



WCH TIMES

WCH Service Bureau 10th Anniversary

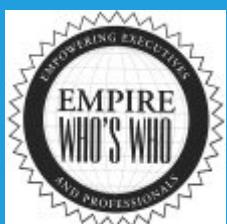
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Aleksandr Romanychev,
founder, and CEO of
WCH Service Bureau

This is special time for me and my company. Throughout this long, and interesting journey, WCH has grown and become well respected and trusted partner within the medical community throughout the United States.

Starting off with 2 clients, and to this day WCH, has serviced over 500 physicians in the last decade. Our medical billing department has provided outstanding reimbursement percents and clients that switched business to WCH increased their income by about 25% and upward.

The credentialing department became well known for credentialing physician, facilities and other entities in the shortest time. WCH knowledge's of CMS,

As founder and CEO of We Can Help Service Bureau, Inc., I am proud to announce that this year WCH has turned ten years old. We are celebrating our 10th year anniversary!

third party insurances and state enrollment guidelines have made WCH the expert in the field of credentialing.

The technical department has created unique software used by our company, and by many other physicians and medical practices, including: Patient Management Billing Operating System (PMBOS), Time Management, Credentialing Application and WCH's Electronic Medical Records software.

Over the ten years, WCH Service Bureau, Inc. has become partners and members with many different prestige organizations such: Better Business Bureau, American Academy of Professional Coders, American Health Information Management Association, American Medical Billing Association, and many more.

As you can see this, company is determined to succeed. Through our services, we offer professional expertise, honesty and hard work. I would like to thank you, our physicians and office managers for helping our business grow into what it is today, without you this would have never been possible. Thank you for your trust and continuous support.



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Time Management

We are excited and proud to announce the release of our Time Management software for sale beginning February 2011!

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Please contact our credentialing department for free consultation for any of the above enrollments. We can help you!



WCH Staff Continues to Become CPC Certified

We are proud to announce that WCH's billing department manager, Zuhhra Kasimova, has passed the Certified Professional Coder examination. WCH staff is constantly working hard to provide our clients with professional and reliable services. By passing the rigorous certification examination administered by the American Academy of Professional Coders demonstrates the skills to: adjust claims for accurate medical coding for diagnoses, procedures, and services in physician-based settings; across a wide range of services, which include evaluation and management, anesthesia, surgical services, radiology, pathology and medicine. Having knowl-

edge of medical coding rules and regulations including compliance and reimbursement, how to integrate medical coding and reimbursement rule changes into a practice's reimbursement process, and the knowledge of anatomy, physiology, and medical terminology to correctly code provider diagnosis and services. A trained medical coding professional can better handle issues such as medical necessity, claims denials, bundling issues and charge capture.



American
Academy of
Professional Coders

Did you know?

WCH has notary public on staff...



Congress Passes Bills Keeping Physicians from Medicare Pay Cut, "red flags" rule

Washington -- Congress has voted to block a Medicare physician pay cut through 2011. In another closely watched physician issue, lawmakers exempted doctors from the so-called red flags rule on security of financial data.

On Dec. 9, the House passed a bill that prevents any Medicare physician payment cuts through 2011. The move followed by one day Senate approval of the bill, which is expected to be signed by President Obama. Once the bill is signed, physicians no longer will face a 25% Medicare pay reduction scheduled to begin Jan. 1, 2011.

The cut was mandated under the sustainable growth rate formula, which now becomes the focus of organized medicine, Obama, lawmakers and others who seek to end a pattern of last-minute congressional overrides of negative pay updates. Since 2002, the formula, based on the economy and Medicare spending, has calculated continued declines in physician pay, which Congress then overrode. Congress has overridden those declines five times in 2010 alone.

Numerous surveys by the American Medical Association and others have found that physicians facing Medicare pay reductions said they were less likely to accept more patients in the program, or that they might drop Medicare altogether. Those surveys said seniors view Medicare physician pay cuts as a serious problem that requires swift congressional action.

"Stopping the steep 25% Medicare cut for one year was vital to preserve seniors' access to physician care in 2011," AMA President Cecil B. Wilson, MD, said after the House vote. "Many physicians made clear that this year's roller coaster ride, caused by five delays of this year's cut, forced them to make difficult practice changes like limiting the number of Medicare patients they could treat."

The delays included the 2010 overrides and a two-month patch passed in December 2009 that covered January and February 2010.

"The AMA will be working closely with congressional leadership in the new year to develop a long-term solution to this perennial Medicare problem for seniors and their physicians," Dr. Wilson said. "This one-year delay comes right as the oldest baby boomers reach age 65, adding urgency to the need for a long-term solution before this demographic tsunami swamps the Medicare program."

The current bill keeps Medicare physician pay at its present level, including the 2.2% increase that physicians received when Congress overrode an SGR-mandated pay cut in June. Obama said he hopes to see a permanent fix of the Medicare payment system passed in 2011. "For too long, we have confronted this reoccurring problem with temporary fixes and stopgap measures," Obama said after the Senate passed the one-year patch on Dec. 8. "It's time for a permanent solution that seniors and their doctors can depend on, and I look forward to working with Congress to address this matter once and for all in the coming year."

The bill passed by the Senate and House grew from a deal struck by four Senate leaders. Senate Finance Committee Chair Max Baucus (D, Mont.), ranking minority member Sen. Charles Grassley (R, Iowa), Senate Majority Leader Harry Reid (D, Nev.) and Senate Minority Leader

Mitch McConnell (R, Ky.) took the lead in crafting the bill, coming up with a deal that allowed the legislation to go to the Senate.

The House took up that bill, rather than legislation introduced in November by a group led by Rep. John Dingell (D, Mich.) and other House Democrats. Dingell's bill, which included a 1% Medicare physician pay raise for 2011, was introduced as a placeholder in the event the House voted first. However, the Senate introduced legislation just before Thanksgiving for a one-month patch that avoided a 23% cut slated for Dec. 1, and the House quickly followed suit.

The latest delay in Medicare cuts is expected to cost \$19.2 billion and would be paid for by expanding Internal Revenue Service recoveries under the national health system reform law. The law offers subsidies based on income to people who sign up for coverage through the health insurance exchanges spelled out by the legislation. If a person earns more than he or she projected that year, the IRS can collect a limited amount of the subsidies paid. The bipartisan agreement would raise that limit, increasing the subsidies the IRS can recover.

Doctors are spared a 25% reduction and the need to come up with identity theft

Meanwhile, a bill to exempt physicians and other professionals from the red flags rule passed the House on Dec. 6, following Senate passage four days earlier, and is headed to Obama's desk for his signature.

The red flags rule required any creditor who held financial data on clients to install identity theft detection and monitoring programs. The rule is the result of the Federal Trade Commission's interpretation of the Fair and Accurate Transactions Act of 2003, which was intended to tighten security of financial data held by banks and credit card companies.

On Nov. 1, 2008, the FTC said physicians were covered under the red flags rule because they bill people for services after they are provided, and because they allow payment plans. The AMA and others objected.

Under the Health Insurance Portability and Accountability Act, physicians are responsible for ensuring the confidentiality and security of patients' medical information. The AMA and others argued that the red flags rule, on top of HIPAA, was redundant, an unfunded mandate that would create unnecessary bureaucracy for practices while resulting in little, if any, public benefit.

On May 21, 2010, the AMA, the American Osteopathic Assn. and the Medical Society of the District of Columbia filed a federal lawsuit to prevent the FTC from holding physicians to the red flags rule. The AMA filed the lawsuit through the Litigation Center of the American Medical Association and the State Medical Societies.

As these battles were being fought, the FTC delayed enforcement of the red flags rule on physician practices five times. FTC Chair Jon Leibowitz told delegates at the AMA Annual Meeting on June 14: "We feel your pain on red flags, and we want to fix it. We agree with you that the red flags rule reaches too far." Dr. Wilson said the FTC had defined creditors too broadly to include physicians and other professionals, who now would be exempt under the bill. "The AMA is pleased that this legislation supports AMA's long-standing argument to the FTC that physicians are not creditors," he said. "This bill will help eliminate the current confusion about the rule's application to physicians."

Source of information obtained from: By Chris Silva, amednews staff. Posted Dec. 13, 2010; <http://www.ama-assn.org/amednews/2010/12/13/gvl11213.htm>

CERT Audit Identifies Top Billing Errors

1. **Insufficient Documentation:** Insufficient documentation errors because the documentation did not include the date of service, the patient's name, or a legible provider identifier are the most noteworthy.

Some claims fail simply because signature requirements are not met. Medicare requires records contain a signature or legible identifier for every service reported. Your physician's signature can be either handwritten or electronic, but stamped signatures (eg, rubber stamps) are not acceptable. Include a signature log if the signature isn't legible and an attestation statement if there is no signature at all. Other errors include:

Incomplete hospital record (13 percent); Incomplete or missing plan of care; Records for wrong date of service; Incomplete physical, occupational, or speech therapy records; Missing results for diagnostic or laboratory test; The valid ICD-9-CM code submitted was insufficient

2. **Medically Unnecessary Services:** For Medicare to determine a service to be medically reasonable and necessary, that service must be:

Safe and effective; Not experimental or investigational; Appropriate in duration and frequency; Performed in accordance with accepted standards of medical practice; Furnished in an appropriate setting; Ordered and furnished by appropriate personnel; Meeting but not exceeding the patient's medical need

To be paid for diagnostic tests, the physician must order the test with the documentation providing evidence of intent for the tests to be performed. In other words, make sure the physician signs the documentation.

