WCH BULLETIN

September 2012
VOLUME 3
ISSUE 8

New ICD-10 Deadline - October 1, 2014

Major Changes in Therapy as of October 1st

Improvements in the Billing Department

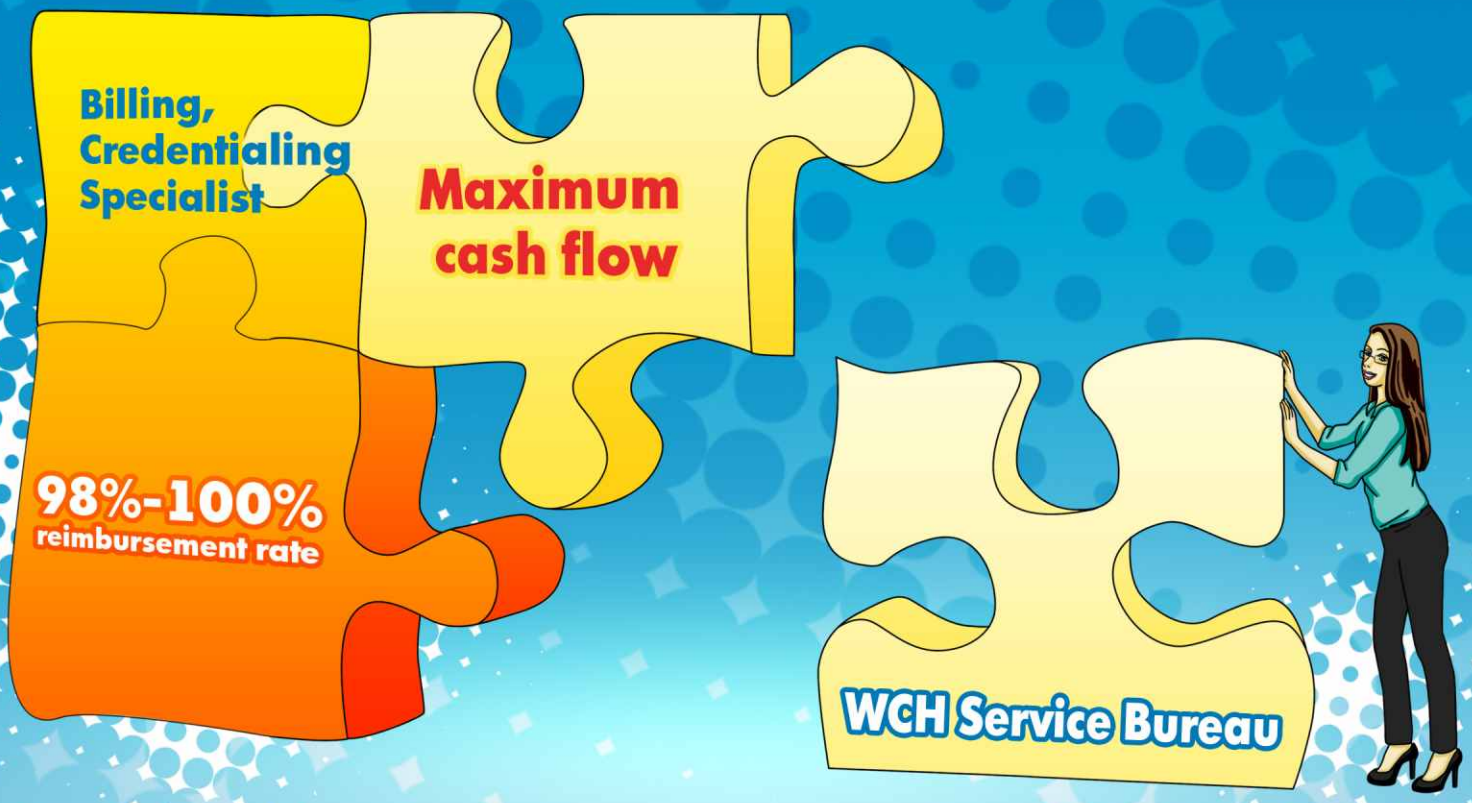
Sign up for CEU credits

We reached 1184 readers!

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

WCH -

An integral part of the successful medical practice



#1 Medical Billing and Credentialing Company

Adress: 3047 Avenue U, Brooklyn NY 11229 // Phone: 888-WCHEXPERTS //
Fax: 347-371-9968 // E-mail: olgak@wchsb.com // www.wchsb.com

INSIDE THIS ISSUE:

WCH BUZZ

MEET OUR BILLING DEPARTMENT MANAGER OKSANA POKOYEVA!

Today, we're excited to introduce Oksana Pokoyeva, as our Billing Department Manager. We are confident that with Oksana Pokoyeva experience, knowledge and well established relationship with insurances vendors will streamline all billing processes and increase your practice revenue and ensure that the accuracy of your medical data to be parallel to the guidelines and requirements of the healthcare industry.

We wanted our readers to learn more about Oksana, so we have prepared a brief interview that will provide outline of her growth in the Billing Department and give you inside look into her personal achievements.

What has your biggest achievement been at WCH?

- Biggest achievement in WCH is becoming a manager of billing department. Result most proud of is certified medical records auditor.

What are your day-to-day job duties?

- I got a lot of things under my control and things that i have to still achieve in the billing department.

Right now I am working on:

- Developing new suggestions and ideas pointed at improvement of the work of the billing department.
- Coordinating department activity.
- Control quality of assignable services.
- Control quality assurance report, account review, work reports and outstanding reports and also indirectly of responses from clients.
- Settling of controversial issues which is appeared in process of work between billers and clients.

But mainly I make sure that all processes in department run smoothly.

