortly to identify such denials. The new EOB message which will appear on both member and provider EOBs will state, “We were unable to accurately apply benefits on this claim as it was submitted without the newborn's complete name. The facility / provider should re-submit this claim for reconsideration with the baby's complete name versus 'baby boy', 'baby girl' or any other description”"Please remind the new parents to enroll their newborn as soon as possible.

- Remember, submissions with all correct information will speed the processing of claims, so please double check your claims prior to submission

Source: empireblue.com

Medicare Advantage Medical policy update

Based on Medicare National Coverage Determination 270.3, code S0157 (Becaplermin gel 0.01%, 0.5 gm) will no longer be reimbursable effective 2/16/13.

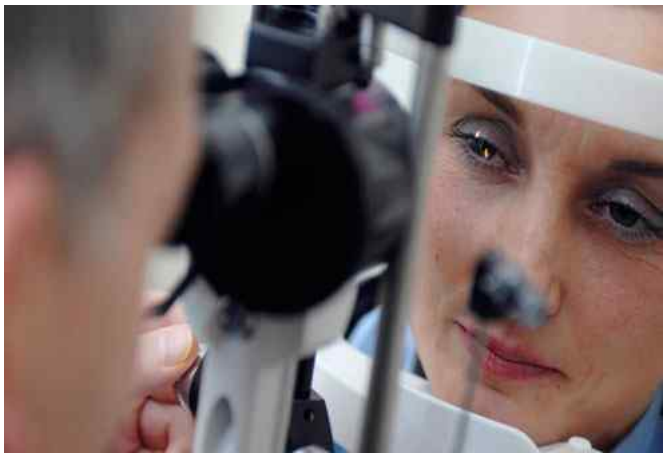
Source: empireblue.com

Glaucoma Screening Covered for Individuals at High Risk

The American Academy of Ophthalmology and American Optometric Association suggest that **glaucoma screening is more useful and cost-effective when it is targeted at populations at high risk for glaucoma**, such as older adults, those with a family history of glaucoma and African Americans and Hispanics. Empire is dedicated to improving glaucoma screening rates and reducing the prevalence one of the leading causes of blindness. Empire covers glaucoma screening for individuals at high risk for this condition. Glaucoma screening is a component of a comprehensive eye exam, which may include measuring intraocular pressures (IOP), measuring other dimensions of the eye, visual field testing, and a dilated eye exam. Empire is committed to ensuring promotion of eye exams. Members without claims evidence of an eye exam last year or year to date will be contacted by our Outbound Call Center and will be given the recommendation to speak with their provider(s) about this important test.

Eye exams for glaucoma should be performed by an eye care professional and should be coded according to the National Correct Coding Initiative.
In recognition of the importance of this screening, performance is measured as part of the Healthcare Effectiveness Data and Information set (HEDIS) and Medicare Plan Quality and Performance Ratings, which may commonly be referred to as Medicare Plan Star Ratings. The following codes are used to report and document the completion of a glaucoma screening exam for initiatives that adhere to HEDIS specifications.

Source: empireblue.com



OIG Blesses Pre-Authorization Services

The U.S. Dept of Health & Human Services' Office of Inspector General (OIG) has issued Advisory Opinion 12-10 approving a radiology group's proposed program offering free pre-authorization services to referring physicians and patients. Although the party responsible for obtaining pre-authorization varies, the radiologists may be denied payment by the insurer if pre-authorization is not obtained.

The radiology group proposed to offer to obtain any required pre-authorization from insurers by contacting the insurer, disclosing its role in seeking pre-authorization, and providing the necessary documentation to show medical necessity and other information needed for pre-authorization, and to make the program free and available on an equal basis to all patients and referring physicians, without regard to value or volume of referrals made to the radiology group.

Although performing such services on behalf of referring physicians could violate the Anti-kickback statute, the OIG would not seek to impose sanctions because the program:

- does not target any particular referring physicians nor involve payments to referring physicians;
- makes no assurances that its pre-authorization services would result in pre-authorization approval;
- would be transparent, with the radiology group disclosing the nature of its pre-authorization program to insurers;
- reflects the radiologists' legitimate business interest because payment for its imaging services are at stake.