3. **Incorrectly Coded Services:** Not surprisingly, most incorrect coding errors reported by the CERT contractor are related to evaluation and management (E/M) services, including:

E/M does not meet level required (66 percent); Services coded incorrectly; Illegible documentation service was denied or down-coded; Exam component not meeting the level required; History component not meeting the level required; Service not meeting the definition of a new patient

Service not meeting the definition of critical care

Source of information obtained from: AAPC | Billing INSIDER Issue #5

Hospital Gets Fined \$45 Million for Stark Law Violations

A South Carolina hospital must pay Medicare and Medicaid \$44.8 million as reimbursement for Stark Law violations, a federal judge has ruled. The judge also approved a request to retry allegations that the hospital's physician self-referral practices broke another federal law. According to court records, Sumter, S.C.-based Tuomey Healthcare System hired 19 part-time staff surgeons to perform cases at its ASC and paid them based on the volume of their referrals. Michael K. Drakeford, MD, a Sumter orthopedic surgeon in private practice, notified federal authorities after Tuomey repeatedly offered him such an employment arrangement in recent years. In a whistleblower lawsuit, Dr. Drakeford and government lawyers argued that these arrangements not only violated Stark Law prohibitions against physician self-referral, but also the False Claims Act in that they fraudulently billed Medicare and Medicaid.

Tuomey denied any wrongdoing and countered that its actions were legitimate, since its employment agreements had been cleared by legal and business advisors in order to ensure their compliance with applicable laws. While a federal jury found Tuomey guilty of Stark Law violations in March, it returned a not-guilty verdict on the billing fraud allegations.

The following month, Judge Matthew J. Perry Jr. issued a verdict levying the \$44.8 million in damages on the hospital.

In June, Judge Perry also granted Dr. Drakeford's and the government's request for a new trial on the fraudulent billing allegations, on grounds that evidence was wrongly excluded from the original trial. Under federal law, monetary damages resulting from False Claims Act actions are tripled. In a statement posted to Tuomey's website, President and CEO Jay Cox says the hospital is appealing each of the rulings issued to date in federal appeals court, a process which could take a year before it is resolved. Tuomey administrators, Dr. Drakeford and an attorney for the plaintiff did not immediately return calls seeking additional comments.

Source of information obtained from: By: David Bernard <http://www.outpatientsurgery.net/news/2010/12/12>

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U.S. Europe to promote EHR exchange standards

Exchanging electronic health record data with European colleagues and researchers may become easier with a new international agreement that promotes common interoperability standards.

Health and Human Service Secretary Kathleen Sebelius and European Commission for the Digital Agenda Vice President Neelie Kroes signed a memorandum of understanding Dec. 17 in Washington that also supports new education programs on information technology.

Under the agreement, HHS and the European Commission will exchange information about their health IT activities and will establish joint working groups to share goals and organize collaborative scientific conferences and workshops, according to *Healthcare IT Management*.

The use of EHRs in the U.S. outside hospitals is four times lower than in Europe, according to *Healthcare IT Management*. In the fu-

ture, the U.S. will invest about \$20 billion in deploying interoperable health records to physicians--which could have a "positive impact on procurement" for European companies in the U.S.

Kroes said that the agreement on "Cooperation Surrounding Health Related Information and Communication Technologies" aims to boost the potential of the health IT market for European companies wishing to do business in the U.S. and vice versa, *Government Health IT* reports.

In addition, promoting the use of electronic health technologies--with a view to improving the quality of healthcare, reducing medical costs and fostering independent living, including in remote places--is a key objective of the Digital Agenda for Europe, Kroes said.

Source of information obtained from: http://www.fierceemr.com/story/us-europe-promote-ehr-exchange-standards/2010-12-22?utm_medium=nl&utm_source=internal

Coming Soon: WCH's " iSmart"



Researchers Call for a 'Pharmacy Home'

Establishment of a "pharmacy home" model, similar to a medical home model, could better coordinate medication therapies for chronically ill patients with many prescriptions, according to a study published Jan. 10 in the *Archives of Internal Medicine*.

Provider organizations, according to authors, need to find ways to help patients simplify, synchronize, centralize and organize their medication management. There is a particular need to synchronize medication regimens because "those who make numerous trips to the pharmacy to pick up their medications, or fill prescriptions at different pharmacies, may have difficulty taking their medications as prescribed," the report contends. Report authors also recommend experimenting with programs and technologies to make it easier for patients to better organize their medications.

Researchers at Harvard Medical School and Brigham and Women's Hospital in Boston studied data from pharmacy benefit management firm CVS Caremark. They analyzed claims over a one-year period for 1.83 million heart patients taking statins and 1.48 million taking ACE inhibitors or renin angiotensin receptor blockers. These are the most widely prescribed medications for treatment of cardiovascular disease.

A view of a pa-

particular three-month period demonstrates the need for a pharmacy home. During that three months, patients filled prescriptions for an average of 11 medications in six different drug classes. Ten percent of these patients had 23 or more medications--representing at least 11 different drug classes--with prescriptions written by at least four prescribers and the prescriptions filled at two pharmacies with at least 11 visits to these pharmacies.

Did you know?

WCH has 4 certified professional coders on staff, ready to help you with chart audit!...

The study, "The Implications of Therapeutic Complexity on Adherence to Cardiovascular Medications," is available for purchase at <http://archinte.ama-assn.org>.

Source of information obtained from: HDM Breaking News (01/11/11)

Seniors may have to pay for Medicare home health

Medicare recipients could see a sizable new out-of-pocket charge for home health visits if Congress follows through on a recommendation issued Thursday by its own advisory panel.

Until now, home health visits from nurses and other providers have been free of charge to patients. But the Medicare Payment Advisory Commission says a copayment is needed to discourage overuse of a service whose cost to taxpayers is nearing \$20 billion a year amid concerns that fraudsters are also taking advantage.

The panel did not prescribe an amount, but its staff has suggested the charge be \$150 for a series of related visits. Medicare requires copays for many other services, so home health has been the exception, not the rule.

Defying opposition by AARP, the seniors' lobby, the congressionally appointed commission voted 13-1 to recommend that lawmakers impose the new charge. Two commissioners abstained and one was absent.

"At the extreme, this benefit can turn into a long-term care social support system," said commission chairman Glenn Hackbarth. "A modest copayment is one tool to help deal with that problem."

The advice comes as lawmakers face a tough budget year. A sluggish economy and tax cuts are draining revenue while deficits soar to ranges widely seen as unsustainable. Republicans won control of the House on a promise to curb spending, yet there's little hope of that unless Congress and the president can agree on ways to restrain health care costs.

More than 3 million seniors and disabled people on Medicare use home health services — visits from nurses, personal care attendants and therapists, available to those who can't easily get out of the house.

Home health was once seen as a cost saver, since it's clearly cheaper than admitting patients to the hospital. But it's been flagged as a budget problem because of rapidly increasing costs and big differences in how communities around the country use the benefit.

Did you know?

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Part of the problem appears to be rampant fraud. In some counties home health admissions exceed the number of residents on Medicare.

Several commissioners said they worried about the impact of a new charge on seniors with modest incomes. Numerous studies have shown that even small copayments can discourage patients from getting medical services.

The charge would be collected for each home health agency admission, not for every visit by a nurse or provider. Patients can be under home health care for weeks at a time.

The recommendation exempts low-income patients, whose copayments would be covered by Medicaid, as well as those just discharged from the hospital. More than 30 million beneficiaries in traditional Medicare would be directly subject to the fee. Repercussions for seniors in private Medicare Advantage plans are uncertain.

The commission was created by Congress to provide unbiased expert advice on complicated issues of Medicare benefits and financing. It's also known as MedPAC.

Source of information obtained from: The Associated Press (01/14/11)

Primary-Care Docs and Specialists Get Their Wires Crossed

What we've got here is a failure to communicate. At least that's the conclusion of a new 4,720-doctor study published in the Archives of Internal Medicine. Researchers at the Center for Studying Health System Change found that while more than 69% of primary-care physicians said they always or mostly passed on a patient's history and reason for a consultation to the consulting specialist, fewer than 35% of specialists reported always or mostly receiving that information.

And that pattern cuts both ways: 81% of specialists said that of course, they always or usually send consult results back to the referring primary-care doctor, but only 62% of those doctors said they got that info. Hmm. Or, as the authors write, "The results suggest much room for improvement." Physicians reporting inconsistent communication were more likely to say patient-care quality was hurt by a lack of timely reports.

Researchers pinpointed a few factors associated with higher reported rates of sending and receiving this kind of information: "adequate" time to spend with patients during an office visit, the involvement of nurses to help manage patients with chronic conditions and the receipt of quality reports on those chronic-disease patients. Specialists who use health IT were more likely to report receiving and sending consult reports, but the same pattern wasn't seen among primary-care docs.

Did you know?

WCH has developed an easy to use time management...

Source of information obtained from: The Wall Street Journal /Health Blog (01/10/11).

FDA Warns of Extortion Scam by Fake Agents

Extortionists posing as FDA agents are targeting customers of online and over-the-phone pharmacies, demanding victims pay cash fines or else face law enforcement action, the FDA warned today. To perpetrate the ongoing international scam, the criminals call victims and tell them they are being fined for illegally purchasing drugs over the internet or over the phone. Unless the victim pays a fine ranging from \$100 to \$250,000, the scammers say, legal action will be pursued. Victims are ordered to immediately wire money to a certain location, often in the Dominican Republic. If they refuse to pay up, they are threatened with "search of their property, arrest, deportation, physical harm and/or incarceration", according to the FDA press release. The FDA told CBS News they don't yet know how many people have been targeted by the scam, but said they are pursuing multiple domestic and international criminal investigations. "Impersonating an FDA official is a violation of federal law," Dara Corrigan, FDA's associate commissioner for regulatory affairs said in press release today. "FDA special agents and other law enforcement officials are not authorized to impose or collect criminal fines." This is not the first time the FDA has warned the public about scammers posing as federal agents; the agency sent out a similar warning in 2008 and another in 2009. The FDA encourages anyone who believes they have been a victim of a phone scam to contact the FDA's Office of Criminal Investigations.