How did you get into the field and into your current position?

- In 2007 I started to work in WCH on a clerical position. I've learned a lot since the time I first started to work in the company. With support of Alex and Olga, I successfully passed my first AAPC examination in 2009 and second in 2010. Right now I'm working on my next certification in specialty coding. I think that interest in what I do and constant learning got me where I am now.

What are the best skills or knowledge to have in order to be successful in job?

- Knowledge of medical billing, coding, WCH processes, technical skills, Health Insurance Portability and Accountability Act (HIPAA) as well as good interpersonal skills.

Describe yourself in five words.

- Strong personality, straight forward, hard-working, practical, serious.

IMPROVEMENTS IN THE BILLING DEPARTMENT

WCH is continuing to grow and expand our departments! The billing department has reached over fifty employees. We are proud to introduce our departments management staff below.

Oksana Pokoyeva,
CPC, CPMA,
Billing Department Manager
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Supervisor
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NEW DEPARTMENT SOCIAL MEDIA

We are pleased to introduce **our new Social Media Department.**
The department will promote WCH services through different channels of marketing:

Please Join Us!

- http://www.facebook.com/pages/WCH-Service-Bureau-INC/184161778305225
- http://twitter.com/#!/wchsb
- http://www.linkedin.com/pub/olesya-petrenko/39/401/469
- http://plus.google.com/u/0/b/113208148387381098226/113208148387381098226/posts
- http://wchsb.blogspot.com/
- http://www.youtube.com/user/TheWchsb

Department will push the WCH into new social media spaces, drive innovation and online communication programming in this arena, provide platform for real-time conversation, collaboration and idea sharing.

WCH PANTHERS-RACE FOR CURE 2012

On **September 9, 2012**, WCH has taken part in **2012 Komen New York City Race for the Cure** in Central Park. As the world's leading breast cancer organization, Susan G. Komen for the Cure is committed to ending breast cancer. We were honored and privileged to take part of such an extraordinary event that not only benefited the foundation by helping them reach the goal of $6 million, but also to promote awareness of local breast cancer screening, education and outreach programs. **WCH set goal to reach $500** with help of our clients and our dedicated staff we are getting closer to the goal. If you wish to support our team WCH Panthers and The Susan Komen Foundation please make the donation by following this link:
http://www.komennyc.org/site/TR/Race/race2012-wide?team_id=45521&pg=team&fr_id=1280

Sign up for CEU credits

DEAR READERS,

We are proud to announce that all our publication effective **9.12.12** were approved for CEU credits: WCH Bulletin and WCH Times have been each approved for 1 CEU credit by AMBA - American Medical Billing Association.

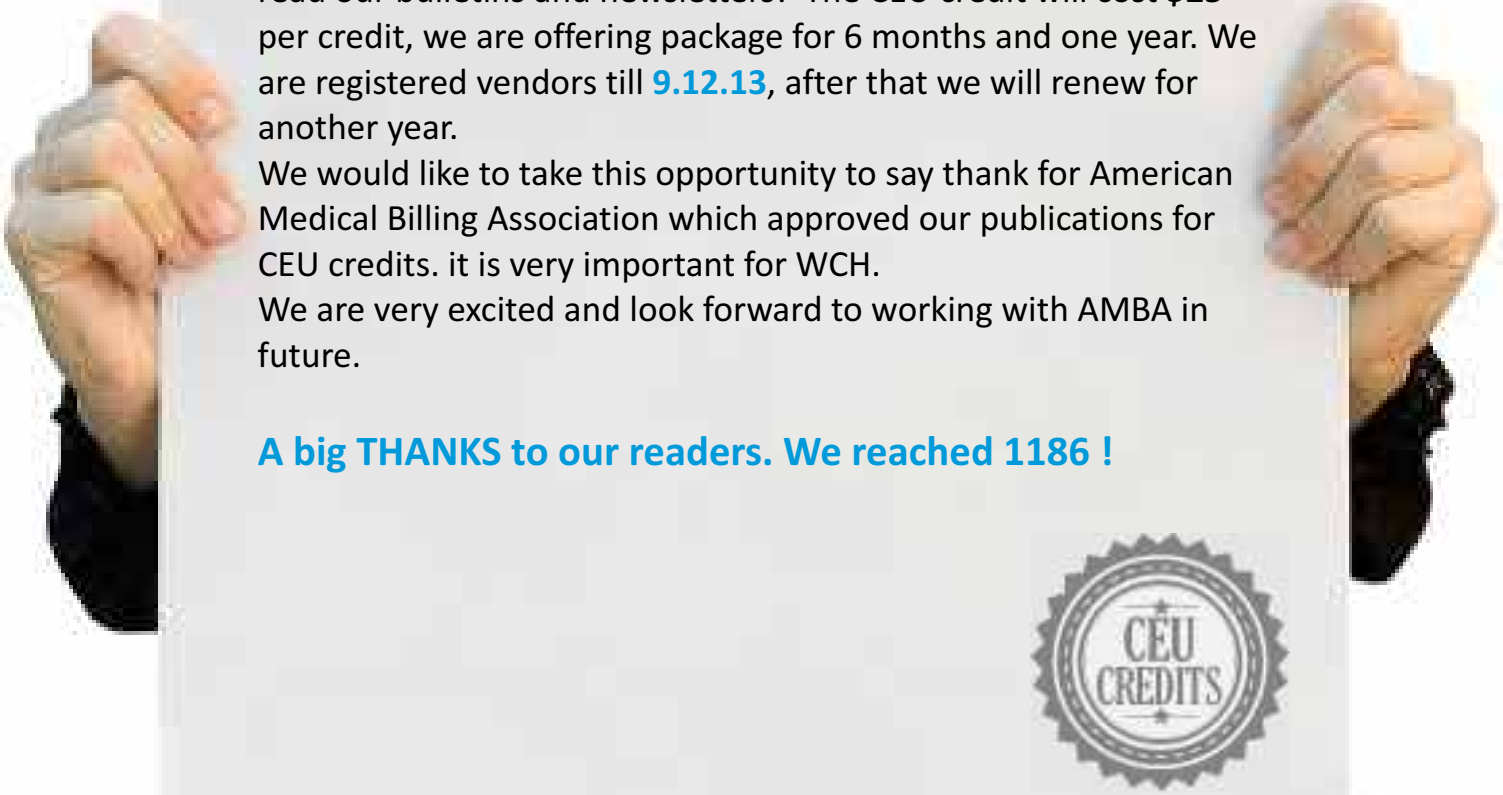
Which mean our readers can benefit even more!!!

