WCH Bulletin

July, 2015

WCH ALLIANCE

How Can We Navigate through the Changing Healthcare System?

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WCH Alliance

How can we navigate through the changing healthcare system? The answer is TOGETHER!

The broken healthcare system has been greatly affecting providers and patients. Factors such as increasing regulations, ever-changing technological advances and demands, as well as many other burdens, are the reasons that what is most important, patient's care, keeps getting lost in the shuffle.

Providers of all specialties and their administrative staff struggle to keep up with coordinating care, following regulations and adapting to changes. Health care is changing, and doctors more than ever need a company that will protect them.

As a dedicated partner, we at WCH truly care about our clients. We always find innovative ways to add value to the WCH network. During these increasingly changing times, we have created WCH Alliance. With the support of the network of doctors, physicians and practitioners, WCH Alliance will become an IPA /ACO to provide our clients with the following benefits:

- Better rates with payers
- Ongoing Education and training : Improve documentation reporting, ICD 10, industry news
- Advocate on behalf of the client with major companies
- Efficient technology platform: EHR and practice management

WCH Alliance will be an Accountable Care Organization (ACO). Simply put, we are a collaboration of independent primary and specialty care physicians in the WCH network. WCH Alliance is dedicated to achieving a system of high-quality, coordinated healthcare that supports physicians and reduces unnecessary costs, while providing profound benefits to patients.

WCH Alliance Member physician practices will gain exclusive advantages that will benefit their practice in the long run. As the network develops, all member's needs and requests will be heard and accounted for in an effort to increase the level of benefits. Benefits ranging from enhanced rates and quality initiatives, to reduced office expenses and improved efficiencies, will be just a few of the positives of joining WCH Alliance. The needs of member physicians will be accounted for in order to maximize the saving opportunities, increase network referral and provide specialized training.

Please contact your dedicated Account Representative for more information about WCH Alliance.

How to Join WCH Network?

Current clients of WCH were sent a letter of request to become a member of WCH Alliance in support of establishing a Health-Care Network and IPA/ACO. Please sign the letter to join WCH Alliance, and return it to the WCH office to be processed.

How to join an IPA/ACO?

All clients that return a signed letter in support of joining WCH Alliance will be given an opportunity to join IPA/ACO by signing a new contract. These contracts are in the process of being prepared.

What is an Accountable Care Organization, or ACO?

ACO is a group of health care providers who come into agreement to take on a shared responsibility for the care of a defined population of patients, while assuring active management of both the quality and cost of medical care.

What is an IPA?

IPA stands for independent practice association and is typically a group of physician practices that have a contractual agreement to work together to provide health care for patients in a health plan network or integrated system. The IPA serves as a vehicle for private practice physicians to get together. It allows the physicians to address issues together without losing their independence.

IPAs are important because they have existing infrastructure, management, information technology, and organizational components that can serve as the basis for a physician-sponsored ACO. ACOs are imperative to control health care costs and improve the overall efficiency and effectiveness of our health care system.

Why I LOVE working in WCH

Interview with Elina Sabilova,

WCH Billing Department
Account Representative

Elina Sabilova,
elinas@wchsb.com

1. How has your experience at WCH helped you in life?

The general experience gained through work at WCH provides me with training in my personal life. I get used to solving my everyday personal issues until I get the desired result. I've learned to think my challenges over, analyze them, and quickly come up with the best way to solve them.

2. Why did you decide to work at WCH?

My decision to start working for WCH has been one of the most important steps in my life. My position provides me with great problem solving skills, critical thinking, and continuous learning. I think it's great when a good job, experience, and skills are of benefit to the individual. I chose to work at WCH because I believe I am provided with these opportunities on a daily basis.

3. What do you consider your three major strengths?

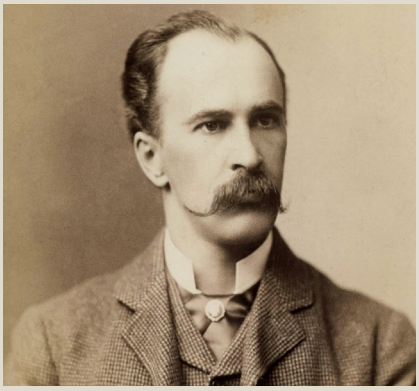
My three major strengths are a desire to learn, ability to analyze problems, and to always think twice before making a decision.