Source of information obtained from: CBS NEWS Investigates (01/07/11)

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Lab Requisition Signature Requirement Postponed

The requirement for a physician's or qualified nonphysician practitioner's (NPP) signature on all requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS) will not be enforced beginning Jan. 1, 2011, as finalized in the 2010 Physician Fee Schedule (PFS) final rule.

The Centers for Medicare & Medicaid Services (CMS) recently announced on its website that it will instead spend the first quarter in 2011 educating physicians, NPPs, and clinical diagnostic labs of this new policy. Educational and outreach materials will be made available on the CMS website as well as other communication channels. "Once our first quarter of 2011 educational campaign is fully underway, CMS will expect requisitions to be signed," the agency states in its [online announcement](#).

In the 2011 PFS final rule, CMS states (on page 1029): "One of the reasons we made this proposal is because we believed that it would be less confusing for a physician's signature to be required for all requisitions and orders, eliminating uncertainty over whether the documentation is a requisition or an order, whether the type of test being ordered requires a signature or which payment system does or does not require a physician or NPP signature."

CMS goes on to clarify in the 2011 PFS final rule that this policy does not concern electronic or telephonic requests, because it does not consider these types of requests to be requisitions. "A requisition is the actual paperwork, such as a form, that is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient," CMS explains.

"However," CMS further states in the 2011 PFS final rule, "this policy does not require a physician or NPP to use a requisition to request a clinical diagnostic laboratory test paid under the CLFS. Many physicians and NPPs currently request clinical diagnostic laboratory tests using an order ... and they may continue to do so without being impacted by our new policy for requisitions." An "order" (as defined in the Internet Only Manual, Pub 100-02, chapter 15, section 80.6.1) is "a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary."

Source of information obtained from: AAPC News & Press 01/03/11



Healthcare News

California

Calif. Insurance Chief Gears Up To Tighten Scrutiny of Rate Hikes



California's new Insurance Commissioner Dave Jones (D) is preparing to combat major rate hikes that have characterized the state's health insurance marketplace in recent years, the *Wall Street Journal* reports.

Recent Rate Hikes: Jones already has started putting pressure on several health plans that recently announced rate increases for individual policies. On Jan. 6, Jones asked Blue Shield of California to delay a planned series of rate hikes that could total as high as 59% for individual policyholders. This week, the commissioner asked Aetna, Anthem Blue Cross and PacifiCare to postpone their planned rate increases so he could review the filings.

Jones said, "We have a long history in California of 10%, 20%, 30%, 40% rate hikes. This is just business as usual." Major Issue in California: Rate increases in the individual health insurance market have been a major issue in California because the state has the largest number of individual policyholders.

About two million Californians purchased individual health insurance policies in 2009, according to the Kaiser Family Foundation. Marian Mulkey -- director of health reform at the California HealthCare Foundation -- said premiums have been rising across California because the state's economic downturn has prompted many healthy residents to cancel their coverage, leaving insurers with a higher proportion of sick people in their coverage pools. CHCF publishes *California Healthline*.

Authority Over Rate Hikes: California regulations require health plans to submit their rates to the insurance commissioner, who can review them to ensure they are in compliance with state law. The state does not allow the commissioner to reject premium increases. During his time in the state Assembly, Jones authored legislation that would have authorized the commissioner to reject rate hikes, but the measure failed to pass. Jones has said he intends to support similar legislation this year.

Meanwhile, the federal health reform law is expected to increase oversight of rate increases nationwide. Starting in July, the federal government will have the authority to review premium hikes exceeding 10% in states that do not have sufficient rate review procedures in place. Although federal officials will not be able to reject the premium increases, insurers will be required to justify their rates (Johnson, *Wall Street Journal*, 1/14).

Read more: <http://www.californiahealthline.org/articles/2011/1/14/calif-insurance-chief-gears-up-to-tighten-scrutiny-of-rate-hikes.aspx#ixzz1BJ12K1Ls>

Source of information obtained from: California Health On-line (01/14/10)

Calif. Medical Groups File Lawsuit Over New Glaucoma Regulations

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on OIG and HIPAA compliance...**

On Tuesday, the California Medical Association and the California Academy of Eye Physicians and Surgeons filed a lawsuit seeking to block the implementation of new state rules allowing optometrists to treat patients with glaucoma, the *Orange County Register* reports (Joseph, *Orange County Register*, 1/12).

The groups filed the suit in San Francisco Superior Court against the California Board of Optometry.

Background: The new rules, which took effect Jan. 8, allow optometrists to treat and manage glaucoma after undergoing a certification process that does not involve treating patients with glaucoma (Clark, *HealthLeaders Media*, 1/13).

The new certification process applies to individuals who graduated from accredited optometry schools prior to May 1, 2008 ([Board of Optometry rule](#), 12/10/10). Previous state regulations required optometrists to treat 50 patients with glaucoma over a two-year period under ophthalmologist supervision before receiving authorization to treat the condition.

Plaintiffs' Argument: According to CMA and CAEPS, the new state rules were established under a faulty process because a consultant hired to advise a key committee was not certified to treat glaucoma. CMA President James Hinsdale said the regulations "jeopardize the quality of eye care Californians deserve." The plaintiffs also highlighted a recent case in which several patients with glaucoma experienced significant vision loss after receiving treatment from optometrists at a Department of Veterans Affairs medical facility in Palo Alto.

Optometrists' Stance: The California Optometric Association could not be reached for comment on the lawsuit, according to *HealthLeaders Media*. In a previous [statement on its website](#), COA praised an administrative law judge's decision to approve the Board of Optometry's new regulations. The association said the new rules would help to address shortages of eye physicians in rural and underserved areas.

Read more: <http://www.californiahealthline.org/articles/2011/1/13/calif-medical-groups-file-lawsuit-over-new-glaucoma-regulations.aspx#ixzz1BJ3F2s3P>

Source of information obtained from: California Health On-line (01/13/10)

Share of Cost Medi-Cal

In addition to covering individuals who receive cash assistance from the government, Medi-Cal offers health care coverage to individuals and families who have incomes too high to qualify for welfare, but too low to cover health care costs. Medi-Cal requires some of these recipients to contribute to their health care by paying a share of the cost of the services they receive.

Share of cost is a term that refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to offer assistance. Once a recipient's health care expenses reach a predetermined amount, Medi-Cal will pay for any additional covered expenses for that month. Share of cost is an amount that is owed to the provider of health care services, not to the state.

Beneficiaries with share of cost Medi-Cal account for a disproportionate amount of program expenditures. While individuals receiving share of cost assistance accounted for just over 1% of all Medi-Cal beneficiaries in October 2007, they consumed about 15% of total fee-for-service expenditures, or an estimated \$2.2 billion for fiscal year 2006–07.

As California lawmakers consider budget actions that may have an impact on Medi-Cal, understanding the share of cost option and the people it serves is essential. This issue brief provides an overview of share of cost Medi-Cal, including an analysis of Medi-Cal data and a description of current policy issues which may affect the program.

Source of information obtained from: <http://www.chcf.org/publications/2010/09/share-of-cost-medical> (Liza said it is important for Dr. Manansala – our client from California, no matter that dated Sept, 2010.)

Implementation of the Affordable Care Act in California: A Window of Opportunity for State Policy Makers

Health care reform, as enacted in the federal Affordable Care Act (ACA), establishes the framework for sweeping changes to the nation's health care financing mechanisms and delivery approaches. This document by the California Health and Human Services Agency examines the challenges facing California during this transitional period. This report resulted from an internal assessment and was funded by CHCF and the Blue Shield of California Foundation.

The authors of the report evaluate eight areas of policy-advancement opportunity for California under the

- Streamlining eligibility and enrollment systems to facilitate coverage;
- Advancing the goal of near-universal coverage through community norm change;
- Establishing an "active purchaser" health benefit exchange to improve the affordability of coverage;
- Increasing collaboration of health care purchasers to improve the delivery system, improve health outcomes, and lower costs;
- Expanding the health care workforce and rethinking care delivery to ensure access to health care services;
- Simplifying the market for consumers and health plans through greater uniformity of health insurance regulation;
- Investing in community transformation to improve the health status of the population; and
- Reconsidering the organization and funding of state programs, state department and regulatory functions, and state-county relationships in a post-ACA context to improve the effectiveness and efficiency of government.

Source of information obtained from: <http://www.chcf.org/publications/2011/01/implementation-aca-california>

Medi-Cal Faces \$1.7B in Funding Cuts Under Brown's Budget Plan

The budget proposal that Gov. Jerry Brown (D) released on Monday called for \$1.7 billion in cuts to Medi-Cal, California's Medicaid program, the *Contra Costa Times* reports (Kleffman, *Contra Costa Times*, 1/11). The cuts to Medi-Cal are part of Brown's larger plan to close the state's estimated \$25.4 billion budget shortfall over the next 18 months (Jewett, *California Watch*, 1/10). For additional coverage of Brown's budget proposal, see today's *California Healthline* article and Capitol Desk post.