Source: albmed.org

Medicaid covers interpreter services

Effective **October 1, 2012**, Medicaid fee-for-service will reimburse outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Effective **December 1, 2012**, medical language interpreter services will also be reimbursed by Medicaid Managed Care and Family Health Plus plans in accordance with rates established in provider agreements or, for out-of- network providers, at negotiated rates. Patients with limited English proficiency shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013-sign language and oral interpretation services and is billable during a medical visit. Medical language interpreter services are included in the prospective payment system rate for those FQHCs that do not participate in APG reimbursement.

HCPCS Procedure Code T1013	Office-Based Practitioners	Article 28, 31, 32 and 16 facilities that bill with APGs
One Unit: Includes a minimum of eight and up to 22 minutes of medical language interpreter services.	$11.00	$11.00
Two Units: Includes 23 or more minutes of medical language interpreter services.	$22.00	$22.00

Source: health.ny.gov

2013 eRx Significant Hardship Exemption Request

Beginning **November 1, 2012**, The Centers for Medicare and Medicaid Services (CMS) will re-open the Quality Reporting Communication Support Page to allow individual eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption for the 2013 eRx payment adjustment. Significant hardship request should be submitted via the Quality Reporting Communication Support Page (Communication Support Page) on or between **November 1, 2012 and January 31, 2013**. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Important — Please note that this is for the 2013 eRx payment adjustment only. Hardship exemption requests for the 2014 payment adjustment will be accepted during a separate timeframe later in calendar year 2013.

Source: CMS.org

Oxford Fined for Failure to Explain Coverage:

The NYS Department of Financial Services (DFS) has announced that Oxford Health has been fined $665,000 for failing to explain coverage to its health plan members. Oxford was cited for approximately 300,000 instances of failing to provide explanation of benefit statements (EOBs). State law requires that the EOB explain what services the plan covers and how consumers can appeal when they believe claims are improperly denied. The violations are cited in an Examination Report undertaken by the NYS Department of Insurance (the predecessor to DFS) for the period **October 1, 2001** through **December 31, 2008**. Oxford failed to send EOBs for certain claims, and in certain instances failed to provide specific explanation of any denial, reduction or other reasons for not providing reimbursement for the amount claimed. The two Oxford companies fined are Oxford Health Plans NY, Inc., and Oxford Health Insurance, Inc. Oxford responded that the violations were not the result of any conscious policy to evade the requirements of the Insurance law or regulations. Oxford must submit a corrective action plan to DFS within 60 days of the approval of the Stipulation it agreed to with DFS.

New York ACO Law Amended:

Governor Cuomo has signed into law legislation that provides significant amendments to the New York State law governing accountable care organizations (ACOs) in the state, effective October 3, 2012. New York's ACO law, enacted in March 2011 as a demonstration program, provided that an entity that wants to operate as an ACO in the state must obtain a certificate of authority (CA) from the NYS Commissioner of Health. The Commissioner was to issue regulations establishing the criteria for the issuance of a CA and was limited to issuing no more than 7 CAs. To date, the Commissioner has not issued regulations for the issuance of CAs and no CA has been issued to any applicant to operate as an ACO in NY. Moreover, there has been uncertainty whether the law, including the requirement to obtain a CA, would apply to ACOs that are approved by CMS to participate in the Medicare Shared Savings Program. The new legislation amends the ACO law to remove the 7 CA limit and requires the Commissioner to establish a program to promote and regulate ACOs. In addition, an ACO approved by CMS may apply for a CA as a "Medicare-only ACO" and the Commissioner "shall" issue such certificate to an entity that documents its status as approved by CMS. The CA will apply only to the Medicare-only ACO's actions in relation to Medicare beneficiaries under its authorization from CMS.

Source: Kaern Augustine Conroy & Schoppmann, P.C.