Every year our readers are able to get 12 credits for reading our issues. Don't lose your chance to receive 12 CEU credits per year, read our bulletins and newsletters! The CEU credit will cost **$25** per credit, we are offering package for 6 months and one year. We are registered vendors till **9.12.13**, after that we will renew for another year.

We would like to take this opportunity to say thank for American Medical Billing Association which approved our publications for CEU credits. it is very important for WCH.

We are very excited and look forward to working with AMBA in future.

A big THANKS to our readers. We reached 1186 !



We now submit directly to New Jersey Medicaid!

WCH is 5010 compliant with NJ Medicaid Program and we are approved as direct vendors to submit claims. We can assure you that your claims are in good hands.

MEDICAL AUCTIONS

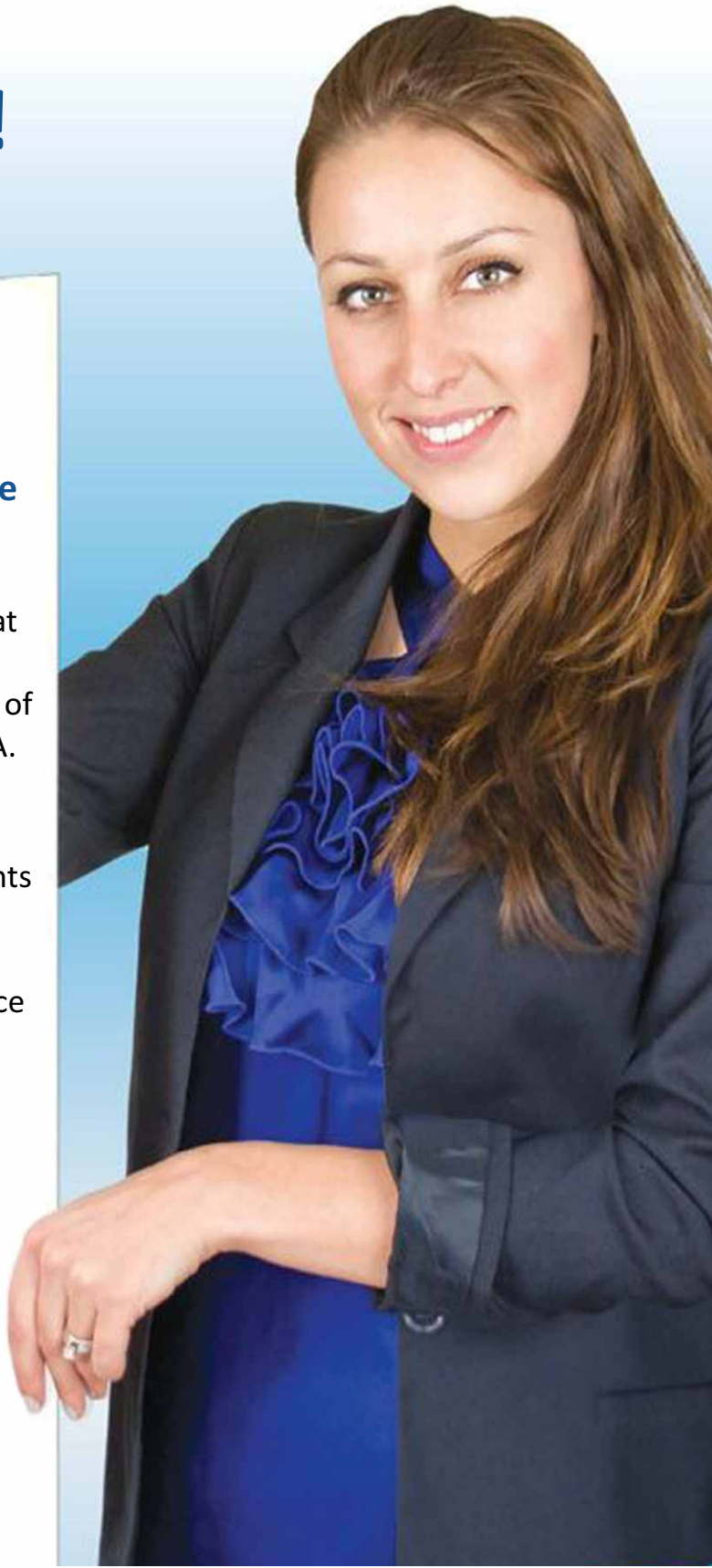
Clients asked us to find more useful information about websites for doctors where they can search medical and hospital equipment, likes as the advertising website for new and used medical equipment for sale or wanted. Here you are some of most popular websites:

1. http://www.dotmed.com/
2. http://www.centurionservice.com/auctions.php#151
3. http://www.slapsale.com/item_listings.aspx?cid=775856496
4. http://www.icollector.com/Electronics-and-Medical-Equipment_as11649_p4
5. http://www.auctionmart.com/
6. http://www.amberusa.com/
7. http://www.shopspecialtymed.com/
8. http://www.rasmus.com/auction_detail.php?id=157826

NEWSLETTER & BULLETIN

THAT WILL BOOST YOUR BUSINESS!

