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

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Dear Providers and Office Administrators,

We created WCH Times with a purpose to provide our clients with the company goals, plans for future, accomplishments, offer professional advice on variety of issues facing healthcare providers in challenging time. Throughout publication we will share with you our ideas as well as provide vital information of today's complex healthcare industry including coding policies, recommendations and important tips on how to run a smooth practice. Additionally we want our clients to receive benefits of reading our publication: receive CEU credits, advertise their services, and meet other professionals in the healthcare industry. WCH Times includes updates on legislation, legal
issues, medical insurance updates, practice management, and billing and coding issues.

All newsletter and bulletin you can find online on WCH website http://wchsb.com/News/Bulletins

We are always looking forward for receiving your feedback, any time you can voice your opinion by providing the article for newsletter. Please feel free to send email with your comments and recommendation to **Olesya Petrenko** WCH Marketing Manager via email olesyap@wchsb.com

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CHANGES IN THE CREDENTIALING DEPARTMENT

Please be aware, that **Dildora Mirkhasilova** has taking over supervising of credentialing department. She is responsible for controlling all credentialing department work flow, routine responsibilities, clients problems resolutions, communications with management and education of staff. Feel free to contact **Dildora Mirkhasilova** about your next credentialing project.

Dildora Mirkhasilova,
Credentialing Department Supervisor,
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ICD 10-WCH INTERVIEWED BY CMS RESEARCH TEAM

We are glad to inform our clients that WCH was selected by CMS to be interviewed by their contracted market research consultants Alan Newman Research on the ICD-10. It was a great honor and privilege to be one of the chosen vendors for this interview. Olga Khabinskay provided on in-depth look of how WCH is internally and externally preparing for the migration process to ICD-10. Per request of the interviewer, we were asked to keep the information discussed confidential.

Following is information pertaining to the transition process.

The ICD 10 transition will have significant impact on healthcare providers, vendors and healthcare plans. Implementation will require business and technical changes. The most important headache every office will face in **October of 2014** is that, if you don't prepare, you won't be able to submit claims, which means you will not get paid for services.

WCH outlined the most vital aspects of the transition process below:

- Each practice will need: Impact assessment (internal education, purchase software, restructuring internal processes, establishing closer relationship with vendors, upgrading computer system, testing with payers, changing from paper to electronic.

- Each practice must identify how ICD 10 will affect them. They must do it early!

- Develop ICD 10 project plan for each level of users in the practice (what doctor must do ,what front desk must do…etc)

- Estimate and secure budget based on the plan.

