



WCH TIMES

Spring 2009

Volume 08

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



Member of AHIMA

<http://www.ahima.org/>

National Association of Healthcare Consultants



Dear Doctors and Office Managers,

Welcome to WCH Times Spring Edition!

A newsletter that is designed to inform you about our developments, insurance policies, community events, and provide ongoing support of current issues taken place in the healthcare community.

Enjoy our Newsletter!

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WCH DIRECTORY

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Visit our website
www.wchsb.com
for more updates.

WCH Corner

As we had informed our readers in the past newsletters, WCH is now working towards transforming all daily operations into electronic data process system. We are converting paper superbills, patient's record, practice reporting and other important documentation into electronic portal. In the next month we will be installing electronic superbills for all WCH PMBOS users, this will eliminate your time writing a superbill for our billers, but instead having a capability with one click to transmit the bill to WCH electronically.

In addition we are continuing on production of the electronic health record, which we strongly feel will be in production by 2010. Currently with collaboration of other physicians we are adding new features that would simplify coding, scheduling, reporting, and other office operations for variety of providers. By late 2009 we will be ready to proceed with certification process and software vendor registration.

At the present time, we would like to offer your practice the following programs that can simplify daily work flow and save valuable time for administrative staff, office managers and healthcare providers in the practice. We currently sell the following programs:

PMBOS - Patient Management Billing Operating System

WCH professionalism in medical billing, provider credentialing, CVO and office management combined with the experience of our programmers has helped to create a one of a kind distinctive practice management system. Please visit our website for more detail presentation of the programs features and screen shots.

<http://www.wchsb.com/pmbos.asp>

Time Management

WCH first created this software to simplify our internal process of task management, staff scheduling, vacation and salary keeping. Later on we developed additional reporting and security features and prepared the program for sale. This program can be used in any setting either medical office or a glass production company. For more information about this program please do not hesitate to contact Olga at OlgaK@wchsb.com

Credentialing Application

Credentialing application eliminates the need for the healthcare provider to complete multiple insurance applications. From our vast years of experience in the healthcare industry we know that the importance of credentialing lies in correct submission of application, necessary paperwork and tracking the application along the enrollment process at the insurance side. In itself the process of credentialing is time consuming and requires a lot of patience and time which not many practitioners have always available. WCH credentialing application allows providers to consolidate their professional information into one unique profile that duplicates the information on the insurance applications. For more information about the credentialing application, please visit

<http://www.wchsb.com/med/wch/default.asp>

Durable Medical Equipment Billing Privileges

WCH has successfully completed testing with National Supplier Clearinghouse this past month and now we are able to submit electronic claims for DME providers. Therefore all clients that are providing shoes or rendering any other medical supplies please contact WCH so we can set up your account billing with NSC. In mid June WCH will be listed on the vendor list as an approved submitter for DME claims.

Becoming Certified Coders

At the present time WCH is preparing our billing staff for the examination to become Certified Professional Coder (CPA). This certification will provide higher level of knowledge in reviewing and adjudicating coding of services rendered by our client. Some of our current clients have asked us for coding services and chart auditing, we had to decline the request due to inability to properly handle these cases. However with the upcoming testing and later certification will be able to accommodate our clients with coding services.

WCH Bulletin- New Edition

Since there is so much taken place in the medical community and at the insurance side, WCH will release monthly bulletins to discuss events taken place for the past month. All bulletins will be posted on our website at www.wchsb.com WCH TIMES newsletters will be continued to be released every three months, please check regularly our website for more updates.