Advertise With Us!



Looking for a way to promote your practice or business?

Advertising in WCH bulletin or newsletter is a great way to leverage your advertising dollars and grow your business. The publication is distributed to all of WCH members and medical office around the USA.

Benefits:

- Get CEU Credits
- Your business will reach over thousand recipients
- You can use as much space to talk about your business
- Our publications are read by physician and office manager - decision makers

For more information please contact
Olga Khabinskay, General Manager at
888-924-3973 (x 1201) or olgak@wchsb.com

CREDENTIALING NEWS

WCHSB Credentialing Department is happy to help our clients to obtain Civil Surgeon Designation.

Who is Civil Surgeon?

A Civil surgeon is a doctor, selected by the United States Citizenship and Immigration Services (USCIS) to conduct medical examinations of aliens in the United States who are applying for adjustment of status to permanent residence, or who are required by the USCIS to have a Medical Examination (Form your practice an additional income for I-693). A physician without designated civil surgeon privileges cannot conduct Medical Examinations or complete any medical forms related to USCIS.

What documentation WCH needs to start the process?

Those Doctors that are interested in being

- registered as a Designated Civil Surgeon should submit the following documentation to WCH:
- A copy of a current medical license;
- A current resume that shows 4 years of professional experience, not including a residency program;
- Proof of U.S. Citizenship or lawful status in the United States;
- Two signature cards (WCH will provide this form).

What will WCH do?

WCH will prepare a detailed letter to the District Director in the provider's service location area requesting consideration for a physician to become Designated Civil Surgeon. Our credentialing specialist will attach all above requested documents and submit it for process to the District Director. WCH will monitor on monthly basis the process of the request and provide the client with the feedback of the ongoing status. Please keep in mind that decision of the District Director can take up to six months. Registration in USCIS as a Civil Surgeon may give your practice an additional income for performing Civil Surgeon Services.
Your name and the location of your practice will be listed on the www.uscis.gov and it will be available to the public. Those patients that will be in need of this service will be able to find the Doctor by the last name on the website.

Please contact credentialing department for additional information or questions by phone **718-934-6714 1102** or email credentialing@wchsb.com.

Dora Mirkhasilova,
Credentialing Specialist

HEALTHCARE UPDATES

MAJOR CHANGES IN THERAPY AS OF OCTOBER 1ST

Effective **October 1, 2012**, according to the Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through **December 31, 2012**, and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1,880 for occupational therapy services and $1,880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

MCTRJCA also established a requirement for manual medical review of claims over $3,700. To implement this law, providers shall be assigned to one of three specific phases by CMS. The requirement for pre-approval of all therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. CMS will publish a list of providers and the respective phases in which they are placed.

In addition, CMS sent a mailing to every provider subject to the therapy manual medical review threshold notifying them of the respective phase in which they have been placed CMS is implementing this process in phases in order to ensure a smooth transition to the new process. **Effective dates for the phases are:**

- Phase I: October 1, 2012 - December 31, 2012
- Phase II: November 1, 2012 - December 31, 2012
- Phase III: December 1, 2012 - December 31, 2012

All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, and physicians shall be **approved or disapproved in advance**. Settings include Part B SNF, CORF, ORF, private practices, Rehabilitation agencies, and Hospital Outpatient Departments. Occupational therapy provided above $3,700 shall also be approved in advance. There are no automatic exceptions. The provider shall send a request for approval to WPS in advance of providing a service. A request for preapproval of up to 20 additional treatment days of services is allowed. Any claims submitted without a preapproval notice will be subject to pre-payment review.

Manual Medical Review for Therapy Claims

1. How am I going to know that the individual benefit is above 3,700?

- We have a change request that will be in effect starting October which will allow, via the HIPAA Eligibility Transaction System, to see the total amount of therapy provided. Those will give providers information as to where the beneficiary stands at that time and will be able to request an exception for services expected to be above.

2. So, to go over this again, any claim about $3,700, people can request an advance exception. If a claim is not received with an advance exception, it will be stopped for prepay review. If an advance exception is requested, there'll be a 10-business-day review time. And if the contractor (inaudible) does not review the claim in 10 business days, the claim will be deemed to be approved and the provider will receive a notice as such.

3. For people that are above 3,700 but are not in the phase, the claims will be treated the same as claims above 1,880 but below 3,700, meaning they need to have a (caps) modifier. But they'll still be treated the same way until your specific date goes into effect.

4. What is the threshold and how is it determined?

- Well, the threshold is 3,700. And there's a separate threshold for P.T. and speech language and a separate threshold for O.T.

5. What does the $3,700 represent?

- The $3,700 represents the total allowed charges under Part B for services furnished by any type of Part B provider who can provide therapy services other than a critical access hospital.

6. What are the phases?

- Phase one is October 1, 2012 to December 31. Phase two is November 1 to December 31. Phase three is December 1 to December 31.

7. How do I know which phase I am in?

- Each provider, subject to the manual medical review process, will be notified via U.S. Mail. They will also post a – making a posting to the cms.gov website which will list all the providers and by phase.

8. How did CMS come up with the phases?

- The phases were developed taking into account specific provider characteristics such as claims volume, the historical number of beneficiaries over the cap and total amounts of payment. And then, we adjusted the workload among the contractor to spread it – spread the workload out.