Podiatry Services Expanded to Include Adults with Diabetes (NY Medicaid)

The New York State Medicaid program will expand podiatry coverage to permit Medicaid eligible individuals, age 21 and older, who have a diagnosis of Diabetes mellitus to obtain care from a private practicing podiatrist.
For Medicaid fee-for-service (FFS), this change is **effective November 1, 2012.** For Medicaid managed care and Family Health Plus (FHPlus) enrollees this change is **effective December 1, 2012.**
Currently, Medicaid FFS covers medically necessary podiatry services provided to all eligible recipients, regardless of age or Medicare status, when provided in Article 28 hospital outpatient departments and diagnostic and treatment centers. In addition, Medicaid FFS reimburses for podiatry services provided in a private practicing podiatrist's office for enrollees who are under 21 years of age and to enrollees that have both Medicare and Medicaid (when Medicare has approved payment).

Source: health.ny.gov

CMS details Medicaid primary-care payments boost

The CMS issued a final rule temporarily increasing primary-care physician payments from Medicaid.

The rule, which implements a provision of the Patient Protection and Affordable Care Act, details the extent and target of the increase, which takes effect in January and lasts through 2014.

The provision is designed to match Medicare rates, but the rule specifically covers only the difference between the Medicare rate and states' Medicaid rates as of July 1, 2009. The additional federal funding may not be enough to increase the rate to Medicare levels because some states have enacted Medicare provider rate cuts since middle -2009.

The rule specifies that federal funding will be provided to states to increase payments for physicians practicing in family medicine, general internal medicine, pediatric medicine and related subspecialties. It also clarifies, that primary-care services provided by practitioners working under the personal supervision of any qualifying physician can qualify for the higher payment rate.

The CMS, in the rule, gives states several options for implementing the rate increase in fee-for-service and managed-care settings. For example, states either can pay in accordance with all Medicare locality adjustments within the state or develop a rate for each code based on the mean Medicare rate for all counties in the state.

Source: CMS.org

NEWS BY SPECIALTY

Cardiology

- For a calcium coronary score you should use:

When calcium scoring is performed alone, assign code 75571 (computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium). Never assign this code when the CT is performed with procedures identified by codes 75572–75574, because it is considered a component of these codes.

- The coding of the coronary angiography depends on the medical necessity for it. For example, if a diagnostic coronary angiogram is ordered and performed prior to the stent placement, assign 93454-59 (catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation) as well as 92980 for the stent placement.

However, if a previous diagnostic study was performed and the patient is returning for a staged interventional procedure, the coronary angiogram would not be coded unless there is medical necessity such as the patient's signs and symptoms have changed since the previous study.

Source: panaceahealthsolutions.com

Radiology

Sometimes the radiopharmaceutical is injected for intra-operative use (breast cancer surgery/parathyroid surgery). You should consider two codes. For the breast cancer surgery, you are probably doing a sentinel node injection. If no images are taken, then the following code is used for the injection: 38792—injection procedure; radioactive tracer for identification of sentinel node. If images are taken, assign instead code 78195—lymphatics and lymph nodes imaging (i.e., not 37892).

In other cases, particularly parathyroid, where you are injecting a radiopharmaceutical and sending the patient to surgery without imaging, assign the following code:

- 78808 Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)

You would also assign the appropriate A-code for the radiopharmaceutical used.

If radiographs have to be repeated in the course of a radiographic encounter due to substandard quality, only one unit of service for the code can be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service should be reported, even if the patient was released from the radiology suite and had to return for additional services. Also, the CPT descriptors for many of these services refer to a "minimum" number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service should be reported. However, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate.

Source: CMS.gov

STATES UPDATES

Aetna, Cigna announce accountable care initiatives

Two major insurers separately announced new accountable care initiatives.

Aetna said it entered into a **risk-sharing accountable care contract** with PrimeCare Medical Network, a group of independent physician organizations in California.

Meanwhile, Cigna Corp. has added nine new ACOs and expanded its accountable care efforts into Nevada and Oregon. Cigna's total ACO count now stands at 42.