Medical Documentation Retention Period

Many of our clients had asked us about retention period of medical records and other vital information concerning their patients. Since EMR will soon take over all of the routine office processes, we thought it would be important for you to know the following time frames for record keeping for different entities:

<i>Place of Service</i>	<i>Document Type</i>	<i>Retention Period</i>	<i>Citation</i>
Hospital	Medical Record	Five Years	42 CFR - 482.24
Healthcare Provider	Claim Records	Six Years, Three	Medical Manual
Long Term Facility	Medical Record	Five Years from date of	42 CFR- 483.75

Photocopying Fees for Patients Record by State

Either it is workers compensation case, or a request of medical records for court hearing, medical practices have to comply with all legal requests and provide data upon request by attorney. It seems that every request a provider receives the fees for the photocopying varies. In fact fees tend to vary per state and per the amount of information being requested, just to give you an idea; we researched few states to see the difference in pricing. For example in New Jersey and Florida minimum fee is \$1.00 per page and in New York fee per page is .75c per page. Please keep mind if the request for documents is being returned by mail make sure the prepaid label is attached. In addition if you are providing X-Rays or any other record that requires special handling, feel free to ask for additional payment from the requester.

Prompt Payment

Every State follows specific payment insurance laws which require an insurance company to reimburse a healthcare provider for the services rendered within a give time frame. In New York paper and electronic claims deadline is 45 days from the receipt of the claim by insurance. For example in New Jersey paper claims deadline is 40 days and for electronic claims its 30 days from the receipt of claim. If you will find that insurance has delayed your payment you have a right to request interest to be paid at the time of making the overdue payment. Some of the insurance had already implemented this practice, in fact United Healthcare insurance pays .2c interest fee on claims that were processed after the given time period for the state. However funds like 1199 NBF back in 2008 neglected this rule and paid to providers based on the receipt of money from the state. WCH billing department follows these rules very strictly and uses them to its advantage if necessary.

Source of information obtained from: 2008 MTBC

The American Psychiatric Association Presents the 61st Exhibit

We are pleased in invite you to participate in the Exhibits Program taking place October 8-10, 2009 at the Sheraton NY Hotel & Towers in New York City. As some may know WCH had participated few years ago in the Exhibit, this year we will be attending the Exhibit as well, we hope to see you there. For more information about the Exhibit please visit www.psych.org/IPS

Healthcare News

Medicare

Speech Therapist New private Practice Payment Policy

Effective July 1, 2009 Speech –Language Pathologist (SPL) in private practice can bill Medicare for services performed to Medicare beneficiaries. CMS will allow enrollment of SPL on June 2, 2009. However SPL can begin billing for outpatient services rendered in private practice beginning with DOS July 1, 2009. Speech Therapy cap is shared with Psychological Therapist provider \$ 1,840.00.

Effective date of Medicare billing Privileges

In beginning of 2009, Medicare has changed enrollment process for new and established providers. The new regulations have greatly impacted many new practices and new providers joining established Medicare practices. New Providers joining Medicare program have the two options for their effective date filling. It is either the date of filling their Medicare enrollment application or the date they first begun seeing patients at new practice location. However this date should be 30 day prior to their effective date, otherwise claims might be rejected. In addition Medicare strengthen the change of information rule, which now requires to report within 30 days changes in ownership and change in practice location. Anyone that doesn't comply with the reporting requirements will be subject to overpayment action.

Source of information obtained from: MLN Matters Number: MM6310

What you need to know about Medicare Overpayments

Once Medicare made a determination hat overpayment has been made CMS seeks to recover the amount from the healthcare provider. The overpayment is a debt to the Federal Government and requires to be paid back in full. The overpayment is usually due to the following:

- Duplicate submission of the claim
- Payment made to the incorrect provider

- Payment for excluded or medically unnecessary services
- Payment made by mistake: Medicare secondary insurance, patient was not eligible, patients was assigned to HHA or HMO....etc

It's a provider responsibility to refund the money back to Medicare if they have noticed inconsistency in payment or the payment has been higher than usual. Medicare recommends that providers make voluntary refund to Medicare as soon as possible without waiting for notification.