9. What are the guidelines CMS contractors will use when conducting review?

- The contractors will use the coverage and payment policies contained in Section 2220 of the Medicare Benefit Policy Manual or any local – applicable local Medicare coverage decisions for making decision on whether to bill a service shall be preapproved

10. Contractors have 10 business days from receipt of all requested information to count towards an exception. What happens if the contractor doesn't make an exception in 10 business days?

- If there is no exception granted in 10 – no decision made in 10 business days, there will be an automatic approval of the request.

11. If the provider doesn't request an exception and a claim for therapy services is provided, what happens when the claim is submitted?
- And in that case, the claim will be stopped and prepayment review would be conducted.

12. If I'm at phase two or three, is – would a contractor be reviewing my claims before the timeframe?
- The answer is likely no. But a contractor can review any claim at any time. And there might be circumstances where an individual provider put on a provider-specific review. And therefore, that rule would apply as opposed to this general notice of review.

13. So, how many days can I request an exception for?
- We will allow people to – providers to request up to 20 therapy days to be approved in advance. So, you can get an advance exception for up to 20 therapy days.

14. What happens if I don't request preapproval?
- Or, if I did request preapproval for 20 therapy days but I actually provided 30? Under that circumstance, that claim would be subject to a prepayment review.

15. Whenever you request the advance exception, is there a form or something that we have to fill out. No. But we're going to have a cover sheet which will be part of the instruction which will be just, basically, demographic information about the beneficiary. All that detail will be provided in the detailed materials for whoever you bill, whatever medical contractor you bill. All that information will be there. But it will basically just be like a cover page identifying you, the bene. And then, attached to that will be things like the order, the plan of care and medical documentation to support the request.

Source: CMS.org
http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODFSpecialODF.html

Please contact billing department for additional information or questions.

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CMS UPDATE:

Nearly 16,000 providers were sent revalidations in July 2012. Expect to see many more sent each month through 2015.

You only have 60 days to submit a complete revalidation starting the day your letter arrives!

CMS is aggressively pushing online PECOS as the method of choice for submitting enrollment applications or changes.
Learn how to handle not just revalidation, but also new providers, ownership changes and every other enrollment update as we cover:

1. **Enrollment and revalidation for beginners -** A pre-conference that explains terminology, 855 forms deadlines and more, with quizzes and prizes.
2. **Using online PECOS starting from scratch -** For anyone with or without previous experience with CMS's Internet system.
3. **Hidden compliance risks within the Medicare billing privilege process –** Learn how Medicare rules such as incident-to billing, site-of-service, and 3-day payment window affects enrollment and revalidation.

As soon as you have received revalidation letter from Medicare you are advised to contact WCH Credentialing Department. Our Credentialing specialists will assist you to pass revalidation process within the time frame.

Please contact credentialing department for additional information or questions by phone **718-934-6714 1102** or email credentialing@wchsb.com.

Source: CMS.org

EVALUATION AND MANAGEMENT SERVICES – MULTIPLE SERVICE SAME DAY

Based on a recent analysis of claim submissions National Government Services has identified a pattern of claim submissions of Evaluation and Management (E&M) services for the same patient, on the same date of service by the same rendering provider.

According to Medicare regulations, only one E&M service may be billed per day, per patient. (The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-4, Chapter 12, Section 30.6, “Evaluation and Management Service Codes - General”

In some instances, physicians may see a patient multiple times on a given day, or in multiple settings. Except in rare circumstances outlined in the above manual section, only the highest level of E&M service rendered on that date should be billed. For example, if a patient is examined in the office and later examined

and admitted into the hospital, the physician would report the hospital admission as the E&M service rendered for that day.

Effective **10.15.2012**, if a physician submits two E&M services for a patient in a single day then Medicare will deny the claim for the second service. For services provided in the office setting that were unrelated and could not have been provided at the same time, please request a redetermination with the supporting documentation of the second E&M services. If the services were an inpatient visit followed by critical care, please request a redetermination with the supporting documentation. National Government Services cannot accept these situations as reopening requests.

In the case of group practices, Medicare pays for one Evaluation and Management (E&M) visit in a day provided to a patient by the same physician or a member of the same group with the same specialty. If multiple visits are provided, the group should select a level of service representative of the combined visits and submit the appropriate code for that level. This does not apply to physicians who are in different groups or physicians in the same group with different specialties.

Source: www.cgsmedicare.com

MEDICARE OVERPAYMENT REQUESTS. THE OVERPAYMENT PROCESS

When it has been determined that a physician/supplier has been overpaid, a refund request will be sent to the physician/supplier. An initial demand letter (i.e., overpayment letter) is issued and will identify the services that triggered the overpayment process. Two items in the demand letter warrant immediate attention; one is the 13-digit claim control number (CCN). The physician/supplier must reference the CCN in any communication with Medicare. The CCN is used to track the overpayment.

The physician/supplier has 30 days from the date of the demand letter to refund Medicare

If full payment is not received by the 40th day from the date of the initial demand letter, the offset process (i.e., deducting payment from the physician/supplier's Medicare check) will begin. Future payments will be offset until the overpayment is recouped. The offset process is placed on hold if a Section 935, Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eligible debt is in the appeal process.

If the offset procedure has begun and payment is subsequently received, interest will be deducted, the amount that had already been applied by offset will be deducted and the balance returned to the physician/supplier—unless there are other debts due to Medicare.

Source: www.wpsmedicare.com

ATTENTION NATIONAL GOVERNMENT SERVICES MEDICARE PROVIDERS IN NEW YORK AND CONNECTICUT: NGSMedicare.com Code Pricing Search Tool Coming September 10th

Now The new Code Pricing Search tool is available and gives you quick access to valuable fee schedule pricing information for most Medicare-covered procedure codes in just a few clicks.