Details on Medi-Cal Cuts: Alan McKay, executive director of the not-for-profit Central Coast Alliance for Health, said Brown's proposed Medi-Cal changes primarily would affect the fee-for-service system (*Contra Costa Times*, 1/11). A portion of the \$1.7 billion in cuts would come from increasing cost sharing for Medi-Cal beneficiaries and imposing limits on service usage. The higher cost sharing could reduce state spending by about \$557 million, while the caps on service usage could reduce state spending by about \$234 million (*California Watch*, 1/10).



To enact such spending reductions, the Medi-Cal provisions of Brown's budget plan would:

- Limit physician visits to 10 annually and limit prescriptions to six monthly, except for lifesaving medications;
- Set mandatory copayments for beneficiaries at \$5 per physician visit, \$50 per emergency department visit and \$100 per day for hospital stays up to a maximum of \$200;
- Cap annual spending for health products such as hearing aids, incontinence supplies and wound care; and
- Decline services to patients who cannot provide a copay, as long as such patients are referred to a county-level indigent health care program (*Contra Costa Times*, 1/11).

In addition, Brown's plan would eliminate adult day health care services to reduce state spending by \$177 million. The proposal also aims to reduce state spending by more than \$900 million by cutting nursing home, physician, clinic, pharmacy and medical transportation rates by 10% (*California Watch*, 1/10). Concerns From Health Care Providers, Advocates: Carmella Castellano Garcia -- who leads the California Primary Care Association -- said Brown's proposed Medi-Cal cuts could place a heavy burden on the state's community health clinics, which typically serve a high number of Medi-Cal beneficiaries.

Castellano Garcia said some community health centers might be forced to close as a result of the cuts ("KPBS News," KPBS, 1/10). Anthony Wright, executive director of Health Access California, said the cuts would negatively affect the health of individual families, the health care system and broader attempts at economic recovery (*Contra Costa Times*, 1/11).



Read more: <http://www.californiahealthline.org/articles/2011/1/11/medical-faces-17b-in-funding-cuts-under-browns-budget-plan.aspx#ixzz1BJ72SEkO>
Source of information obtained from: California Health On-line (01/11/10)

Recent Lawsuits Target Staffing Levels at Calif. Nursing Home Facilities

Attorneys have filed several recent lawsuits alleging that California nursing homes are not meeting state staffing requirements, *California Watch* reports.

Skilled Healthcare Case: In July 2010, a Humboldt County jury imposed a \$671 million verdict after finding that nursing home chain Skilled Healthcare had failed to meet state staffing requirements. After the verdict, attorneys from both sides negotiated an agreement calling for Skilled Healthcare to pay \$50 million to settle the claims and avoid bankruptcy. Skilled Healthcare admitted no wrongdoing in the case.

Additional Lawsuits: Several attorneys involved in the case against Skilled Healthcare now are bringing similar complaints against other nursing homes over alleged understaffing. Kathryn Stebner -- a San Francisco attorney who is working on the new cases -- said lawyers have used state data to identify nursing home chains and facilities that provide inadequate staffing levels.

The new cases include:

- Hazel Walsh v. Kindred Healthcare, filed Nov. 23, 2010 in San Francisco on behalf of a resident at San Francisco's Golden Gate Healthcare Center;
- Phyllis Wehlage v. Evergreen California Healthcare, filed Nov. 15, 2010 in Sonoma County on behalf of a resident at Evergreen Lakeport Healthcare in Lake County;
- Valentine v. Thekket Health Services, filed Nov. 12, 2010 in Alameda County on behalf of a resident at Gateway Care and Rehabilitation in Hayward; and
- Maria Hernandez v. Beverly Healthcare California, filed Nov. 10, 2010 in San Francisco on behalf of two residents at Golden LivingCenter facilities in Bakersfield and Petaluma.

Another lawsuit working its way through the courts targets understaffing at nursing home chain Covenant Care. The case was filed in April 2010 in Sacramento County on behalf of a resident at Emerald Gardens Nursing Center in Sacramento.

Health Facilities Weigh In: Mark Reagan, an attorney who represents the California Association of Health Facilities, said he does not expect any of the new complaints to lead to jury awards of the magnitude seen in Humboldt County.

Reagan has disputed whether state law guarantees nursing home residents a right to certain staffing standards. He also has suggested that the authority to enforce staffing requirements belongs to the state Department of Public Health, not the courts (Jewett, *California Watch*, 1/10).

Read more: <http://www.californiahealthline.org/articles/2011/1/10/recent-lawsuits-target-staffing-levels-at-calif-nursing-home-facilities.aspx#ixzz1BJ7Ubx5c>

Source of information obtained from: California Health On-line (01/10/10)

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Healthcare News: Florida



Business and Healthcare Leaders told that Reform is Here to stay and that it will be Good for Business

With congressional Republicans expected to push next week for the repeal of healthcare reform, major American business and healthcare leaders said Thursday at a Miami conference that reform is forging ahead because it makes sense for the nation's economy.

``Reform is not going to be repealed," said James Forbes, an executive with Bank of America Merrill Lynch said at the University of Miami's Global Business Forum. ``It's not going to happen, folks. Quite honestly, most of your private equity firms view this as a tremendous opportunity."

Forbes noted that the Social Security Act faced similar grumblings about repeal shortly after passage in the 1930s, but opposition died away. He believes opposition to healthcare reform also will shrink as reforms kick in during the next four years -- starting this year with required insurance coverage for children even with preexisting conditions and extending family coverage to children up to age 26 even if they are not in school. Forbes spoke during the two-day conference, called The Business of Health Care, which attracted about 700 people. Forbes said aging baby boomers requiring more healthcare are creating a ``really inexorable" push for businesses to meet the needs. Reforms will simply increase those needs, providing more money for such things as electronic medical records, Forbes said. Another big opportunity will be for insurers specializing in Medicaid, the state-federal insurance for the poor, which in 2014 is expected to be covering an additional 13 million people who are currently uninsured.

Cecil B. Wilson, a Florida physician and president of the American Medical Association, said his group continues supporting the Affordable Care Act, urging ``improvements where improvements are needed," such as changes in malpractice laws and larger payments from Medicare. The AMA is urging the nation's doctors to get involved in forming regulations that will provide details of the reforms. Richard Umberstock, president of the American Hospital Association, said the nation's hospitals continue to firmly support the need for reform because their emergency rooms are now providing more than \$35 billion a year in uncompensated care, mostly to the 50 million Americans who don't have coverage and often use ERs as their sole source of healthcare. He said the AHA has submitted a brief supporting the government in the court case filed by almost two dozen states -- including Florida -- challenging the new healthcare law on constitutional grounds because the law requires virtually everyone to have health insurance.

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With that provision, insurers would face economic disaster, according to the insurers' trade organization, America's Health Insurance Plans, because people would only get insurance when they were sick. Healthy people wouldn't be paying into the pool because they would only get insurance when they needed it. All of America's major insurers supported the requirement for coverage, called the individual mandate. Without it, reform ``just doesn't work," said Mike Tuffin, AHIP's executive vice president.

In a morning session, Kathleen Sebelius, secretary of Health and Human Services, called the proposed Republican vote against reform a ``symbolic" protest because there was no chance it would make it through both houses of Congress and be signed by the president.

Sebelius, who was a Democratic governor in the heavily Republican state of Kansas, said she's working hard to forge bipartisan efforts for healthcare reform. She said her main fear is that Congress will engage in broad, across-the-board cuts that would be ``extraordinarily harmful" for some aspects of healthcare, including scientific research.

UM President Donna Shalala, who was HHS secretary under President Bill Clinton, said there has been ``no indication in the polls that the majority of Americans have turned against reform, and that the Republican victories in November were more a basic 'throw the rascals out.' " She continued to promote the idea: ``For everyone who says we can't afford healthcare reform, I'd say, 'We can't afford not to have healthcare reform.'"

Miguel ``Mike" Fernandez, a healthcare entrepreneur who has donated hundreds of thousands of dollars to Republican candidates, said he's confident reform is here to stay. ``There's no going back on healthcare. I think there are plenty of opportunities for the private sector," he said. He's investing heavily in Medicaid insurers, seeing their stock rising as more people qualify for coverage. Leaders of the nation's hospitals, doctors and insurers said reforms need to include a cost restructuring. ``We are on a path that is not sustainable," said Tuffin of AHIP.

Source of information obtained from: Health News Florida 01/14/11 - <http://www.miamiherald.com/2011/01/14/2015404/experts-reform-good-for-economy.html>

Nail-biting time for FL health programs

Memo to Florida's health and human services programs: Don't expect any crumbs from Sen. Joe Negron. The chairman of the Senate's health-budget committee said Wednesday he wants to halt a trend of the state increasingly paying for Medicaid and other health- and human-services programs at the expense of education. I think our HHS budget has grown to the detriment of other parts of our state budget that are equally important," Negron said during a committee meeting packed with health- and human services lobbyists and agency officials.

The comments probably wouldn't be notable if made by most lawmakers. After all, politicians often talk about wanting to provide more money for education and rarely boast about their abilities to bring home Medicaid bacon. But Negron's riff was remarkable because he will play a huge role as chairman of the Senate Health and Human Services Appropriations Committee. His predecessors, such as former Sen. Durell Paden, openly lobbied for more money for the programs --- with Paden describing the panel as the "life and death committee." After listening to Negron, committee member Eleanor Sobel, D-Hollywood, said she thinks the issue poses a different question: Why does Florida have an increase in the number of poor people, which drives many of the increased health- and human-services costs?