4. Where would you like to be in your career three years from now?

I have a goal to achieve as much as possible in a three-year time frame to the best of my ability. I would like to learn every billing, coding, and collection issue of all specialties of our Clients. I would like to be as useful as I can to both our Clients and the company. And I will do my best to achieve that.

5. What do you like to do for fun?

I always strive to spend my free time actively. I go to the gym on a regular basis. Just a couple weeks ago, I learned to ride a bike. So, on the weekends, I take my bike and ride around the city. That's how I love to relax, and it helps keep my mind clear for a new workday.



Famous Doctor in Medicine!

William Osler

Founder of Residency Program

Not many Physicians have influenced modern American medicine as much as William Osler did. William Osler has been described as the "Father of Modern Medicine." He served as the first chairman, clinician, teacher, Professor of Medicine and Physician-in-Chief at John Hopkins Hospital. He also served on the Regius Chair of Medicine at Oxford University.

William Osler was born in Canada on July 12, 1849. His early education and passion revolved around following his father's footsteps into ministry. However, under the influence of James Bovell and Rev. William Johnson, Olser switched his career because he became increasingly interested in medical science. In 1868, he enrolled in Toronto School of Medicine, but left the educational institution after being accepted to the MDCM program at McGill University Faculty of Medicine in Montreal. McGill University is where he successfully completed his medical degree in 1872.

After completing his medical degree, Osler traveled to Europe to study. Upon his return, he went to teach at the University of Pennsylvania as Professor of Medicine for five years. At the opening of the Johns Hopkins Hospital in 1889, Osler accepted the position of Physician-in-Chief. He quickly established a reputation as clinician, humanitarian, and teacher. In the hospital's first year, it had 220 beds, and 788 patients were seen for a total of 15,000 days of treatment. Sixteen years later, when Osler left for Oxford, over 4,200 patients were seen for a total of nearly 110,000 days of treatment.

One of Osler's greatest achievements that still remain in place today is his theory that students learn from seeing and talking to patients. With that philosophy, Osler began making dramatic, progressive changes in medical education with the establishment of the medical residency program.

Until then, medical school consisted of basic science classes. Osler set up residency systems where staff physicians lived in the administration building of the hospital. He pioneered the practice of bedside teaching, making rounds with a handful of students- what is known today as the residency program. The residency program was open-ended, and a long tenure was the rule. Doctors spent as long as seven or eight years as residents, during which time they led a restricted life with great focus on medicine. Osler's contribution to medical education of which he was proudest still remains in place today in most teaching hospitals.

Osler's most famous work, *The Principles and Practice of Medicine*, has been popular among medical scholars and physicians around the world. Osler's essays were important guides to physicians.

It is safe to say that with many achievements and innovations to the medical world, William Osler is one of the greatest influences on modern medicine. Without the knowledge that we have gained from Osler, modern medicine would not be where it is today.

Source: www.hopkinsmedicine.org

As of July 1, 2015, Medicaid is no longer reimbursing Medicare coinsurance.

Dear WCH Clients,

WCH wants to inform you of the important changes taking place as of July 1, 2015 concerning your New York Medicaid secondary payments:

Medicaid is no longer reimbursing partial Medicare Part B coinsurance amounts. The total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received for a Medicaid-only patient. If the Medicare payment is greater than the Medicaid fee, no additional payment will be made.

This news effects the reimbursements of your practice. For any questions regarding your practice reimbursements, please speak to your dedicated account representative.

Here is the actual cut out from the Medicaid Bulleting informing the providers on June 29th.

Insurance Updates:

Amerigroup NY updates

Preauthorization requirements for L3000 to L3630 orthopedic footwear codes

Background:

Effective June 1, 2015, HealthPlus, an Amerigroup Company, will require preauthorization for orthopedic footwear codes L3000 to L3630. Please note that these codes have specific criteria that must be met in order to be covered.

What this means to you: Effective June 1, 2015, HealthPlus Amerigroup will require preauthorization approval for the orthopedic footwear codes (L3000 to L3630) based on guidelines set up by the New York State Medicaid Fee-for-Service Guidelines for this group of Durable Medical Equipment (DME). Guidelines can be found here.