How to Access

Access the new Claim Pricing Search tool from any of the following site areas:

- Claims side menu
- Claims > Fee Schedules landing page
- Self-Service Center > Transactions category

How it Works

- 1. Select a fee schedule type from the drop-down menu, then enter the following information:
- Date of Service
- Procedure Code
- Region, Area (if applicable), and County (when applicable) where the service is performed

2. Select Submit

Once the information is validated, the following Medicare fee-for-service (FFS) information will be returned (if applicable):

- Payment amounts (e.g., participating/nonparticipating, facility rates, RVUs, etc.)
- Effective date for payment amount
- Description (if available)
- Policy indicators for Medicare physician fee schedule (MPFS) pricing only (e.g., global surgery days, bilateral/multiple surgery indicators, etc.)
- Status of procedure (MPFS pricing searches only) (e.g., active/inactive, bundled, etc.)

See an Example

Upon selecting Submit, the following Medicare FFS information is returned and appears below the search form:

PROCEDURE CODE ?	99201
EFFECTIVE DATE ?	01/01/2012
STATE/TERRITORY ?	13202
LOCALITY ?	02
SHORT DESCRIPTION ?	Office/outpatient visit new

NON-OPPS CAPPED PAYMENT RATES (NON-OPPS) ?						
MODIFIER ?	NON FAC PAR ?	NON FAC NON PAR ?	NON FAC LC ?	FAC PAR ?	FAC NON PAR ?	FAC LC ?
(Details)	49.22	46.76	53.77	29.00	27.55	31.68

Selecting the (Details) links provides you with MPFS policy indicator data (available for MPFS code searches only).

Note: You may hover over any of the question marks to view field descriptions.

Modifier Selected: (blank)			
Status ?	A	Global Surgery ?	XXX
Conversion Factor ?	34.0376	Facility Pricing ?	1
Update Factor ?	1	PC/TC ?	0
Work RVU ?	0.48	Preoperative Percentage ?	0%
FAC PE RVU ?	0.00	Interoperative Percentage ?	0%
NON FAC PE RVU ?	0.73	Postoperative Percentage ?	0%
Malpractice RVU ?	0.04	Multiple Surgery ?	0
Work GPCI ?	1.049	Bilateral Surgery ?	0
Practice GPCI ?	1.212	Assistant At Surgery ?	0
Malpractice GPCI ?	1.441	Two Surgeons ?	0
Reduced Therapy Amt ?	0.00	Team Surgery ?	0
Endoscopic Base ?			

Source: NGSMedicare.com

HELP YOUR PATIENTS SAY YES TO HIV TESTING

As a result of changes to New York State Public Health Law, health care providers in NY are required to offer voluntary HIV tests to patients 13 to 64 years old. The law applies to anyone receiving treatment for a non-life-threatening condition in a hospital, hospital emergency department or primary care setting such as a doctor's office or outpatient clinic. Since this change to the Public Health Law for proactive, voluntary HIV testing, insurance company claims for the HIV test increased 20 percent, leading to earlier diagnosis and treatment.

Consent for HIV testing can now be included in a patients general consent for routine medical care as long as the consent form allows the patient to opt out of HIV testing.

Source: health.ny.gov

EMBLEMHEALTH RADIATION THERAPY PROGRAM

Beginning **October 1, 2012**, CareCore will manage the prior approval process for certain radiation therapies and the corresponding CPT-4 codes. **Please note:** Prior approvals will be given for a radiation therapy treatment plan rather than for individual CPT-4 codes. In addition, CareCore will conduct clinical standard and expedited appeals except for Medicare plan members.

All services included in the EmblemHealth Radiation Therapy program must have prior approval from CareCore if services are rendered on or after **October 1, 2012**, or be registered with CareCore if treatment begins before **October 1, 2012.**

Prior approval for radiation therapy services to plan members will be required for both commercial and government sponsored benefit programs, HMO and PPO. Certain members are excluded from these requirements.

Source: emblemhealth.com

EMBLEMHEALTH CARDIOLOGY IMAGING PROGRAM AND HIP RADIOLOGY PROGRAM APPLY TO MORE MEMBERS

The EmblemHealth Cardiology Imaging Program and the HIP Radiology Program will be adding members from other HIP, GHI and EmblemHealth benefit plans beginning **October 1, 2012**. Some exclusions may apply. Managed by CareCore, these programs are already in place for EmblemHealth Medicare HMO and other plans underwritten by HIP Health Plan of New York.

Source: emblemhealth.com

ONE-YEAR DELAY ON ICD-10 TO OCTOBER 2014 FINALIZED

The federal government has finalized a one-year delay in the compliance deadline for the nationwide conversion to ICD-10 code sets. The delay, first proposed in April, will move the compliance deadline to **October 1, 2014**.

OTHER THERAPY CHANGES

The MCTRJCA requires the National Provider Identifier (NPI) of the physician or nonphysician practitioner (NPP), as applicable, certifying the therapy plan of care (POC) to be reported on all claims for therapy services. This permanent provision of the law becomes effective for claims with dates of services on and after **October 1, 2012**. The NPI-related instructions are found in CR 7785.

In addition, the MCTRJCA requires CMS to implement, by **January 1, 2013**, a claims-based data collection strategy related to patient function. This requirement is being addressed through the rulemaking process; and, will be included in the CY 2013 proposed rule for Medicare policies under the physician fee schedule expected to be release in early July. It will be available on the Physician Fee Schedule Federal Regulation Notices webpage.