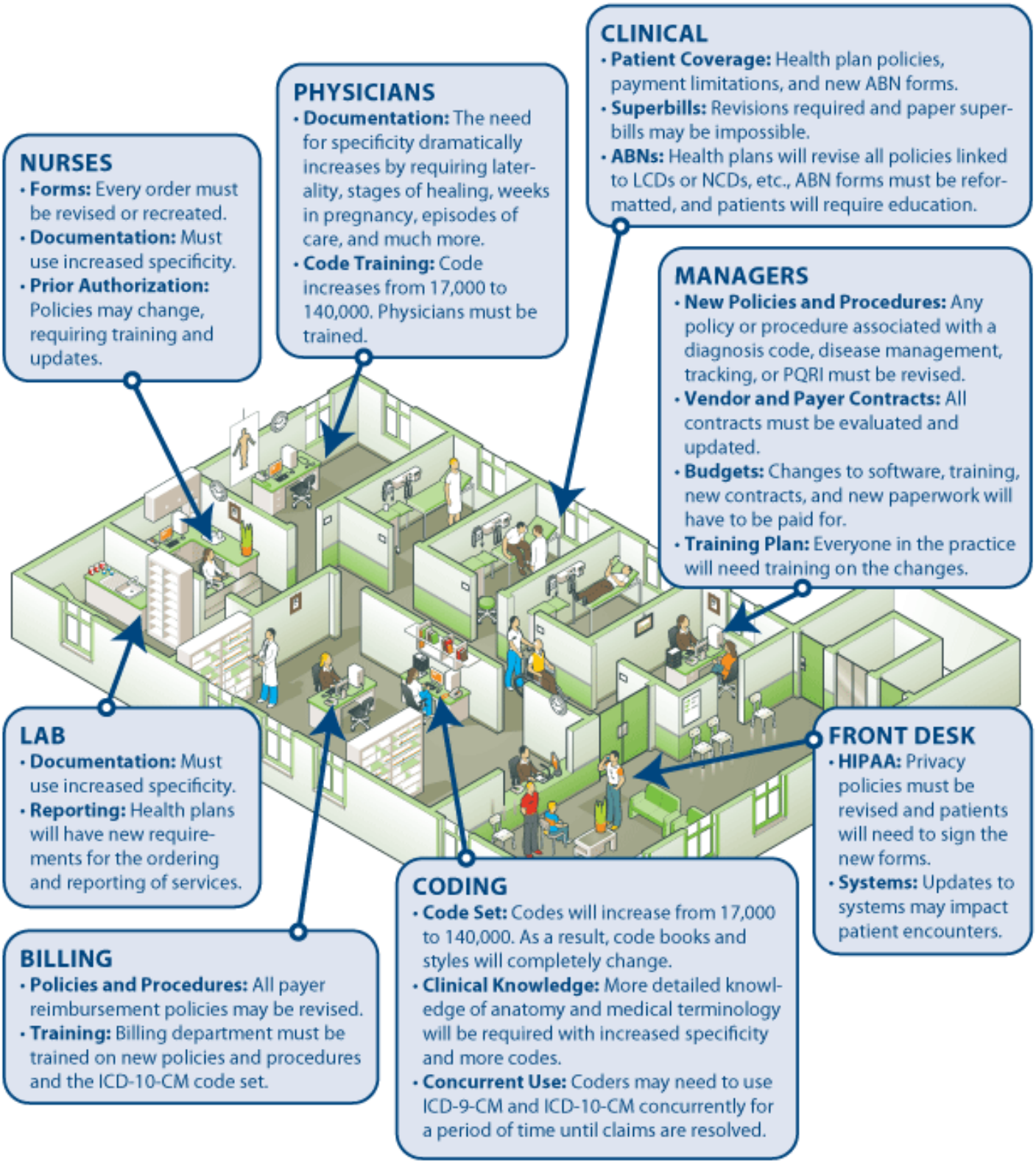
About the ICD-10 Transition

On **October 1, 2014**, all HIPAA-covered entities must transition from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding. The transition promises to reduce health care costs while improving quality. Currently, ICD-9 codes are used to report medical diagnoses and inpatient procedures.

The ICD-9 codes are nearly obsolete; the more definitive code selection available in ICD-10 will reduce follow up correspondence to insurers to substantiate services and support payment decisions. Implementation of the new code sets will yield richer data, resulting in more accurate payment for new procedures; fewer rejected and improper claims; and a better understanding for the payer of new procedures performed by the provider. Overall care coordination and improved disease management is also enabled by use of the more descriptive codes in combination with medical record notes.

Already the standard in most countries, ICD-10 implementation will enable medical researchers to make meaningful comparisons of the U.S. experience with international health data and to obtain improved knowledge when conclusions are drawn from aggregated data using the improved categories. It will also help pave the way for efficient and widespread use of electronic health records (EHRs) because the required SNOMED-CT will be cross-walked to ICD-10 codes. Because diagnosis codes are core elements of many health IT systems, ICD-10's improved structure and specificity are needed to fully realize the benefits of EHRs and other health IT.

WCH is an active member of many professional organizations. We take time to review all the important updates put out by these associations. Recently AAPC released a diagram concerning the ICD-10 transition and its potential impact on the medical practice. We felt that this would be beneficial to share this diagram with you, since it strongly relates to the ICD 10 topic.



Source of image: http://www.aapc.com/ICD-10/office-map/index.aspx

2013 NATIONAL CONFERENCE: ORLANDO, FL APRIL 14-17, 2013

WCH is continuing an education effort about ICD-10. WCH team is attending AAPC National Conference this April in Florida.

The AAPC National Conference features sessions covering various specialties, including medical coding, audit/compliance, billing, practice management as well as legal trends and issues.

The 2013 National Conference will also mark AAPC's launch of ICD-10-CM general code set training - with a full conference track providing comprehensive education for medical coders to prepare for the 2014 implementation of ICD-10. The National Conference will be followed by seven independent regional conferences scheduled through 2014, combining both ICD-10-CM general and specialty code set training and offering supplementary ICD-10 sessions to meet the specific needs of all practice sizes.

Who will be attending :

Olga Khabinskay, General Manager

Oksana Pokoeva, Billing Department Manager

Veronika Mukhamedieva, Account Representative Specialist

She is planning to take CPC exam at the conference, we will announce her results in the Spring issue.

AAPC National Conference topics:

- Risk-Based or Random: How to Determine the Scope of Your Audit
- When EHR and E/M Intersect
- How to Respond to a Payer Audit
- Communication With Providers: An Auditor's Perspective

Please if you have any questions about conference contact Olesya Petrenko via email olesyap@wchsb.com

WCH is proud to announce new attorney on staff - Marina Tylo, ESQ.

She is experienced attorney in general law, divorce, contracting, litigation, etc.
Feel free to contact her for your practice needs.

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CREDENTIALING NEWS

2 NEW YORK CITY HEALTH PLANS MERGE

Two New York City health plans that serve the Medicaid and Medicare market are merging. Healthfirst, the largest Medicaid managed care plan downstate, has entered into an agreement to acquire Neighborhood Health Providers.

The deal marks the second time in a year that Medicaid managed care plans have joined forces. Healthfirst has 700,000 members, and is the sixth largest insurer in the city, according to Crain's Annual List of the Largest Health Plans. Neighborhood Health is a 218,000-member Medicaid plan and ranked 12th, according to Crain's. The transaction is subject to state regulatory approval and will take several months to close.

New York state is moving away from paying providers for every service they perform and are instead paying set fees to manage patients' health. As a result, the state is shifting its Medicaid population into so-called managed care plans, which has spurred consolidation in a fragmented Medicaid managed care market. Last October, Amerigroup paid $85 million to buy Health Plus from Lutheran Medical Center. The terms of the Healthfirst deal were not disclosed.

"We already are the biggest [Medicaid] plan in the New York City area, but this was the right opportunity to gain more scale and [do] a better job of making changes that are very important," said Healthfirst President and CEO Pat Wang.

The economies of scale will help contain administrative expenses. Ms. Wang said the larger scale also will mean more efficient implementation of care coordination.