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Sobel also pointed to statistics that show Florida spends less per Medicaid enrollee than the national average. As an example, Florida ranked 45th nationally on spending on children in the Medicaid in 2007, according to information provided to the committee Wednesday. "We're not really spending a lot compared to the other states in the country," Sobel said. Nobody disputes that Florida has major budget problems: state economist Amy Baker said lawmakers are looking at a \$3.6 billion shortfall for the 2011-12 fiscal year that starts July 1.

That led Senate President Mike Haridopolos, R-Merritt Island, to say Wednesday that he is not pursuing tax cuts promised by Gov. Rick Scott during last year's campaign. Haridopolos said any such tax cuts would have to be offset by spending cuts. "My first and primary responsibility is to balance the budget," Haridopolos said. Also, nobody disputes that the Medicaid program has become more costly, putting pressure on the overall budget. Medicaid, which is jointly funded by the state and federal governments, is expected to cost about \$22.1 billion in 2011-12. By comparison, it cost \$14.4 billion in 2006-07.

Negron, Haridopolos and other Republican legislative leaders take every opportunity to point out the increasing Medicaid costs. That could help fuel an expected move this year to overhaul the Medicaid program, requiring beneficiaries to enroll in managed-care plans. House leaders drew up such an overhaul last year, though it did not become law because the Senate did not approve it.

House Health and Human Services Chairman Rob Schenck, R-Spring Hill, said this morning the House will use the basic parts of that plan --- gradually requiring all Medicaid beneficiaries to enroll in managed care --- as a starting point for this year's debate. Negron said the Senate also will start discussing a Medicaid-overhaul proposal before the legislative session begins in March. He said the proposal is still being put together.

But whatever happens with the Medicaid overhaul, lawmakers still will have to find a way to balance the budget for the coming year.

Negron attributed at least some past spending to political power of health- and human-services groups. He said groups present visions of "dueling apocalypses" if funding is cut, and lawmakers have reacted to programs that tell the most-dire stories. In writing the 2011-12 budget, Negron said he expects to divide the health- and human-services budget into levels of priority. He said some areas of the budget will be cut, but other parts could see increases. "I don't believe in across-the-board cutting," Negron said.

Source of information obtained from: Health News Florida 1/13/2011 <http://www.healthnewsflorida.org/index.cfm/go/public.stories/article/21336> By Jim Saunders

Senators find out about super-secret drug contract costing FL state millions

The state of Florida is paying too much for prescription drugs because, in part, its contract with a middleman bars discussion about potential cost-savings, a consultant told the Senate Budget Committee this afternoon. In addition, the state – the largest employer in Florida – is paying way more than other businesses for prescription drug dispensation, consultant Jeffrey Lewis, who analyzed state agencies' spending on prescription drugs, found. The state pays a \$4.28 dispensing fee to pharmacies for each prescription filled, more than three times more than the \$1.25 market rate. But the state's getting ripped off even worse for mail-order drugs, Lewis said. Florida pays a dispensing fee of \$4.22 for each prescription filled through home delivery while most other companies pay nothing. "Paying for mail-order is unheard of," Lewis said. Senate budget chief J.D. Alexander requested the analysis of prescription drug spending after running into trouble getting information from state agencies about what they were spending on drugs.

Just before Lewis' presentation, Alexander, R-Lake Wales, and his committee learned that the state's budget hole is continuing to grow and is now at an estimated \$3.62 billion. Lewis, the president of the Heinz Family Philanthropies, estimated the state could save about \$230 million in two years by revamping how it buys prescription drugs. Florida should renegotiate the contract with Minnesota Multi-State Contracting Alliance and its distributor Cardinal Health, Lewis recommended, among other things. "This is incredible," said Sen. John Thrasher, R-St. Augustine. "Hopefully somebody from the governor's office is in here. If they're not I would recommend somebody hand carry this down to the first floor right now," Thrasher said, waving a copy of the presentation. Thrasher asked if Gov. Rick Scott, whose office is now scrutinizing all state contracts worth more than \$1 million, could issue an executive order to change any of the state's prescription drug purchasing processes. "Our governor obviously likes those kinds of things," Thrasher said.

Source of information obtained from: The Palm Beach Post (01/12/11) - <http://www.postonpolitics.com/2011/01/senators-find-out-about-super-secret-drug-contract-costing-state-millions/> by Dara Kam

FL State's AIDS drug program now in 'crisis'

State officials are desperately trying to figure out how to keep a program that pays for AIDS drugs going until new federal money comes down in April, caught up in a nationwide problem caused in part by a down economy.

The Department of Health's AIDS Drug Assistance Program is \$14 million in the red and by next month patients may not get their drugs, two Department of Health officials told a state Senate committee on Wednesday. "We're out of money," Lorraine Wells, Program Director for Florida's AIDS Drug Assistance Program, told the Senate Budget Committee's Health and Human Services Appropriations Committee.

Help may be on the way. The committee's chairman, Sen. Joe Negron, said lawmakers are interested in finding a solution to prevent anyone from going without drugs, and, he said, the governor's office is also looking into the issue. A national foundation that works with the pharmaceutical industry may have at least a partial solution, as well. The program is mostly federally funded – it gets about \$85 million through the federal Ryan White Care Act – but the state chips in just under \$10 million. The program pays for drugs to stem the disease for about 10,000 people in Florida.

But with the next round of federal funding not expected until April, the program needs \$14.5 million, essentially immediately, to continue to be able to pay for drugs until then. "We're exploring options," Wells told the committee. The only way the Legislature could likely help would be to move money around in the current year budget, something that would have to be done by the Legislative Budget Commission. That's one option that lawmakers are looking at said Negron, R-Stuart. "We're going to explore which avenues are available," he said. "Obviously it's a crisis situation. I know the governor's office is looking at it as well."

Another possibility is that a pharmaceutical industry effort may chip in and solve the problem. Several drug makers, led by a South Carolina company called Welvista and the Heinz Family Philanthropies Foundation have already set up a program where they give the drugs for free to anyone on a waiting list for a similar state assistance program – such programs run in every state and many have experienced cash flow problems like in Florida. Heinz Family Philanthropies President Jeffrey Lewis said Wednesday that the state should talk to him because he thinks he can solve the short term problem, hinting that the industry may be able to help.

Florida, which has one of the nation's largest HIV/AIDS case loads, is suffering the same fate as other states, the economy is causing a big part of the problem. "It's unprecedented demand is what it is," said Jesse Fry, co-chairman of the Florida HIV/AIDS Advocacy Network. "It got a lot worse than anybody thought it would. People that are working and maybe lost a job to which prescription coverage was attached, if they lose that job they go right to an AIDS service organization and the demand was overwhelming in a very short period of time." AIDS patients are also living longer, increasing demand for drugs.

Source of information obtained from: The News Service of Florida - <http://www.healthnewsflorida.org/index.cfm/go/public.stories/article/21320> By David Royse

Insurance News: New York

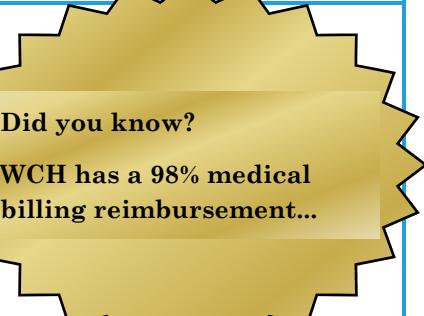
Medicare

Medicare Proposes Multiple Procedure Reduction for Same Day Treatments

Section 3134 of The Affordable Care Act added section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 75 percent payment for the PE. For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

The reduction applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at <http://www.cms.gov/Transmittals/downloads/R800OTN.pdf> on the CMS website. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example:



	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed Total Payment	Proposed Pay- ment Calcula- tion
Work	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	no reduction
PE	\$10.00	\$10.00	\$8.00	\$28.00	\$23.50	\$10 + (.75 x \$10) + (.75 x \$8)
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	no reduction
Total	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	\$18 + (\$18-\$10) + (.75 x \$10) +(\$20-\$8) + (.75 x \$8)

There claims are impacted by the MPPR, Medicare will return a Claim Adjustment Reason Code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a Group Code of Contractual Obligation (CO).

Source of information obtained from: <http://www4.cms.gov/MLNMattersArticles/downloads/MM7050.pdf>

Medicare Assigns G Codes for Medicare Wellness Visits

Medicare beneficiaries will be thrilled that Medicare will cover annual well checks.

The Center for Medicare introduces a new benefit of wellness visits for beneficiaries annually, except during the year of their Welcome to Medicare exam. You'll use two HCPCS level II codes to represent the new annual wellness visits, as follows:

G0438 – Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit

G0439 – Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

Medicare crosswalked the RVUs of 2.43 from new patient office visit code 99204 to G0438, and the RVUs of 1.50 from established patient office visit code 99214 to G0439.