Source: cms.gov

EDITS ON THE ORDERING/REFERRING PROVIDERS IN MEDICARE PART B

What Providers Need to Know

Phase 1: Beginning **October 5, 2009**, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim, but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web,require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Source: cms.gov

CHIROPRACTIC SERVICES (PLAN OF CARE)

Under the Medicare program, chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promotes health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

Documentation Requirements:

- All documentation must be maintained in the patient's medical record and available to the contractor upon request
- Documentation must be legible and include appropriate patient identification (name, date of service, name of responsible party that performed the service
- ICD-D-CM code(s) and CPT/HCPCS codes that best describe the service performed.

Initial visit should include:

- History of the patients symptoms as to why they were seeking treatment
- Family history, Past health history
- Mechanism of trauma
- Onset, duration, intensity frequency, location and radiation of symptoms
- Prior interventions, treatments, medications and secondary complaints
- Treatment plan which should include the following:

❑ Recommended level of care (duration and frequency of visits)
❑ Specific treatment goals;
❑ Short term goals include reducing pain and/or restoring normal function and muscle balance
❑ Long term goals include restoring functional independence and tolerance to normal daily activities
❑ Objective measures to evaluate treatment effectiveness

Subsequent visits should include:

- History, review of chief complaint, changes since last visit and system review
- Exam of are of spine involved in diagnosis
- Assessment of change in patient condition since last visit
- Evaluation of treatment effectiveness

Diagnoses codes/treatment given on the day of the visit should be documented in the medical record.

Source: novitas-solutions.com

NEW PSYCHOTHERAPY BILLING CODES FOR 2013:

Fundamental Services Underlying New Codes Will Not Change

Starting January 1, all mental health providers must use new CPT® code numbers for psychotherapy when billing insurance carriers, including Medicare. The fundamental services underlying these new codes will not change. This transition is a result of the Centers for Medicare and Medicaid Services (CMS) Five-Year Review of the psychotherapy codes conducted by the American Medical Association (AMA).

The APA Practice Organization (APAPO) has represented the psychology practitioner community in the process for more than two years, but has been unable to report on much of the ongoing work because of strict confidentiality requirements. As information is made available to the public, we will assist practitioners in understanding and making the transition to the new codes. The 2013 Medicare reimbursement rates for these new codes will be released in early November.

All mental health professionals including psychologists, psychiatrists, nurses and social workers delivering psychotherapy services will use the same applicable codes for psychotherapy, though psychiatry will change how they bill for medical services.

The changes are minimal. For example, the most frequently billed service by psychologists, 90806 (45-50 minute psychotherapy), will become 90834 (45 minute psychotherapy). Use of a particular psychotherapy code and reimbursement for that service will not differ depending on whether the service is provided by a physician or a psychologist. The code numbers and descriptions for psychoanalysis, family psychotherapy (with and without the patient), multi-family group psychotherapy, and group psychotherapy will not change in 2013.

Some specific key code changes include:

(1) Outpatient and inpatient psychotherapy codes will be replaced by a single set of codes that can be used in both settings.

(2) The new psychotherapy codes will have specified times rather than ranges:

- 30 minutes, not 20-30 minutes
- 45 minutes, not 45-50 minutes
- 60 minutes, not 75-80 minutes

(3) The single psychiatric diagnostic evaluation code will be replaced by two codes: one for a diagnostic evaluation and the other for a diagnostic evaluation with medical services.

Source: American Medical Association

NEWS BY SPECIALTY

Cardiology

In the event declotting of the CVA device or catheter is required more than once per day, code 36593 may be reported with the modifier 59 (distinct procedural service).

According to CPT Assistant, December 2009, declotting of a partially or completely implanted device or catheter may necessitate the use of a thrombolytic agent (e.g., urokinase), which is introduced through a syringe and then slowly instilled into the device or catheter. Do not use this code for routine flushing of vascular access devices with saline or heparin. This type of flushing is considered inclusive in chemotherapy services and should not be separately reported.

Code 36953 should not be reported multiple times for each sequential administration of thrombolytic (tPA) during the same episode. It should only be used multiple times when defined separate declots take place.

Source Internet

Radiology

CPT 2012 shows no narrative instructions or parenthetical notes before or after the codes for selective diagnostic renal angiography (36251–36254) precluding assignment of IVUS codes (37250–37251, 75945–75946) with CPT options 36251–36254. There also are no national correct coding initiative (CCI) edits.

A potential problem may exist, however, since the parenthetical note following codes 37251 and 75946 indicates the codes that IVUS may be used with, and codes 36251–36254 are not included. Some payers may interpret this to mean that IVUS codes cannot be used with 36251–36254. Verify your payer's specific coding/billing requirements before submitting these codes together

Radiology

The renal angiography codes (36251–36254) include “flush aortography.” Since “flush aortography” is not defined, many payers consider any aortography to be included in the renal angiogram. The American Medical Association (AMA) introduced the new renal angiogram codes at the 2011 CPT Symposium and stated that these codes included an aortogram (not “flush,” just “aortogram”).

The national correct coding initiative (CCI) edits bundle 75625 into 36251–36254. The edit may be bypassed by a modifier, but for Medicare at least, that would only be correct if the aortogram was performed at a separate session/encounter on the same date of service.

Source Internet

STATES UPDATES

AmeriHealth to expand in Philadelphia Medicaid market

AmeriHealth Mercy Health Plan, Philadelphia, will expand its presence in Pennsylvania's Medicaid managed-care market after winning approval from the state to enter 30 new counties during the next six months.

The expansion will bring the health plan's Pennsylvania market to 48 counties.

AmeriHealth is a subsidiary of AmeriHealth Mercy Family of Companies, which is jointly owned by Blue Cross and Blue Cross Blue Shield of Michigan and Independence Blue Cross.