Source article on amerigroup.com

Recovery Look-Back Period to Align with CMS

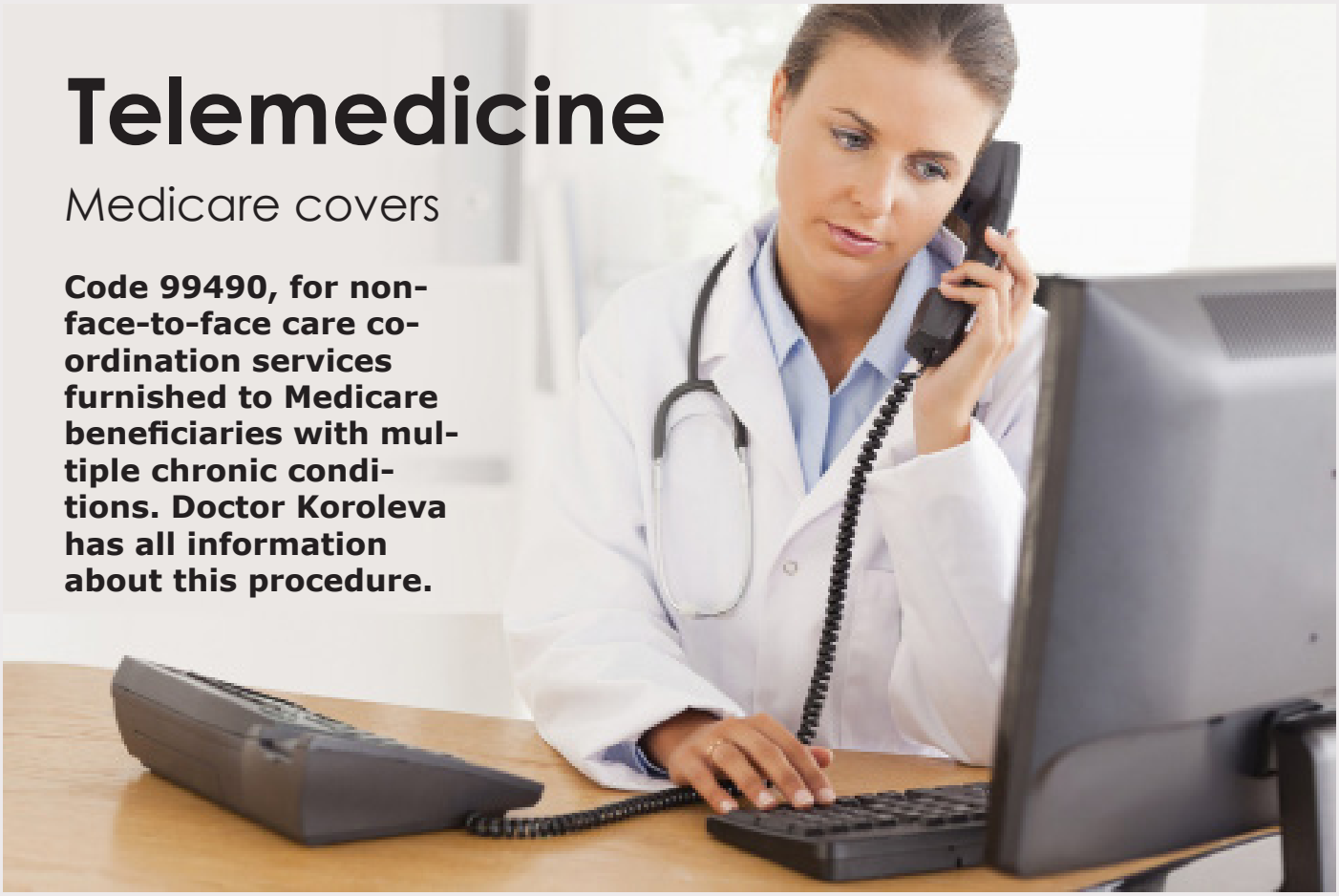
To align with Centers for Medicare & Medicaid Service guidelines, HealthPlus, an Amerigroup Company, will begin recovering Medicare Advantage claims overpayments within four years of the claim payment date. Currently, HealthPlus Amerigroup recovers overpayments within three years of the claim payment date.