New York health plans that specialize in Medicaid and other government programs saw a jump in premium revenue of more than 20% between 2009 and 2010, fueled by a boom in enrollment. Their combined net income was $200 million. In comparison, premiums for all New York insurers totaled nearly $51.3 billion in 2010, up only 3.3% over 2009, according to data from the United Hospital Fund.

Source: http://www.healthfirstny.org

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

HEALTHCARE NEWS

ERROR IDENTIFIED IN 1099 FORMS ISSUED FOR 2012 FROM NATIONAL GOVERNMENT SERVICES

National Government Services has identified that the year printed on the 1099 forms issued for the 2012 calendar year is incorrect. The year is listed as 2011 instead of 2012. All other information on the form is correct. All 1099 forms have been reprinted and reissued on Friday, February 1, 2013. Please disregard the version you received in January 2013.
Contact National Government Services at 877-232-1099 if you have further questions.

Source: National Government Services

HOW PHYSICIANS CAN GET PAID FOR CARE COORDINATION

The transitional care management codes should be used when a practice takes care of the issues of a patient returning home or going to another care setting from a hospital or skilled nursing facility. Both codes, 99496 and 99495, require a physician to have and document some kind of medical discussion, although not necessarily in person, with the patient or their caregiver within two business days of discharge. The higher-level code, 99496, calls for a face-to-face visit within a week.

For the lower-level code, 99495, the face-to-face visit may be within two weeks. The other set of new codes can be used for patients a physician or insurer considers in need of significant care coordination services outside of usual face-to-face visits. These services can be provided by a physician, but

coding designers say they are a better fit for nurses or others staffers within their scope of practice. These codes cover designing care plans, linking patients with multiple medical professionals and community service agencies as well as organizing, and attending medical team conferences.

The code 99487 should be used if the patient is not actually seen by the physician, but instead if other practice staff spend an hour over a 30-day period on care coordination involving that patient. Code 99488 includes this hour of care coordination time and a face-to-face visit. Code 99489 should be used for 30-minute increments over the initial hour of care coordination. Medicare considers these codes as bundled with other services, but commercial payers may cover them.

The key to the care coordination codes, consultants say, is to develop systems that track actual time spent. A physician and medical practice staffers may spend 10 minutes coordinating a patient's care one week and 15 minutes the next, but these codes are to be used only once per patient per month and are dependent on the total number of minutes spent on these activities over 30 days. Other evaluation and management services would be billed separately.

Source: www.ama-assn.org

MEDICARE QUALITY REPORTING PENALTY EXPECTED TO STRIKE MOST PHYSICIANS

Physicians could lose up to a total of $1.3 billion a year from their Medicare pay by not satisfactorily reporting quality measures to the program, researchers determined in an analysis of reporting trends.

The loss would be the result of hundreds of thousands of physicians and other health professionals not participating in, or not meeting criteria for, the Medicare physician quality reporting system. Medicare payments will be cut 1.5% in 2015 — and 2% in 2016 and beyond — for every eligible physician who fails to meet PQRS requirements by sending quality data to the Centers for Medicare & Medicaid Services. The 2015 penalty will be based on 2013 reporting activity.

By 2016, radiologists face annual penalties totaling $100 million, while other physicians

would see total penalties of well over $1 billion. Only 21% of the more than 600,000 eligible physicians earned PQRS bonuses in 2010, the latest full year of reporting statistic available from CMS. Federal law requires CMS to start penalizing physicians and other eligible health professionals who do not participate in PQRS by 2015. Due to operational issues, CMS is using 2013 PQRS reporting to determine which physicians would be penalized in 2015.

Under one major change, a physician or group of physicians that attempts to report PQRS measures in 2013 but does not meet the criteria for a bonus still will not have pay rates downgraded in 2015, Dr. Conway said. CMS adopted this policy because 2013 is the first reporting year that involves a possible penalty. At some point, physicians will need to meet the minimum reporting criteria to stop future penalties, but Dr. Conway did not specify when that change would occur.

One code in 2013 could prevent the penalty
CMS has lowered reporting thresholds and increased ways to prevent the 2015 penalty. Agency officials believe a minority of eligible professionals will end up seeing the penalty applied now that a number of these program changes have taken effect.

For example, CMS will deem the submission of at least one quality measure, in the form of a G-code, during an applicable 2013 patient encounter as being satisfactory to stop the 2015 payment adjustment. Submission of the G-code must follow the rules for reporting the PQRS measure, so it must be associated with a service provided during an eligible patient encounter that fits the correct diagnosis codes and criteria for the measure denominator.

Source:
http://www.ama-assn.org/amednews

EDITS 02160 AND 02163 (DELAY REASONS 4 & 8) FOR ORIGINAL AND ADJUSTED DELAYED CLAIMS WILL DENY

New York State Medicaid continues to work to increase provider compliance with delay reason reporting on claims aged more than 90 days. As published in the March 2012 Medicaid Update, eMedNY editing will verify the validity of Delay Reason Codes reported on claims.
Effective January 17, 2013, claims with dates of service over 90 days old may be denied with **edit 02160 - Delay Reason Code 4 (Delay in Certifying Provider) Invalid or edit 02163 – Delay Reason Code 8 (Delay in Eligibility Determination) Invalid**. The associated HIPAA reason code will be THE TIME LIMIT FOR FILING HAS EXPIRED and for Pharmacy claims NCPDP Reject code NV-M/I DELAY REASON CODE.