AmeriHealth will expand into 13 northwestern Pennsylvania counties in October.

The health plan will provide medical, dental and vision benefits covered under Pennsylvania's Department of Public Welfare's Health Choices, the mandatory managed-care plan for medical assistance enrollees, according to the release.

States Seek a Middle Ground on Medicaid

Some Governors Aim to Curtail Program's Expansion, Steer More People Toward Federally Subsidized Private Insurance

A handful of states are considering only partially expanding their Medicaid programs under the federal health-care overhaul. Indiana, New Mexico and Wisconsin are among the states asking the federal government to let them omit from the Medicaid expansion residents whose incomes put them just above the poverty level. The states hope to take advantage of provisions in the Affordable Care Act that offer a federal subsidy to help these residents buy private insurance, starting in 2014.

New York seeks to tap Medicaid-reform savings

The state of New York has asked federal officials for $10 billion the state is projected to save from Medicaid reform for investment in New York City's public hospitals and other healthcare initiatives.

The extra funds would support New York's Medicaid overhaul and help to position the state for Patient Protection and Affordable Care Act opportunities.

The state would spend the money on multiple initiatives, including $1.25 billion to boost primary care with aid for strategic planning, electronic health records, quality improvement and behavioral health, capital investments and efforts to preserve and improve primary care access. The $1.25 billion would also be used to expand health information technology.

Pioneering health reform state enacts cost controls

Physicians and hospitals in Massachusetts have concerns about their roles in enabling the measure's savings target of $200 billion over 15 years.

A long-awaited bill to restrain health spending and implement new payment reforms in Massachusetts has obtained its final stamp of approval. But while they hailed the inclusion of provisions designed to reduce medical liability lawsuits, physicians and other health care professionals have lingering concerns about how the state will meet the legislation's ambitious cost-containment goals.

Source Internet

QUESTIONS AND ANSWERS

Mariami Tchrelashvili,
Billing Specialist
(718) 934-6714 ext 1217
mariamit@wchsb.com

Question:

- What Medicare carriers cover Detroit Michigan?

Answer:

- Medicare carrier for Detroit Michigan is Wisconsin Physicians Services.

Question:

- What are Michigan's regulations for MOBILE IDTF, can they only bill technical or global?

Answer:

- IDTFs in Michigan can bill both for TC and PC.

Dora Mirkhasilova,
Credentialing Specialist
(718) 934-6714 ext 1102
credentialing@wchsb.com

Question:

- How much do the commercial insurances pay for **Pneumococcal Polysaccharide (23 Valent)?**

Answer:

- CPT code 90732, GHI pays $40.00, Oxford $40.00, Hip $32.27 and still if you are interested Medicare pays $57.19.

Question:

- Can PA form a Professional Corporation in the state of NY?

Answer:

- PA cannot form a Professional Corporation in the state of NY, because of the way the department of education interprets the description of the PA's License- he has to always be supervised by a physician, so he can not form a pc, he can not hire PA's.

Julia Bondarenko,
Credentialing Specialist
(718) 934-6714 ext 1102
credentialing@wchsb.com

Question:

- How does WCH assure the security and availability of the software and the practice's data?

Answer:

- Security is an important factor to us; your practice's information will always be backed up and assured security. During the course of every day, including weekends and holidays, the computer sever automatically generates the back-up file every four (4) hours. At the end of each day, the last back up file is automatically written to a data CD. In addition there to, at the

QUESTIONS AND ANSWERS

end of each week, the last back-up file is automatically written to a CD. Therefore, there are a total of eight (8) CDs at the end of each week that is stored on external drive safely, in a fire-proof facility. WCH provides technical support Sunday-Friday through phone, e-mail, or in person. Your data and access is reliable at any time. Data in our PMBOS program is confidently stored and is only given access to parties which are authorized by the client and WCH Service Bureau. All information and paperwork you provide to our company will only be used for work purposes only. We will not share your information with outside parties. Our staff signs a confidentially agreement to assure that your information will not be accessed outside of WCH Service Bureau.

Olga Khabinskay,
General Manager
olgak@wchsb.com

Question:

♦ Can OTA provide services to patients in New York without supervision of the licensed OT?

Answer:

♦ Education Law and Regulations of the Commissioner of Education require that occupational therapy assistants receive direct supervision.

OTAs must work under the supervision of a licensed OT. In certain settings, a licensed physician may supervise an OTA. OTAs should receive supervision in all aspects of their work, including carrying out initial assessments, treatment and assessments to terminate services. The occupational therapist supervisor must meet with and observe the occupational therapy assistant on a regular basis to review the implementation of treatment plans and to foster professional development. The amount and type of supervision provided should be based on the ability level and clinical experience of the occupational therapy assistant and the setting in which the occupational therapy assistant is providing the services.

Good practice suggests that the occupational therapist supervisor participate in the services delivered by the OTA including:

Initial Evaluation
Intervention Planning and Goal Setting
Final Evaluation /Discharge

Additionally, the supervisor should periodically assess each patient's progress, and review and sign treatment notes and reports prepared by the occupational therapy assistant.

Supervising students or applicants for licensure:

When occupational therapists act as supervisors for persons gaining experience for licensure, the supervise should not directly pay the supervisor. The supervisor should not accept payment directly from the supervise for supervision that would lead to course credit in academic programs or licensure. When a supervisor accepts payment directly from the supervise in these situations, it could be considered a conflict of interest and a dual relationship.

Please contact credentialing department for additional information or questions by phone **718-934-6714 1102** or email credentialing@wchsb.com.

George Osipyants,
Credentialing Manager

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