Under Cigna's accountable care agreements, the insurer will pay providers for medical and care-coordination services, and providers will be eligible for performance-based payments tied to quality and cost targets.

Source: Cigna

Massachusetts launches statewide health info exchange

Massachusetts launched a statewide health information exchange that will allow healthcare providers to share electronic health information as they seek to improve coordination of care, lower costs and increase patient safety.

Source: modernhealth.com

Washington becomes second state CMS approves for dual eligible-targeted program

The Centers for Medicare & Medicaid Services has approved a second state to start a demonstration project aimed at improving care for dual eligibles.

HealthPathWashington, a voluntary program, will integrate services and establish “health homes” to bring Medicare and Medicaid-eligible beneficiaries better care. The state is projected to save nearly $14 million over five years and will focus on 30,000 of its dual eligibles at the highest risk for poor outcomes.

CMS is pushing states to build financial models that improve care and reduce cost of dual eligibles. Washington is the first approved state to try a fee-for-service payment model.

Source: CMS.org

Group of Arkansas doctors return to medical marijuana

Dozens of doctors from around Arkansas say they're supporting a proposal that would make the state the first in the South to legalize medical marijuana.

Arkansans for Compassionate Care released a list of 79 doctors from around the state who support the proposed initiated act on next week's ballot. The measure would allow patients with qualifying conditions to buy marijuana from nonprofit dispensaries with a doctor's recommendation.

Seventeen states and the District of Columbia have legalized medical marijuana in some form.

Source: sfgate.com

QUESTIONS AND ANSWERS

Question:

♦ What kind of reporting does WCH provide for my practice? Can reports be customized?

Answer:

♦ WCH provides a large variety of reports from basic to specially detailed to fit the client's requests. Some of the customized reports include: average report, patient responsibility report, 1099 amount by insurance, payment provider within a practice, and many other reports that may be requested. Some of our standard reports include: amount of claims billed within a certain time frame, claim's notes, outstanding details, total visits, processed claims, etc. Standard reporting of the billing and collection activities are provided at a weekly basis.

Olga Khabinskay,
General Manager
olgak@wchsb.com

Question:

♦ What are the financial benefits of participation in the Physician Quality Reporting System (Physician Quality Reporting, formerly called PQRI)?

Answer:

♦ A Physician Quality Reporting participant who reports satisfactorily will earn a financial incentive based on a percentage of the Medicare Part B Physician Fee Schedule (PFS) total estimated allowed charges for covered services provided during the longest or most advantageous reporting period for which the professional satisfied criteria for at least one reporting option.

Source: CMS.gov

Question:

♦ What is the Advanced Payment Initiative of Accountable Care Organization (ACO)?

Answer:

♦ Advance payments are structured in this manner to acknowledge that new ACOs will have both fixed and variable start-up costs. CMS's Advance Payment Initiative is for health care providers and stakeholders with limited financial resources to invest in the infrastructure and staff development necessary to participate in the MSSP. Through this initiative, selected organizations will receive an advance on the shared savings they are expected to earn. Participating ACOs will receive three types of payments, according to CMS:

- *An up-front, fixed payment*: Each ACO will receive a fixed payment.
- *An up-front, variable payment*: Each ACO will receive a payment based on the number of its historically-assigned beneficiaries.
- *A monthly payment of varying amount depending on the size of the ACO*: Each ACO will receive a monthly payment based on the number of its historically-assigned beneficiaries.

Question:

- Is Medicare the only payer participating in ACOs or offering incentives for shared savings? What other payers are adopting this delivery model or a similar incentive program?

Answer:

- Medicare is not the only payer participating in ACOs and offering incentives for shared savings. Private payers such as Humana, WellPoint, United, Aetna and Cigna are actually significantly ahead of Medicare in this activity. These companies, as well as private groups such as Premier, have also been piloting efforts in this area. In recognition of the advances already made by some private payers and integrated health systems, the CMS Center for Innovation introduced the Pioneer Program, which is similar to the Medicare Shared Savings program but allows private payers to participate with providers who are more sophisticated with coordinated care.

Source: cap.org

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.

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