Source of information obtained from: <http://codingnews.inhealthcare.com/hot-coding-topics/medicare-assigns-g-codes-for-medicare-wellness-visits/>

Emergency Update to the CY 2011 Medicare Physician Fee Schedule Database

Medicare Physician Fee Schedule Revisions and Updates

Some physician work, Practice Expense (PE) and Malpractice (MP) Relative Value Units (RVUs) published in the CY 2011 MPFS Final Rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS Final Rule Correction Notice public use data files located at <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp> on the Centers for Medicare & Medicaid Services (CMS) Web site. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at <http://www.cms.gov/Transmittals/downloads/R828OTN.pdf> on the CMS Web site.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS Final Rule has been revised. This CF will be published in the CY 2011 MPFS Final Rule Correction Notice. Legislative changes subsequent to issuance of the CY 2011 MPFS Final Rule have led to the further revision of the values published in the CY 2011 MPFS Final Rule Correction Notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows:

- **Physician Payment and Therapy Relief Act of 2010** On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and

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Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS Final Rule policy of a 25 percent Multiple Procedure Payment Reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Security Act. This change is detailed in recently released CR7050. CMS published *MLN Matters* article 7050, related to CR 7050, which may be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM7050.pdf> on the CMS Web site. This Act also made the therapy MPPR not budget neutral under the Physician Fee Schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

- **Medicare and Medicaid Extenders Act (MMEA) of 2010** On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare Fee-For-Service program policies. A summary of MPFS-related provisions follows.
- **Physician Payment Update** Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is \$33.9764.
- **The calculation of the CY 2011 conversion factor is illustrated in the following table.**

December 2010 Conversion Factor	\$36.8729
MMEA "Zero Percent Update"	0.0 percent (1.000)
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)
CY 2011 Conversion Factor	\$33.9764

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- The revised CY 2011 MPFS payment files will reflect this conversion factor.

- **Extension of Medicare Physician Work Geographic Adjustment Floor** Current law

requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished through December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCCIs can also be found in the attachment to CR 7300 as noted previously.

- **Extension of MPFS Mental Health Add-On** Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by five percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy can also be found in the attachment to CR 7300.

- **Extension of Exceptions Process for Medicare Therapy Caps** Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011. The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

- **Extension of Moratorium That Allowed Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients** Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for

claims with dates of service on or after January 1, 2011, through December 31, 2011.

Source of information obtained from: NGSMedicare What's New (01/12/11)

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Abduct restrainer canvas & Web);
- L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Acromio/clavicular canvas & Web); and
- L3675 SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, and PREFABRICATED INCLUDES FITTING AND ADJUSTMENT (SD: Canvas vest SO).

These three "L" codes will continue to stay active codes for January 1, 2011.

Source of information obtained from: NGSMedicare What's New (01/12/11)

Healthcare Common Procedure Coding System Code Set Update - April 2011 Quarterly Update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web site at: http://www.cms.gov/HCPCSRReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

G0431	revised	drug screen single class	Drug Screen single class, high complexity test, (e.g. immunoassay, enzyme assay), each specimen
G0434	new	Drug screen, multi drug class	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G0435	revised	Oral HIV-1/HIV-2 screen	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening).
G0436	new	Tobacco-use counsel 3-10 min	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes

Changes are effective on the date indicated on the update.

Source of information obtained from: NGSMedicare What's New (01/11/11)

Rewrites to Claims Processing Instructions for Services Rendered in Place of Service Home

This article is for physicians and other providers who bill Medicare contractors (carriers and Medicare administrative contractors [A/B MAC]) for services provided to Medicare beneficiaries in Place of Service (POS) Home (or any other place of service that Medicare contractors consider to be home).

What You Need to Know: CR 6947, from which this article is taken, represents no change to payment policy. CR 6947 requires that you now enter the address of where services were performed, including the ZIP code, on claims for anesthesia services and every service payable under the Medicare Physician Fee Schedule (MPFS), for services provided in all places of service, including Home. This change will be effective for claims that you submit on the 5010 version of the ANSI X12N 837 P electronic form that are processed by Medicare on or after January 1, 2011, and on the paper Form CMS-1500 for claims processed on or after January 1, 2011. (Claims submitted on the 4010A1 electronic form are not impacted by this change.) You should make sure that your billing staffs are aware of this change.

Background: Currently, you are required to submit claims for anesthesia services and for services payable under the MPFS with the address and ZIP code of where the service was performed included on the claim for services provided in all places of service (POS), except when the POS is home. In order to stay consistent with the 5010 version of the ANSI X12 N 837 P format (which is to become effective on January 1, 2011) the exception for POS home will no longer be effective.

Specifically, CR 6947 from which this article is taken, announces that effective for claims that you submit using the 5010 version of the ANSI X12N 827 P electronic claim form that are processed on or after January 1, 2011, and for paper claims that you submit on the Form CMS-1500 for claims that are processed on or after January 1, 2011; you will need to submit the address and five-digit ZIP code (or the nine-digit code when required per the CMS ZIP Code file) of where the service was provided for services performed in all places of service, including POS home – 12, (and any other POS that contractors at their discretion consider to be home). Your carrier or A/B MAC will use that ZIP code to determine the correct payment locality.

Additionally, please remember that you cannot submit the Form CMS-1500 with more than one POS. Separate the Centers for Medicare & Medicaid Services (CMS)-1500 claims must be submitted for each POS. Your carrier or A/B MAC will return as unprocessable such claims if you include more than one POS. When returning these claims with more than one POS, Medicare contractors will use the following claims adjustment reason code (CARC) and remittance advice remark codes (RARCs):

- CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- RARC M77 - Missing/incomplete/invalid place of service.

RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When returning claims for failing to include the address where the service was performed, Medicare contractors will use the following CARC and RARCs:

- CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- RARC MA114 – Missing/incomplete/invalid information on where the services were furnished.

RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note that claims submitted on the 4010A1 version of the electronic claim form are not affected by CR 6947.

Source of information obtained from: NGSMedicare What's New (01/10/11)

Beneficiaries Who Choose Medicare Advantage Plans in Lieu of Traditional Fee-for-Service Medicare

Medicare Advantage Plans are health plan options that are part of the Medicare Program.

Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans

Did you know?

WCH credentials providers in the shortest amount of time...

Medicare beneficiaries have the option of receiving their care through the traditional fee-for-service (FFS) Medicare Program or by enrolling in one of the Medicare Advantage Plans mentioned above. When a beneficiary chooses to enroll in a Medicare Advantage Plan in lieu of traditional Medicare fee-for-service, traditional Medicare does not become secondary to the Medicare Advantage plan. Claims for items and services provided to the beneficiary must be submitted to the Medicare Advantage plan in which the beneficiary is enrolled. Upon receipt of payment or denial from the beneficiary's Medicare Advantage plan, a secondary claim may not be submitted to traditional fee-for-service Medicare for secondary payment, as Medicare is not secondary to Medicare Advantage Plans.

Source of information obtained from: NGSMedicare What's New (01/14/11)

No Date Set for Expanded Ordering/Referring Provider Claim Edits

Due to recent inquiries, the Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding expanded ordering/referring provider claim edits. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS will give providers ample notice before claim rejections begin. Recent revisions to Change Requests (CRs) 6417 and 6421 require Medicare administrative contractors to delay rejecting claims until receiving further direction from CMS.

Source of information obtained from: NGSMedicare What's New (01/10/11)

Americhoice by UnitedHealthcare

NDC Soon Required for in Office Administered Drugs

The Patient Protection and Affordable Care Act (PPACA), a product of the health care reform; included in the act are the provisions of the Drug Rebate Equalization Act of 2009 (DRE), intended to equalize the treatment of prescription drugs discounts between Medicaid managed care and Medicaid fee-for-service. DRE is seen as a way to provide relief for federal and state budgets, mitigating the need for added cuts to Medicaid benefits or populations. In accordance with the Act, MCOs are responsible to provide and electronic file to the State, summarizing pharmacy payments, which includes retail pharmacy and physician administered drugs in professional and outpatient settings.

UnitedHealthcare released a letter stating the above and following information: UnitedHealthcare has not received direction from NYS with regard to an effective date, but are asking providers to begin including the National Drug Code (NDC) information, in addition to the HCPCS code, when billing for a physician administered drug in an office. Once the effective date is released we will be notified immediately. Once their systems have been updated, any claim submitted with a drug administered code without an NDC will be denied. We ask you that you begin providing the NDC with your billing when administering a drug.

Source of information obtained from: December 6, 2010 Americhoice by UnitedHealthcare Provider update letter



Beacon Health Strategies

Effective January 1, 2011 all requests for outpatient review must be submitted electronically via Beacon's eServices. There are many advantages to electronic submission, including efficiency, accuracy, timeliness, and environmental impact.

- Avoid denials, fewer claim denials and resubmissions
- Quicker transactions on eServices: fewer fields required than on paper forms, more text space to explain, if warranted; forms note the required fields to avoid denials or incomplete submissions; facilities can submit claims via EDI
- Get automatically emailed when authorization decisions are made
- Save authorization requests and return to them later
- Get the most accurate eligibility information: Eligibility on eServices is directly from FlexCare system; View benefit information, by product of member-specific
- Access clinical information, including level of care criteria
- Ecologically friendly, reduce paper use
- Potential for automatic authorization
- More secure and reliable

Visit www.beaconhealthstrategies.com and choose PROVIDER, then PROVIDER TOOLS

Register for eServices now at: <https://provider.beaconhs.com>



HomeFirst/Elderplan Merger

Effective December 31, 2010 HomeFirst was merged into Elderplan. The purpose of this merger was to streamline processes, reduce overhead costs, and improve member, provider, and vendor services. The new name of the organization is Elderplan, Inc. d/b/a HomeFirst. Current health plan benefits have not changed for HomeFirst or Elderplan members as a result of the merger. Elderplan will continue to operate the HomeFirst program, without interruption. All of the terms and conditions set forth in your agreement with HomeFirst shall continue in full force and effect without interruption.

If you have any questions or concerns contact Stephn Rice at (718) 759-4054.

Source of information obtained from: HomeFirst/Elderplan Notice of Merger



Aetna Building a Case for a "Mind-Body" Approach to Stress Management

Aetna, Duke Integrative Medicine, eMindful Inc. and American Vinyoga Institute Conduct Randomized Controlled Studies on Potential of Therapeutic Yoga and Meditation; Initial results prompt Aetna to expand pilot in 2011.