Delay Reason 4, "Delay in Certifying Provider", is valid when a change in a provider's enrollment status causes the delay in timely submission. The claim must be submitted within 30 days from the time submission came within the provider's control.

Delay Reason 8, "Delay in Eligibility Determination", is valid when the beneficiary's eligibility date and/or coverage was changed or backdated due to eligibility determination administrative delays, appeals, fair hearings or litigation. The claim must be submitted within 30 days from the date submission came within the control of the provider.

The **eMedNY Delay Reason Code Form** is available online at: https://www.emedny.org/HIPAA/QuickRefDocs/index.aspx

Remember: it is the provider's responsibility to determine and report the appropriate delay reason code. Refer to your provider manual's **Information for All Providers General Billing Section** for more details about delayed claim submission at:

Source: https://www.emedny.org

DON'T LET MEDICARE REVALIDATION REQUIREMENTS STOP CASH-FLOW

When Medicare requests your provider to certify the accuracy of his or her existing enrollment information with Medicare revalidation, comply in a timely manner. If you don't, you may lose Medicare billing privileges or disrupt reimbursement.

Revalidate when Requested
Medicare requires revalidation every five years, but also may perform "off cycle" revalidations (including possible site visits). Off cycle revalidations may be triggered by:

- Random checks
- Health care fraud problems
- National initiatives
- Complaints, or other reasons that cause CMS to question the provider's/supplier's compliance with Medicare enrollment requirements
- CMS is actively targeting the following types of providers for revalidation:
  - Providers who are not registered in the Medicare Provider Enrollment, Chain,

and Ownership System (PECOS)

- Providers who have not updated their enrollment within the last five years
- Providers located in historically high-risk areas for Medicare fraud
- Providers who do not receive electronic funds transfer (EFT) payments

Note: Do not submit a revalidation application unless a Medicare contractor contacts you. Upon receipt of the notification, you must respond within 60 days of the request.

Source: http://news.aapc.com

USE E/M BENCHMARKING TO ASSESS YOUR AUDIT RISK

The 2013 Office of Inspector General (OIG) Work Plan also includes scrutiny of providers with high cumulative Medicare Part B payments and trends in coding of Evaluation and Management Services—Potentially Inappropriate Payments in 2010

Calculate E/M Coding Benchmarks

The first step in determining a provider's audit risk is to compare the provider's utilization of E/M codes against other physicians' usage in his or her specialty. The Centers for Medicare & Medicaid Services (CMS) publishes Medicare Part B utilization data each year to compare against. Using this data, you can calculate benchmarks, or bell curves, for E/M service usage in your specialty by comparing the number of allowed services for each CPT code as a percent of the total allowed services for a given E/M subcategory billed by providers in the same specialty.

When the benchmark or bell curve for a specialty has been determined, a physician's claims for E/M services can be compared to identify deviations from benchmarks.

To ensure billing and coding compliance you must understand the accuracy of physician coding. An effective auditing program is central to every corporate compliance plan (see OIG Compliance Program for Individual and Small Group Physician Practices, 65 FR 59434). You can minimize risk and improve compliance by aligning your auditing program to reflect the auditing programs of major payers. For E/M services, this may include periodically focusing your reviews on any high-level codes where the physician's usage is above the “bell curve.”

Source: http://news.aapc.com

SECTION 603 – EXTENSION RELATED TO PAYMENTS FOR MEDICARE OUTPATIENT THERAPY SERVICES

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on **January 1, 2013**. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services which is $1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished **January 1, 2013** through **December 31, 2013**, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Source: cms.gov

MEDICATION POLICY UPDATES FOR OFFICE-ADMINISTERED DRUGS

As a result of the **December 2012** Pharmacy and Therapeutics (P&T) Committee meeting, Blue Shield of California announced updates to some medication coverage policies for office-based drugs covered in the medical benefit. Changes are effective **December 13, 2012** unless otherwise noted.

NEW Office-Administered Medication Coverage Policies:

- Gel-One
- Synribo

UPDATED Office-Administered Medication Coverage Policies:

- Abraxane
- Actemra
- Arzerra
- Avastin
- Avonex
- Betaseron
- Cimzia
- Copaxone
- Enbrel
- Extavia
- Eylea
- Forteo
- Herceptin
- Humira
- Kineret
- Orencia
- Prolia
- Rebif
- Remicade
- Rituxan
- Simponi
- Tysabri (effective 1/1/2013)
- Vivitrol
- Xiaflex
- Zaltrap

Source: blueshieldca.com

CHANGES TO THE PRIOR AUTHORIZATION LIST FOR CERTAIN COMMERCIAL PLANS

Effective **April 1, 2013**, UnitedHealthcare will implement an important change in the advanced notification review process for the administration of certain specialty medications covered under the medical benefit.
All participating network physicians will be required to submit for prior authorization review and approval prior to administration of H.P. Acthar® (repository corticotropin injection) and immune globulins for members (intravenous or subcutaneous immunoglobulin pooled from human plasma) with UnitedHealthcare commercial coverage plans, including those members currently on therapy. This will impact any dates of service beginning **April 1, 2013**. These requests may be subject to medical necessity review to determine coverage.

Some members have benefit plans that provide for pre-service clinical coverage reviews, while others do not. The process for you to initiate an Advance Notification or a Prior Authorization request is the same, regardless of the type of benefit plan.