What this means to you: Effective May 1, 2015, providers will be notified, in writing, of any Medicare Advantage claim overpayments identified with good cause within four years of the claim payment date consistent with the CMS guidance below. Notifications will vary if a different time frame is specifically noted for unless a different time frame is specifically noted for Medicare Advantage plans in the provider's contract.

Telemedicine

Medicare covers

Code 99490, for non-face-to-face care co-ordination services furnished to Medicare beneficiaries with multiple chronic conditions. Doctor Koroleva has all information about this procedure.



For other telemedicine- Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

1. A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
2. A county outside of a MSA.

Medicaid recently started providing coverage for Telemedicine consultations for **Practitioner offices** when certain requirements are met.

The patient **Originating"spoke"** (location of patient) site must be one of the following:

- Practitioner offices
- Article 28 facilities providing dental services
- FQHCs that have "opted out" of APGs
- Article 28 Hospitals (Emergency Room, Outpatient Department, Inpatient);

Article 28 Diagnostic and Treatment Centers (D&TCs); and **Telemedicine consultations are covered when medically necessary, and when the following requirements are met:**

- The patient must be physically present at the originating "spoke" site; the consulting practitioner is located at the "hub" site.
- The practitioner at the "hub" site, who is performing the consultation, must be licensed in New York State, enrolled in New York State Medicaid and credentialed and privileged at both the "hub" and" spoke" sites according to the applicable setting-specific standards.
- The request for the telemedicine consultation, the medical necessity for the telemedicine consultation and the findings of the distant "hub site" practitioner must be documented in the patient's medical record.
- The telemedicine consultation must be "real time," and provided via a fully interactive, secure two-way audio visual telecommunication system ("store and forward" is not covered by Medicaid).

Source: here

NY Behavioral Health Transition to Managed Care

Behavioral Health Transition to Managed Care. New York Medicaid.

Jason Helgerson, NYS Medicaid Director, has announced a change in the implementation date for the transition of behavioral health services into Medicaid Managed Care to April 1, 2015 for adults in NYC, and October 1, 2015 for adults in the rest of NYS. The Department of Health, OMH, and OASAS have revised the timeline to reflect this change, and will be posting an updated timeline shortly. Please visit the link below to view the letter from Jason Helgerson to the MRT Behavioral Health Work Group announcing the implementation date change.

Significant changes are taking place in 2015 and 2016 in the delivery of behavioral health care in Medicaid managed care.

Behavioral Health Managed Care Phase Two will integrate all behavioral health (BH) and physical heath (PH) services under the management of risk bearing Qualified Mainstream Managed Care Plans and Health and Recovery Plans (HARPs).

The implementation dates for the final phase in the behavioral health transformation are:

- April 1, 2015: Adults in NYC (HARP and Qualified Mainstream Managed Care Plans)
- October 1, 2015: Adults in Rest of the State (HARP and Qualified Mainstream Managed Care Plans)
- January 1, 2016: Children Statewide

Behavioral Health Carve Outs

For many years, people who are certifiably disabled under Medicaid, have had their behavioral health services "carved out" of the Medicaid managed care benefit package, meaning that while other services transitioned to managed care, behavioral health remained fee for service.

Those who receive mental health services but are not certifiably disabled have had the coverage carved-in for as long as they have had managed care.

In 2015 and 2016, behavioral health will be carved into the Medicaid managed care benefit package for all members, including those who are certifiably disabled.

Sources:

health.ny.gov

omh.ny.gov

wnylc.com

Benefit Update — Behavioral Health Services and Health and Recovery Plan (HARP)

Pending CMS approval, effective April 1, 2015, Medicaid Managed Care (MMC) plans will replace regular Medicaid for the coverage of behavioral health services for MMC members age 21 and older who reside in the five boroughs of New York City.

Additionally, effective April 1, 2015 (pending CMS approval), a new kind of MMC plan — Health and Recovery Plan (HARP) — will offer eligible individuals all of the behavioral health services and medical services provided by MMC plans, in addition to home- and community-based services. HARP plans will meet the unique needs of eligible members living with serious mental illness and/or substance abuse. EmblemHealth's current Medicaid network will provide medical benefits to HARP members.

Source: emblemhealth.com

Changes in effect regarding the therapy cap

As a result of the Medicare Access and CHIP Reauthorization Act, the manual medical review process at $3,700 is replaced with a new medical review process. Under this new process, CMS will determine which therapy services to review by considering a couple of factors. These factors would include:

- reviewing providers with patterns of aberrant billing practices compared with their peers;
- providers with a high claims denial percentage or who are less compliant with applicable Medicare program requirements; and
- newly enrolled providers.