Hartford, Conn., January 13, 2011 — Aetna announced that early results from randomized controlled pilot studies of two stress-reduction programs showed significant reductions in stress as compared to the control group. Aetna's review of medical claims' data showed a positive correlation between costs and study participants' stress levels, suggesting potential health care costs savings could be realized by reducing stress. Additionally, health improvements were suggested in the treatment groups over controls, leading to further studies.

Aetna collaborated with eMindful Inc.'s research team headed by Ruth Q. Wolever, PhD, Director of Research at Duke Integrative Medicine, and Gary Kraftsow, MA, E-RYT 500 of the American Vinyoga Institute, to test whether mind-body approaches, such as mindfulness meditation and therapeutic yoga, can reduce stress and improve overall health. The success of both programs offers evidence that certain mind-body approaches can be an effective complement to conventional medicine, a field broadly known as Integrative Medicine.

"Helping people take control of their health is a critical step in achieving better health and reducing the cost of health care," said Aetna CEO and President Mark Bertolini. "Stress takes a significant toll on physical and

mental health. We want to understand, and also demonstrate, whether integrative medicine can offer our members options that both better suit their lifestyles and can be proven to improve their health. We will continue to build an evidence base for the mind-body approach to health."

The American Psychological Association estimates that 43 percent of U.S. adults suffer adverse health effects from stress including reduced immunity to illness, increased risk of diabetes and weight gain. Among the Aetna study volunteers, those reporting the highest level of stress had higher medical costs, nearly \$2,000 more annually, than those reporting the lowest level of stress.

"Prior evidence for effectiveness of stress-reduction programs has typically been linked to higher program doses – requiring more class time and intensity," said Dr. Ruth Wolever, director of research at Duke Integrative Medicine and Principal Investigator on the study. "We found these new mind-body programs to produce results in about half the time of other commonly used mind-body interventions. We are highly encouraged by the effectiveness observed in these studies."

"Prior evidence for effectiveness of stress-reduction programs has typically been linked to higher program doses – requiring more class time and intensity," said Dr. Ruth Wolever, director of research at Duke Integrative Medicine and Principal Investigator on the study. "We found these new mind-body programs to produce results in about half the time of other commonly used mind-body interventions. We are highly encouraged by the effectiveness observed in these studies."

"The positive results seen in these

studies offer evidence that mind-body approaches to health improvement are an effective and targeted solution for employers who want to lower the costs associated with stress and help their employees achieve better overall health," said Kyra Bobinet, MD, MPH, medical director of Health and Wellness Innovation at Aetna, and clinical director of the study. "Furthermore, the studies showed that online classes and in-person delivery showed equivalent results, and both had high engagement rates among participants. This finding is particularly important as it will enable the program to be offered to customers with employees in multiple locations and among different organizational levels."

Research study

In 2010, 239 Aetna employees who volunteered to participate in a mind-body stress reduction program had access to a pilot that offered complementary therapies focused on mindfulness meditation and yoga. As part of the studies, 96 employees were assigned to mindfulness-based classes, 90 were assigned to therapeutic yoga classes and 53 were assigned as the control group.

The 12-week mindfulness meditation-based online program was developed and offered by eMindful. Participants interacted using video, audio and instant messaging chat or in-person instruction. Expert instructors from eMindful helped participants learn self-care, with the objective of improving overall health and energy levels. Participants also learned stress reduction techniques, more effective management of work load and better ways to prioritize tasks to increase efficiency and effectiveness.

The second group of Aetna employees participated in a 12-

week therapeutic yoga-based program developed by American Vinyoga Institute founder Gary Kraftsow. Participants received instruction for managing stress including physical yoga postures, breathing techniques, guided relaxation and mental skills. The yoga classes helped relieve muscle tension in the back, neck and shoulders, improve sleep and increase feelings of well-being. The classes also provided coping strategies for dealing with stressful events and promoted use of home and office strategies for reducing stress through yoga. The program offered weekly in-person classes, home practice handouts and yoga break handouts for home and office use.

"According to the National Institutes of Health, 40 percent of Americans use alternative health therapies and, among these, mind-body techniques have shown the greatest increase in adoption over the past few years," said Elease Wright, head of Human Resources at Aetna. "We are seeing the benefits first-hand here at Aetna. We offer programs and services that balance the focus between the physical aspects of health, as well as the mind and emotions." Aetna will expand the research studies to more Aetna employees, and pilot the mind-body programs with select employers this year. Full results from the pilot program will be available later this year.

About Aetna

Aetna is one of the nation's leading diversified health care benefits companies, serving approximately 35.4 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability

plans, and medical management capabilities and health care management services for Medicaid plans. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates. For more information, see www.aetna.com. To learn more about Aetna's innovative online tools, visit www.aetnatools.com.

About eMindful

eMindful, Inc. (www.eMindful.com) is the nation's leading evidence-based provider of live, online mind-body wellness programs. Its courses are led by highly credentialed instructors who deliver engaging curriculums in a virtual classroom to participants around the world. With the ability of participants and instructors to interact with each other in a real-time format the resultant experience produces an effective and efficient means of learning. eMindful, Inc. is based in Vero Beach, FL and has support facilities throughout the United States.

About Duke Integrative Medicine

Duke Integrative Medicine is a gateway to patients' optimal health and healing, a portal to the vast spectrum of scientific advances at Duke Medicine, and an open door to the innate healing power held within each person. The focus of care is on individual patients and how cutting-edge medical research and the powerful impact of their knowledge, choices and spirit can transform their health and healing. Duke Integrative Medicine guides patients through the complexity of modern medicine to unleash their individual power for optimal health. Experts partner with patients -- providing treatments, resources, time and support -- so they can address and plan for all their health needs and goals

About American Viniyoga Institute

American Viniyoga Institute (AVI) is an organization of yoga practitioners and professionals sharing core values, guided by the teachings of Viniyoga, and dedicated to offering quality experiential educational and professional training opportunities in the fields of health and fitness, therapy and self-care and personal transformation. AVI (www.viniyoga.com) is a leader in the United States in training advanced-level Viniyoga teachers and yoga therapists.



Source of information obtained from: Aetna News Release (01/13/11)

Medicaid: Physician Enrollment

Effective 1/1/11, Physicians wishing to enroll in the FFS Medicaid program must also participate in the CAQH® Universal Provider Datasource.

Physicians not enrolled in CAQH must complete a CAQH registration kit and obtain for CAQH Provider ID.

To complete the CAQH you will need:

- CAQH Provider ID number (included in registration kit sent from CAQH).
- Previously completed credentialing application (for reference)
- List of all previous practice locations.
- Copies of: Curriculum vitae (resume), Medical license, DEA certificate (if applicable), IRS Form W-9, Malpractice insurance face sheet, Summary of any pending settled malpractice cases



For help completing the CAQH application, contact the CAQH Help Desk: Phone: 1-888-599-1771 E-mail:caqh.updhelp@acsqs.com Once New York Medicaid Authorized in CAQH provider must submit the Physician Request for Enrollment form to request for enrollment. All forms are available at www.eMedNY.org.

CAQH mandatory only for physicians

- Enrollment as a group requires that all group members be enrolled as individual providers in the New York State Medicaid program.
- Group and multi-service providers will continue to use the paper enrollment forms
- A solo practitioner (PC) who chooses to bill the New York State Medicaid program using an EIN and organizational NPI must complete a group application and enroll as a one man group.
- Office Based Surgeries: A complete Office Based Surgery form (EMEDNY 432501) accompanied by the appropriate accreditation certificate must be submitted to address on the form.
- If provider has been excluded or terminated from the Medicaid or Medicare Program OR answered "Yes" to any of the first four questions in the Disclosure of Ownership and Control section of the Request for Enrollment form must submit the completed Prior Conduct Questionnaire along with Request form.

Insurance News: New Jersey

Governor Signs Bill to Upgrade the Offense of Assaulting a Nurse in N.J.

Madden legislation to upgrade the offense of assaulting a nurse in N.J. now law

TRENTON — Legislation to upgrade the offense of assaulting a nurse or other health care profession to aggravated assault was signed into law Wednesday by Gov. Chris Christie.

The law — whose sponsors include Sen. Fred Madden, D-Washington Township — upgrades the offense for any individual who assaults a nurse or other healthcare professional, while in the performance of his or her official duties, from a simple assault to aggravated assault. If the nurse or healthcare professional suffers bodily injury as a result of the assault, it will be classified as a third degree crime; otherwise it will be a fourth degree crime.

"Health care workers are faced with the threat of violence on the job far too often," said Madden. "This law would make the punishment for assaulting a nurse just as severe as the penalty for assaulting a law enforcement officer, volunteer firefighter, or EMT."

Source: NJ.com (01/05/2011). http://www.nj.com/gloucester-county/index.ssf/2011/01/madden_legislation_to_upgrade.html

Did you know?

WCH staff is fraud, waste, and abuse compliance certified by CMS...

Coding News

AMA Corrects Vestibular Test Codes to Allow Partial Reporting

In the beginning of 2010, the Correct Coding Initiative (CCI) put restrictions on practices from reporting 92541, 92542, 92544, and 92545 individually if three or less of the tests are performed, notes Debbie Abel, Au.D., director of reimbursement and practice compliance with the American Academy of Audiology.

However, since October 1, 2010, "if two or three of these codes are reported for the same date of service by the same provider for the same beneficiary, an NCCI-associated modifier may be utilized to bypass the NCCI edits," CMS wrote in a decision to alter the edits.