The current processes for submitting an Advance Notification or a Prior Authorization request will not change

Source: UnitedHealthcare

CMS DELAYS HIPAA 'OPERATING RULES' ENFORCEMENT

CMS issued a notification on **January 3, 2013** stating that it will not enforce compliance with new "operating rules" for the HIPAA eligibility and claim status transactions until **March 31, 2013**. The compliance date for the rules was **January 1, 2013**.
CMS extended the deadline due to the industry not having met the compliance deadline. Below is the agency's notice:

"Today, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that to reduce the potential of significant disruption to the health care industry, it will not initiate enforcement action until **March 31, 2013**, with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable)

that are not in compliance with the operating rules adopted for the following transactions as required by the Affordable Care Act: eligibility for a health plan and health care claim status. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for using the operating rules remains **January 1, 2013**.

"Industry feedback suggests that HIPAA covered entities have not reached a threshold whereby a majority of covered entities would be able to be in compliance with the operating rules by **January 1, 2013**. This enforcement discretion period does not prevent applicable HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules from doing so, and all applicable covered entities are encouraged to determine their readiness to use the operating rules as of **January 1, 2013** and expeditiously become compliant. Although enforcement action will not be taken, OESS will accept complaints associated with compliance with the operating rules beginning **January 1, 2013**. requested by OESS, covered entities that are the subject of complaints (known as "filed-against entities") must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period. HHS will continue to work to align the requirements under Section 1104 of the Affordable Care Act to optimize industry's ability to achieve timely compliance.

"OESS is the U.S. Department of Health and Human Services' (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.

Source: CMS.gov

INCREASING MEDICAID PRIMARY CARE FEES FOR CERTAIN PHYSICIANS IN 2013 AND 2014:

A Primer on the Health Reform Provision and Final Rule Executive Summary Under the ACA, beginning in 2014, millions of uninsured Americans will gain Medicaid in states that implement the Medicaid expansion. To help ensure access to meet expected higher demands for care in Medicaid, the health reform law requires states to pay certain physicians Medicaid fees at least equal to Medicare's for many primary care services in 2013 and 2014. The idea behind the fee increase is to boost physician participation in Medicaid and to provide increased support for physicians who already participate and who might expand their Medicaid service. The fee

increase is federally funded. On **November 6, 2012**, CMS published a Final Rule outlining how states are to implement the higher fees. This brief explains major elements of the statute and rule.

Key provisions

- Qualified physicians and services. Family physicians, internists, and pediatricians, as well as subspecialists, qualify for the higher Medicaid fees if they attest that they are Board-certified, or that at least 60% of the Medicaid codes they billed in the previous year were primary care codes identified in the ACA. The 146 ACA primary care services are visits and other care central to primary care practice. Services furnished by non-physicians under the supervision of a qualified physician also qualify for the higher fees.
- Minimum Medicaid fees. In 2013 and 2014, Medicaid fees for the ACA primary care services cannot be less than Medicare fees. The effective date of the provision is **January 1, 2013**. States can make the higher Medicaid payments as add-ons to their existing rates, or as lump-sum payments.
- 100% federal match. The federal government will fund the full cost of the fee increase, up to the difference between Medicaid fees as of **July 1, 2009** and Medicare fees in 2013 and 2014. The estimated federal costs are $11.9 billion. States with current fees below their 2009 fees have to fund their regular share of that difference; the 100% federal match applies only to increases over **July 1, 2009** rates. By the same token, states whose current fees exceed their 2009 fees will realize savings, estimated to total $545 million.
- Managed care. The ACA requires that qualified physicians in MCOs also receive the full benefit of the fee increase, whether the MCO pays them on a fee-for-service, capitation, or other basis. States have considerable flexibility in implementing this requirement, but they must submit methodologies for identifying what MCO payments to qualified physicians would have been for ACA primary care services as of **July 1, 2009**, and for identifying the portion of their 2013 and 2014 capitation payments attributable to the fee increase, for which the 100% federal match is available.

December 2012

- Dual eligibles. Most states limit how much of the Medicare 20% coinsurance they pay on behalf of dual eligibles to the amount that brings the total provider payment to the state's Medicaid fee. Thus, physicians serving dual eligibles often lose out on some or all of the 20%

coinsurance. Because 2013 and 2014 Medicaid fees for primary care services must at least equal Medicare fees, all qualified physicians serving dual eligibles will receive the full Medicare amount.

- State plan requirements. States have to submit a state plan amendment (SPA) to reflect the higher Medicaid fees in 2013 and 2014 unless they already pay at least the Medicare fee for every ACA primary care service. If a state's SPA is not approved by **January 1, 2013**, the state can increase its fees and wait until the SPA is approved to submit claims for 100% federal matching, or it can pay 2012 fees and make supplemental payments once the SPA is approved.

- Evaluation. States are required to provide information to CMS on physician participation in Medicaid and utilization of the ACA primary care codes as of July 1, 2009 and during 2013. of the ACA primary care codes as of **July 1, 2009** and during 2013.

Looking ahead Bringing Medicaid primary care fees up to Medicare fee levels, and financing the fee increase with federal dollars, will likely have important impacts on qualified physicians, access to care, and the states. In 2013, average Medicaid fees for the ACA primary care services will rise by an estimated 73%. If the Medicaid fee increase succeeds in increasing physician participation in Medicaid, as intended, primary care access for beneficiaries should expand, helping states and the health care system prepare for significantly increased Medicaid enrollment due to the ACA. State data on changes in physician participation and primary care use relative to 2009 will be of keen interest as decision-makers evaluate the fee increase and consider policy beyond 2014.