Source: apta.org

Key Points of H.R.2 and FAQ

Key Provisions of the Medicare Access and CHIP Reauthorization Act

- Full and permanent repeal of the broken sustainable growth rate (SGR) formula used to calculate Medicare physician payments;
- Annual positive updates of 0.5 percent from July 2015-2019;
- Maintenance of fee-for-service as a payment option;
- Elimination of current-law penalties from the existing quality programs, such as the Physician Quality Reporting System (PQRS), Electronic Health Record (EHR) Meaningful-Use Program and the Value-Based Modifier (VBM) Program in 2019, and combining these programs into a single Merit-Based Incentive Payment System (MIPS). The merit-based program would be based on physicians achieving a threshold, or benchmark. Such a system makes it possible for all providers who reach these quality benchmarks to achieve positive incentives or payment updates;
- Incentives to move into advanced alternative-payment models (APMs), including a five percent bonus payments from 2019-2024, and exemption from some other reporting requirements;
- Inclusion of appropriate pathways for surgeons to develop, test, and participate in APMs, such as the Clinical Affinity Groups (CAGs) in ACS's Value-Based Update (VBU) proposal; and
- Prohibits CMS from implementing its plan to transition 10- and 90-day global payments to 0-day global payments;
- Clarification that no standard or guideline created under federal health programs shall be construed as setting the standard of care for purposes of malpractice claims.

IMPORTANT AUTHORIZATION CHANGES

PT, OT, ST, Pain Management, Spinal Surgery, and Podiatry Services

Healthfirst is committed to working with valued providers like you to help our members receive the services they need to stay healthy. As your partner in health, we are pleased to announce that Healthfirst has contracted with OrthoNet, a provider-based musculoskeletal disease management company that offers a broad range of administrative and medical management services. Effective July 1, 2015, OrthoNet will be responsible for utilization management services for all outpatient Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Pain Management, Spinal Surgery, and Podiatry services provided to Healthfirst members.

After July 1, 2015, all outpatient PT, OT, ST, Pain Management, Spinal Surgery, and Podiatry services for Healthfirst members will require preauthorization through OrthoNet, by phone or fax, at the numbers detailed below.

Contact for Authorization	Phone	Fax
PT/OT/ST Services	1-844-641-5629	1-844-888-2823
Pain Management/Spinal Surgery/Podiatry Services	1-844-504-8091	1-844-478-8250

To better assist our providers with this transition, we have detailed guidance regarding authorizations through OrthoNet, including a list of applicable CPT codes, in the form of Frequently Asked Questions (FAQs) posted in the Provider Resources section of our website at

www.healthfirst.org/provider-notices

If you have any questions regarding this, you may contact OrthoNet Provider Services at 1-888-678-4663, Mon-Fri 9am-5pm, or your Healthfirst Network Representative.

Questions and Answers

What will replace the SGR? What is the Merit-Based Incentive Payment System (MIPS)?

The Merit Based Incentive Payment System is a new payment mechanism that will provide annual updates to physicians starting in 2019, based on performance in four categories: quality, resource use, clinical practice improvement activities and meaningful use of an electronic health record system.

Unlike the flawed SGR, the new system will adjust payments based on individual performance. It does not set an arbitrary aggregate spending target, which is what has led to the need for annual patches to prevent cuts in the current system.

What happens to the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM) Program that adjusts payments based on quality and resource use; and the Meaningful Use of Electronic Health Records (EHR) Program?

H.R. 2 consolidates the three existing quality programs into the MIPS program, which is designed to give certainty for providers, reward those who meet performance thresholds, and improve care for seniors. The MIPS program will assess the performance of eligible professionals in four performance categories: quality, resource use, meaningful use (MU) of EHRs, and clinical practice improvement activities. The penalties associated with the current programs are subject at the end of 2018, including the two percent penalty for failure to report PQRS quality measures, the three percent (increasing to five percent in 2019) penalty for failure to meet EHR MU requirements, and potential negative modifiers associated with the VBM.

The money expected from these cuts would be returned to the physician fee pool, increasing the overall amount available for incentive updates.