Source of information obtained from: <http://codingnews.inhealthcare.com/provider-news/92541-92544-will-soon-be-ok/>

CPT 99406, 99407 Coverage Extended to All Smokers

In the past, CMS only covered 99406-99407 (*Smoking and tobacco use cessation counseling visit...*) for a beneficiary with a tobacco-related disease or with signs or symptoms of one. But on Aug. 25, CMS announced that "under new coverage, any smoker covered by Medicare will be able to receive tobacco cessation counseling from a qualified physician or other Medicare-recognized practitioner who can work with them to help them stop using tobacco."

The new tobacco cessation counseling coverage expansion will apply to services under Medicare Part B and Part A. "The new benefit will cover two individual tobacco cessation counseling attempts per year," CMS indicated in an Aug. 25 news release. "Each attempt may include up to four sessions, with a total annual benefit thus covering up to eight sessions per Medicare patient who uses tobacco."

Source of information obtained from: <http://codingnews.inhealthcare.com/provider-news/cpt-99406-99407-coverage-extended-to-all-smokers/>

CPT 2011: Goodbye 90465-90474, Hello Vaccine Administration Component Coding

For combination vaccines that may involve counseling on as many as five different diseases, getting paid as though you counseled on one never seemed fair, but CPT 2011 lets you capture that extra counseling work.

Although multiple component vaccines require counseling on each disease, physicians have only been able to capture counseling for vaccine administration once per administration. CPT 2011 solves the problem with new immunization administration with counseling codes that you'll code per vaccine component.

CPT 2011 deletes 90465-90468 (*Immunization administration younger than 8 years of age ... when the physician counsels the patient/family ... per day*). Codes 90471-90474 (*Immunization administration ...*) remain.

Use 90460 as Vaccine Administration With Counseling Base Code

No more looking at administration route when choosing which immunization administration with counseling code. For vaccine administration, you'll

assign one code for each vaccine's initial component: 90460 — *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component.*

Definition: A component refers to the antigen in a vaccine that prevents disease caused by one organism.

CPT streamlines your coding of the vaccine counseling codes by giving you one universal base code. The code includes "any route of administration." You no longer have to choose a different code based on whether the code is intramuscular/subcutaneous or oral/intranasal.

Step 2: Report Second Vaccine Component With +90461

Coders can breathe a sigh of relief as the complexities over deciding which 90465-90468 code to use as the base code will soon end. CPT 2011 gives you only one vaccine administration with counseling base code (90460). For each additional vaccine component, you report the same add on code: +90461 — *Immunization administration through 18 years of age via any route*

Source of information obtained from: <http://codingnews.inhealthcare.com/hot-coding-topics/cpt-2011-goodbye-90465-90474-hello-vaccine-administration-component-coding/>

Update on Medical Review Audit for Chiropractic Codes 98941 and 98942

National Government Services recently conducted a Medical Review audit on chiropractic current procedural terminology (CPT) codes 98941 and 98942. Over 10,000 claims for these services have been received to date. Medical record documentation has been requested to support these claims.

Because of the volume of claims involved in this audit, and the amount of medical records submitted, some of the claims are being denied for timely submission in error.

If we submitted the medical record documentation—but have received a denial due to not submitting the requested information on a timely basis—the Medical Review team at NGS will review each claim for which records were received. They will reopen those claims that have denied as long as they have received the requested documentation.

There is no time frame for the completion of this process.

If NGS finds that two records were combined into one case as records are reviewed, the records will be separated and claims reviewed appropriately.

NGS requested that we do not fax any records to their Medical Review staff unless you have received a specific request.

In those cases in which claims were denied as not having received the requested information on a timely basis and you did not submit the requested information, these claims were denied correctly. We will need to submit a written appeal for these claims along with the documentation.

Source of information obtained from: What's New NGS Medicare website

Did you know?

WCH has developed an educational website, with 3D lessons design...

Clear The Smoke On Debridement And Active Wound Care Codes

Confused about when to choose a debridement code and an active wound code? CPT 2011 is here to your rescue with revised debridement code guidelines that clarify how to choose between the two code groups — and the key word that will tighten up your coding is depth.

"Depth is the only documentation item you need to determine the correct code," explained Chad Rubin, MD, FACS, AMA Specialty Society Relative Value Scale Update Committee (RUC) Alternate Member with Albert E. Bothe, Jr. MD, FACS, American College of Surgeons, AMA CPT Editorial Panel Member at their joint presentation "General Surgery" at last month's CPT Symposium in Chicago.

Active wound care, which has a 0 day global period, is for active wound care of the skin, dermis, or epidermis. For deeper wound care, use debridement codes in the appropriate location.

Example: Codes 11040 (*Debridement; skin, partial thickness*) and 11041 (...*full thickness*) have been deleted. The parenthetical note under the codes' deletion reads, "For debridement of skin, i.e., epidermis and/or dermis only, see 97597, 97598." The codes are revised for 2011 to reflect this change. For instance, the revision for code 11042 (*Debridement, subcutaneous tissue [includes epidermis and dermis, if performed]; first 20 sq cm or less*) removes "Skin, and" and adds after subcutaneous tissue "includes epidermis and dermis, if performed."

Code 97597 is revised to (*Debridement [e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], open wound, [e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm], including topical application[s], wound assessment, use of a whirlpool, when performed and instruction[s] for ongoing care, per session, total wound[s] surface area; first 20 sq cm or less]*). Code 97597's revision involves "mainly rewording to make clear how active wound care is separate from integumentary wound care," Bothe explained.

Source of information obtained from: <http://codingnews.inhealthcare.com/hot-coding-topics/cpt-2011-clear-the-smoke-over-debridement-and-active-wound-care-codes/>

Questions You've Asked

Question: If a nurse has to check vitals to make sure an allergy injection is the correct quantity or if she has to educate the patient about the administration or side effects of the injections, we've been billing 99211 with 95115 or 95117. There is only 1 diagnosis for both CPT codes. We are getting denials for the injection. Can we attach modifier 25 to 99211 or should we consider 99211 included in the injection?

Answer: You may report 99211 and 95115/95117. There is no National Correct Coding Initiative edit on the codes.

However, you should not use 99211 every time you are giving an allergy injection. Providers may bill for a nurse-only 99211 when dealing with clinical issues surrounding allergy injection administration, according to the Joint Council of Allergy, Asthma and Immunology (JCAAI).

The nurse must document the medically necessary E/M service that she provided. The JCAAI suggests the service could represent directing a nurse who gives injections on what to do if a patient was ill; missed an injection; or had a large, local reaction or mild unreported systemic symptoms after his last injection.

Be careful: Do not consider the required post-injection observation sufficient reason for reporting 99211. Codes 95115-95199 include the professional services necessary for allergen immunotherapy, according to CPTs Allergen Immunotherapy instructions. CPT goes on to state, Office visit codes may be used in addition to allergen immunotherapy if other identifiable services are provided at that time. You do not technically need modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on 99211 with 95115 for single injection or 95117 for multiple injections. When you bill 99211 for providing clinical advice related to the injection, modifier 25 is unnecessary and does not apply, according to the JCAAI member letter (for a copy, go to <http://codingnews.inhealthcare.com/category/toolkit/>).

Source of information obtained from: Jen Godreau, CPC, CPMA, CPEDC

Question: I would like to know the correct codes for billing a PPD test provided in the office. Should I use 86580 with V74.1 and what should I bill for the PPD administration?

Answer: You are using the correct diagnosis code: V74.1 (Special screening examination for bacterial and spirochetal diseases; pulmonary tuberculosis). Since the test is an inoculation screening test, which detects antibodies and the presence of the disease, rather than a vaccination, the test includes administering the skin test and you should not code separately for the administration. The AMA Resource Based Relative Value System does not include costs for a reading. Many patients who do not show a response to the test may never return for a reading so this nurse administration cost is not included in the RVUs for 86580 (Skin test; tuberculosis, intradermal). If the patient does return for a reading, you may code 99211 for the nurse reading. If the test is positive, a physician will typically have a face-to-face visit with the patient (99212-99214, Office or other outpatient services) discussing the diagnosis and further evaluation and treatment options.

Do not code separately for the Mantoux. Code 86580 includes the purified protein derivative (PPD). Charge all allowed services with advice from Pediatric Coding Alert

Source of information obtained from: Jen Godreau, BA, CPC, CPMA, CPEDC.

Question: (Regarding Multiple Office Locations)- I have a provider with 2 offices and splits time between both but does their billing exclusively under one office. I'm thinking we need to possibly register the second location - am I understanding this correctly? Also, if a FP Doc asks a MH provider to share their office one day a week to see patients - and the MH provider will bill all encounters separately do we need to register an additional office address for the MH provider? (Most likely the MH provider will only see the client once at the FP location with subsequent visits being at the client's home).

Answer: Yes. You will need to update the insurance carriers with that location and you will need a separate facility NPI for that location. This is especially important for Medicare as you are non -compliant. The actual place of service where the services were performed must be on the claims.

Source of information obtained from: http://www.ambanet.net/amba_news0810.htm

Question: Records Retention - I know some time back someone had a great link to a resource listing medical or billing record retention requirements by State. Does someone still have that link? I'm not finding it online.

Answer: Here is an updated list from AHIMA on records retention.

http://library.ahima.org/xpedio/groups/p...ok1_012545

Source of information obtained from: http://www.ambanet.net/amba_news0810.htm

Some recent pictures from the staff



WCH Feedback Form

Please use this form for your suggestions and comments.

Your Name

Email Address