Source: CMS.gov

CARE-QUALITY PENALTIES LOOM FOR MEDICARE DOCS

Physicians are struggling to meet the targets set by the CMS' Physician Quality Reporting Program, and large numbers could see their future Medicare payments docked as a result, according to a study.

Despite growing participation in the PQRS program since its inception as a pilot in 2007, fewer than one in five eligible and participating providers actually qualified for an incentive payment, according to the study, released by the American College of Radiology's Harvey L. Neiman Health Policy Institute.

The institute found that radiologists fared better than other physicians, with nearly 24% qualifying for bonuses in 2010 compared with 16% of nonradiologists, the study found.

Under the PQRS program, physicians choose a minimum of three measures from a list of more than 200 and report on at least 80% of their Medicare patient encounters involving each measure. Bonus payments have decreased incrementally each year, dropping from 2% in 2009 to 0.5% in 2013.

Those carrots will soon become sticks as PQRS penalties kick in starting in 2015, when physicians face a 1.5% payment penalty for failing to meet reporting requirements. This year, 2013, is the performance period that will determine 2015's penalty, which makes physicians' lackluster progress so worrisome.

Source: Moderhealthnews.com

AS OF JANUARY 1, 2014, 30 MILLION PEOPLE WILL BE ADDED TO THE INSURANCE ROASTERS!

Washington — In a long-awaited interpretation of the new health care law, the Obama administration said Monday that employers must offer health insurance to employees and their children, but will not be subject to any penalties if family coverage is unaffordable to workers. The requirement for employers to provide health benefits to employees is a cornerstone of the new law, but the new rules proposed by the Internal Revenue Service said that employers' obligation was to provide affordable insurance to cover their full-time employees.

The rules offer no guarantee of affordable insurance for a worker's children or spouse. To avoid a possible tax penalty, the government said, employers with 50 or more full-time employees must offer affordable coverage to those employees. But, it said, the meaning of “affordable” depends entirely on the cost of individual coverage for the employee, what the worker would pay for “self-only coverage.”
The new rules, to be published in the Federal Register, create a strong incentive for

employers to put money into insurance for their employees rather than dependents. It is unclear whether the spouse and children of an employee will be able to obtain federal subsidies to help them buy coverage — separate from the employee — through insurance exchanges being established in every state. The administration explicitly reserved judgment on that question, which could affect millions of people in families with low and moderate incomes.

Many employers provide family coverage to full-time employees, but many do not. Family coverage is much more expensive, and the employee's share of the premium is typically much larger.
In 2012, according to an annual survey by the Kaiser Family Foundation, premiums for employer-sponsored health insurance averaged $5,615 a year for single coverage and $15,745 for family coverage. The employee's share of the premium averaged $951 for individual coverage and more than four times as much, $4,316, for family coverage.

Employers Must Offer Family Health Care, Affordable or Not.

Most Americans will be required to have health insurance. Low- and middle-income people can get tax credits to help pay their premiums, unless they have access to affordable coverage from an employer.

In its proposal, the Internal Revenue Service said, “Coverage for an employee under an employer-sponsored plan is affordable if the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's household income.”

The rules, though labeled a proposal, are more significant than most proposed regulations.

The Internal Revenue Service said employers could rely on them in making plans for 2014. In writing the law, members of Congress often conjured up a picture of employees working year-round at full-time jobs. But in drafting the rules, the I.R.S. wrestled with the complex reality of part-time, seasonal and temporary workers.

In addition, the administration expressed concern that some employers might try to evade the new requirements by firing and rehiring employees, manipulating their work hours or using temporary staffing agencies. The rules include several provisions to prevent such abuse.

The law says an employer with 50 or more full-time employees may be subject to a tax penalty if it fails to offer coverage to “its full-time employees (and their dependents).” Employers asked for guidance, and the Obama administration provided it, saying that a dependent is an employee's child under the age of 26.

“Dependent does not include the spouse of an employee,” the proposed rules say. Thus, employers must offer coverage to

children of an employee, but do not have to make it affordable. And they do not have to offer coverage at all to the spouse of an employee. The administration said that the rules — which apply to private businesses, nonprofit organizations and state and local government agencies — would require changes at many work sites.

“A number of employers currently offer coverage only to their employees, and not to dependents,” the I.R.S. said. “For these employers, expanding their health plans to add dependent coverage will require substantial revisions to their plans.”
In view of this challenge, the agency said it would grant a one-time reprieve to employers who fail to offer coverage to dependents of full-time employees.
Under the rules, employers must offer coverage to employees in 2014 and must offer coverage to dependents as well, starting in 2015. The new rules apply to employers that have at least 50 full-time employees or an equivalent combination of full-time and part-time employees. A full-time employee is a person employed on average at least 30 hours a week. And 100 half-time employees are considered equivalent to 50 full-time employees.

Thus, the government said, an employer will be subject to the new requirement if it has 40 full-time employees working 30 hours a week and 20 half-time employees working 15 hours a week.