Surgeons with low numbers of Medicare patients and those who receive a significant portion of their revenues from eligible APMs are excluded from MIPS.

How is the MIPS program different from current law if it is using existing programs?

Beginning this year, the existing programs (PQRS, EHR MU, and the Value-Based Modifier) penalize surgeons for non-compliance. These penalties will grow to seven percent or more of a surgeon's annual Medicare revenue. Under the MIPS program, the three programs will be combined and the associated penalties eliminated. They will then be used along with additional factors to determine a single composite score. Surgeons who achieve a composite score above the performance threshold are eligible for positive incentive payments. The potential downside risk remains similar to the penalties associated with the existing quality programs (growing to nine percent for 2022 and beyond), but with the potential for substantial updates. The highest achievers could be eligible for updates three times larger than the corresponding potential negative updates for a given year.

When does MIPS begin?

The MIPS program will begin in 2019. Surgeons who treat a small number of Medicare patients and professionals who receive a significant portion of their revenues from eligible APMs will be excluded from the MIPS.

Is there any law that advises doctors not to hold medicare claims due to deductibles? Because many doctors are holding claims in the beginning of the year, so that another doctor can bill first. Also is there a law that I can show to doctors to force them to collect copay from patients? They are all being too nice to patients.

No law requires that they submit right away, just with the Medicare rules, they have a limited time period to submit them.

On the forcing them to collect co-payments – yes – the doctor's contract with the insurer or Medicare contractually binds them to collect co-payments. Failure to do so is a breach of contract and also a violation of NYS Insurance Law (as per established case law). Doctors must make a "good faith effort" to collect co-payments – I define as three collection attempts. This could be a time of visit bill and two mailed bills thereafter.

We have developed a number of strategic partnerships referring to our practice. I would really like to compensate them because it just makes sense. I should be able to incentivize! Can I? (If it helps, we have a totally out of network practice...)

Well, I'm glad you asked instead of implemented! No, you cannot pay for referrals, per referral, percentages based on net collections based off of referrals, nada! The big statute most people know about is the Federal Anti-Kickback Statute, which rightfully identified and prohibited referrals involving Medicare money - so here the out of network does make a difference.

But, do you take assignment of benefits? Do you provide any covered/reimbursable services? Regardless of the answer, most states prohibit remuneration for referrals. Regardless of participation status, NO you cannot pay for referrals in most jurisdictions. Failure to abide by the prohibition has a host of very negative potential ramifications - licensure impact and potentially criminal proceedings.

If you are hiring an individual to perform marketing services, you can do that so long as compensation is structured appropriately. Happy to help on that arrangement.

Who can be an owner of a professional medical corporation?

Answer: At least 51% of the shares must be owned by a licensed physician and surgeon. The remaining 49% may be owned by: Podiatrists, Psychologists, Registered nurses, Optometrists, marriage and family therapists, Clinical Social Workers, Physician Assistants, Chiropractors, Acupuncturists, or Naturopathic doctors. The number of these licensed persons cannot exceed the number of physicians and cannot exceed a combined share total of 49%. A lay (unlicensed) person cannot own any shares of a medical corporation.

Source: mbc.ca.gov

I was served today at my practice with a subpoena duces tecum. What does this mean? It says I have to show up and bring my records to court this week. I have patients! What do I do? Do I have to go?

A subpoena duces tecum requires the production of documents, and does not require in person appearance. Typically this type of subpoena is accompanied with a check and an address where you can send requested records. You may not be a party to the underlying action, or even know what circumstances gave rise to the litigation. Before you start getting a postage ready, you have some due diligence to perform. For instance, make sure that a proper HIPAA authorization has accompanied the subpoena, because otherwise you are not authorized to disclose patient information. Before you send out your documents, I recommend contacting your lawyer to look into the matter at hand to ensure that the records that you submit are appropriate and do not actually open a bigger can of worms. With the help of your lawyer, you will be advised on how to respond to this subpoena; whether you should act upon this case or your participation is not particularly necessary.

FEEDBACK

Your feedback is very important to us!

In our continued dedication to improve, we want your feedback, opinions, ideas, news and comments. Please send us your feedback today.

Let us know what you would like to read in our next issue and share with us your ideas and thoughts.

Simply Email your comments to us at nanak@wchsb.com

Thank you!