Source:
http://irinabregman.com/index7.aspx

WHEN PATIENT SUBMITS MEDICAL BILLING FORM TO INSURANCE

Sometimes, when patient goes to the doctor or other medical provider, who is out of network with patient's insurance plan, patient may be told that patient have to submit patient's own insurance claim form. This means that the doctor or facility does not ask the health insurance company to pay for patient's bill and patient must do so. If patient have to file patient's own health insurance claim here are the steps patient will need to take along with some helpful tips on submitting patient's insurance claim form:

4 Steps to Filing Patient's Health Insurance Claim Form:

1. Obtain Itemized Receipts: Patient will need to ask patient's doctor for an itemized bill. An itemized bill lists every service that patient's doctor provided and gives the cost of each of the services. Patient's health insurance company will need patient to

attach the original itemized bills to the claim form.

2. Get Patient's Claim Form: Patient will need to contact patient's insurance company to obtain a health insurance claim form. The claim form should be fairly self explanatory to fill out. It will ask such things as patient's insurance information, who patient want the payment made to, what was the visit for (accident, workers compensation), etc. Patient's claim form will also give patient additional instructions pertaining to what other information they may need from patient's doctor or health care facility.

3. Make Copies: Once patient have patient's claim form filled out and patient's itemized bills from patient's doctor, don't forget to make copies of everything. This will eliminate any errors that may be made in the claim process and make it easier for patient to re-file patient's health insurance claim if it gets lost.

4. Review then Send: To make sure everything is completely accurate, call patient's health insurance company and tell them patient are about to send in patient's health insurance claim form. Review with them all the paperwork patient have and ask them if there is anything else patient need. Also, ask patient's insurance company how long should patient expect to wait for patient's claim to be paid and mark that date on patient's calendar. Once patient have everything in order, send out the claim form to patient's insurance company. The address to send the claim form should be on the claim form itself. Keep an eye out on patient's calendar for the claim date that patient marked and contact patient's insurance company if patient don't receive patient's claim within the time frame given to patient.

Source: http://personalinsure.about.com

NONPHYSICIAN PRACTITIONERS BILLING FOR GLOBAL AND TECHNICAL COMPONENTS OF RADIOLOGICAL PROCEDURES

Effective **January 1, 2013**, National Government Services has restored an edit in our claims processing system to not allow payment for global radiologic procedures or the technical component of radiologic procedures when performed by a nonphysician practitioner. The basis for limiting nonphysician practitioners such as physician's assistants and nurse practitioners from performing the technical component of x-ray procedures is that this service falls outside the scope of their license. National

Government Services will allow nonphysician practitioners to perform the professional component x-rays, therefore the global codes as well as the technical codes will be denied.
Additional guidance can be found in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Medical Policy Benefit Manual, Chapter 15, Section 80

Source: CMS.gov

OPTUM HEALTH 2013 CPT CODES: AUTHORIZATION REQUIREMENTS

Extended sessions, those beyond 45-50 minutes, have historically required prior authorization. With the implementation of the 2013 CPT Codes, Optum is retaining the prior authorization requirement for extended sessions. These two "60 minute" codes require prior authorization:

90837 – Psychotherapy, 60 minutes with patient and/or family member

+ 90838 – "Add on" code used with an appropriate E/M code

Please note that widely available 2012 to 2013 code crosswalks reflect that 90837 is a replacement for the 90808 code used in 2012. Requiring authorization for this extended session does not represent a change. For guidance on authorization of extended sessions, please see our Coverage Determination Guidelines for Extended Outpatient Treatment Visits.

Note that the former 90806 (45-50 min psychotherapy) code has been replaced with 90834 and, as before, typically does not require prior authorization.

Source: NGSMedicare News

POST OFFICE TO CHANGE MAIL DELIVERY SERVICE, STARTING IN AUGUST 2013

Starting in **August 2013**, the U.S. Postal Service will no longer deliver regular mail to street addresses on Saturdays. Mail will be delivered Monday through Friday.

The following services will NOT change:

- Packages will still be delivered on Saturdays.
- Mail will still be delivered to PO Boxes on Saturdays.
- Post Office locations currently open on

- Saturdays will remain open on Saturdays.

Discontinuing Saturday delivery is expected to save the Postal Service $2 billion annually. The Postal Service is an independent government agency and does not receive tax money to support its operations. It relies on the sale of postage, products, and services to fund its operations.

Source: USA.gov

MENTAL HEALTH PROFESSIONALS MUST REPORT PATIENTS BELIEVED TO BE A THREAT

Governor Cuomo has signed into law the NY Secure Ammunition & Firearms Enforcement (SAFE) Act of 2013 requiring a mental health professional (a physician, psychologist, registered nurse or licensed clinical social worker) to report patients believed to be a threat to self or others.

Under the new law, when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the Director of Community Services, who shall report to the Division of Criminal Justice Services, whenever he or she agrees that the person is likely to engage in such conduct.
The information is cross checked against the new gun registration database and used to determine if the gun license should be suspended or revoked, and the person's firearms removed. A mental health professional is not required to take any action which, in the exercise of reasonable professional judgment, would endanger such professional or increase the danger to a potential victim(s).

The law provides that the decision of a mental health professional to disclose or not disclose, when made reasonably and in good faith, shall not be the basis for any civil or criminal liability, but many professionals remain concerned about potential liability. Most provisions of SAFE take effect immediately, but the new reporting requirement for mental health professionals takes effect in 60 days.

Source: Kern Augustine Conroy & Schoppmann, P.C. Announces Expansion

NEWS BY SPECIALTY

CARDIOLOGY

It is inappropriate to report a cardiac stress test and the component codes used to perform a simple pulmonary stress test (CPT code 94620), when performed. If a standard exercise protocol is used, serial electrocardiograms (ECGs) are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, the professional components for both a cardiac and pulmonary stress test may be reported. Modifier 59 should be reported with the secondary procedure. Both tests must satisfy the requirement for medical necessity. (Since a complex pulmonary stress test includes ECG recordings, the technical components for both the cardiac stress test and the pulmonary stress test should not be reported separately.)

RADIOLOGY

1. Code 36147 defines a fistulagram (angiogram) of a dialysis fistula (which would use fluoroscopy), and this code cannot be used for an ultrasound study. If you are doing a duplex study of an arteriovenous (AV) graft, see instead 93990 (duplex scan of hemodialysis access, including arterial inflow, body of access and venous outflow). If you are asking about using ultrasound guidance for access prior to an AV fistulagram, then you would assign code 76937 in addition to 36147, if the requirements are met.

76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)

2. According to the latest version of the NCCI Policy Manual, if a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with radiologic guidance (e.g., 76942, 77012, 77021, 77031, 77032), the physician should not separately report a post-procedure mammography code (e.g., 77051, 77052, 77055–77057, G0202–G0206) for the same patient encounter. The radiologic guidance codes include all imaging required to perform the procedure.

3. The Centers for Medicare & Medicaid Services' (CMS) have withdrawn their plan (announced via transmittal R2472CP) to have provider reports HCPCS level II code G9157 instead of unlisted code 76999 for ultrasound diagnostic procedures for transesophageal (TE) Doppler used for cardiac monitoring.Whether the agency will revise and/or reissue a new code in the future is unknown at this time.

STATES UPDATES

More hurdles for California Medicaid pay bump

The good news came early November in the form of the CMS' final rule on implementation of the Patient Protection and Affordable Care Act's Medicaid primary-care payment parity provision. The measure provides federal funding to boost payment for some primary-care services provided by family doctors, internists and pediatricians (or a related subspecialty) to the same level as Medicare reimbursement for two years.

The law called for the pay increase to be effective January 1. First, California's Department of Health Care Services will have to submit a “State Plan Amendment” detailing its plan to implement the pay increase, and then get federal approval for the plan. After approval and implementation, retroactive payments will be issued.
Under Medicare, the payments are much higher. According to the California Medical Association, a level 3 office visit (for a “moderate” level of service with an established patient), Medicare pays $54.09 in the Alameda/Contra Costa region (which includes Oakland and Berkeley), and $52.23 for the Los Angeles area.

Seeking autonomy, N.Y. doc groups join forces

St. Peter's Health Partners, Albany, N.Y., has created a fully affiliated physician practice with its existing medical group and five others, establishing an organization of more than 250 doctors. The new organization, St. Peter's Health Partners Medical Associates, began operating Jan. 1 and practices in more than 40 locations through five counties in central New York. The deal means new employees for St. Peter's—106 physicians, 30 advanced practitioners and 451 others who were employed by the newly affiliated practices. The group now numbers 257 physicians and 66 advanced practitioners.

Texas Health Resources, Blues announce ACO talks

Texas Health Resources, Arlington, Texas, and insurer Blue Cross and Blue Shield of Texas announced talks to form an accountable care organization. Texas Health Resources was among the first to form a Medicare ACO under the Center for Medicare and Medicaid Innovation's Pioneer ACO program.

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QUESTIONS AND ANSWERS

Question:

♦ What kind of reduction for cardiovascular diagnostic tests will be implemented effective January 1 2013 for Medicare claims, based on new Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures?

Answer:

♦ The MPPRs on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services, and to the TC of global services. For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day.

The MPPRs do not apply to professional component (PC) services. The current and proposed payments are summarized below in the following examples:

	PC	TC	Global
Code 78452	$77.00	$427.00	$504.00
Code 93306	$65.00	$148.00	$213.00
Total Current Payment	$142.00	$575.00	$717.00
Total CY 2013 Payment	$142.00	$538.00	$680.00
Payment Calculation	no reduction	$427 + (.75 x $148)	$142 + $427 + (.75 x $148)

The complete lists of codes subject to the MPPRs on diagnostic cardiovascular and ophthalmology procedures are in Attachments 1 and 2, respectively in CMS Transmittal 1149 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1149OTN.pdf

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QUESTIONS AND ANSWERS

Question:

♦ Since October last year Medicare started processing the applications much longer than usual, e.g. reassignment of benefits that used to be processed for 3-4 weeks is now pending for 2-3 months; new enrollment applications that took 4-6 weeks to be finalized can now take up to 90 days or even more.

Answer:

♦ That is correct we've always had 90 days to process an application which 30 of it is for prescreening making sure everything is intact with credentials being properly license, and registered with the proper website. We also give 30 days of the process for developing for additional information that we may need. With the last 30 days is entering the information within the system, pulling PTAN's, with overnight cycles to go from on system to the next hoping that everything goes through correctly, and creating the appropriate letters to go out. Basically when things were rush they were being done incorrectly which means people were doing double work on same application and our quality suffered. So we have to make sure things are done right the first time. We do have some cases that move faster than others based on what information is needed. Hope this help you understand our process a little bit better.

Albert L Allen, Provider Enrollment Specialist, National Government Services

FEEDBACK

Please send us your feedback today. Let us know what you want to see in upcoming issues or changes to the format that you would like to see.

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