Upon the return of refund, make sure you will include the following information:

- Provider Number
- Medicare number of the patient, DOS, and amount overpaid
- Brief description of the reason of the refund
- Copy if remittance showing the claim in question
- Check for the overpayment amount

Usual overpayment processing time that should be followed by Medicare providers is 30-40 days. The first request for refund requires response in 30 days; a second demand letter shall be send between 31-45 days. If full payment is not received in next 40 days Medicare will start recoupment from future payments on the 41st day. If the physician disagrees with the overpayment request they have a right to appeal the request by submitting a letter within the first 30 days of the received request for overpayment.

Source of information obtained from: Medicare's Learning Network ICN # 006379

Medicaid

Billing Medical Recipients

In the previous newsletters WCH had informed our clients that healthcare providers cannot bill Medicaid recipients once they had entered into contract with Medicaid. The provider is prohibited from requesting any monetary compensation from the Medicaid recipient. It is only allowed to bill patient for the services if there was a set mutually agreed upon agreement prior to rendering of service. Medicaid suggested that the provider maintain the patient signed consent on patient record. Moreover Medicaid recipient or Medical Managed enrollee cannot be referred to collection agency for unpaid medical bills. Therefore high responsibility falls on the front desk to check eligibility of Medicaid patients.

Responsibilities and Requirements of Being a Group Member

Physicians and other practitioners may practice in group setting and group will bill Medicaid according to claim policy. Any group that bills Medicaid must register with Medicaid under category of group (single specialty/multi-specialty). Claims submitted to Medicaid under the group must show:

- Medicaid Provider of the rendering service practitioner
- Group Medicaid Provider number (where the service was provided)

Medicaid will issue payment to the group provider number. Please keep in mind if an individual practitioner leaves the group but fails to notify Medicaid program in writing, that provider is liable for groups activity. Upon leaving the group, a provider may no longer use the group number to bill. Similarly a group may not use the provider number of an individual who has left the group.

Claims submitted by the group must identify their Medicaid number as well as individual provider of care must be identified. Once the claim is submitted under the group to Medicaid:

- All members in the group are liable for overpayments
- All members are subject to administrative sanctions

All administrative sanctions, terminations and recovery of overpayment is investigated by States Attorney General Office.

Source of information obtained from: DOH Medicaid Update July Vol 18, NO.7, Office of Medicaid Management

Neighborhood Providers

As many of you become aware on April 1, 2009 Neighborhood plan took over the NY Presbyterian Care Insurance and facilitated changes in member's card and provider contract. Fortunately this change did not require providers to re-credential with new plan and many providers were switched to Neighborhood automatically. If you still did not receive your welcome letter from Neighborhood please contact WCH credentialing department for more information.

Scam or Neglect by Providers

Here are few examples of recent cases under investigation, you be the judge of situation.

Physician: Dr. Cassandra Thomas, Jackson, MS.

Penalty: Dr. Thomas was arrested for allegedly billing Medicare \$16 million in false claims.

Type of Violation: Physical Therapy services were billed as incident-to through Dr. Thomas, but were provided by unqualified, unlicensed technicians with no supervision.

Physician: Dr. Otto Garcia, Montenegro, Elmwood Park, IL

Penalty: Dr. Montenegro faces 10 years in prison and more than \$250,000 in fines for billing fraud.

Type of Violation: Dr. Montenegro allegedly created hundreds of bogus bills for treatments and visits that never occurred.

Note: Also, Dr. Montenegro is charged with purposely not collecting co-pays and deductibles from patients.

Relax and don't Panic During Audit!

If your medical practice is ever randomly audited, please stay calm and follow these important tips:

- Involve your practice lawyer right away
- Designate a main auditors contact
- Record all communications with the auditor
- Notify the full group of the audit
- Check for errors when gathering information
- Include all referrals and diagnostic tests related to the auditors request

- Don't panic, if your practice medical records are in good shape, you have nothing to worry about.

Source of information obtained from: Internal Medicine Coding & Reimbursement, April 2009

Qualifications “for incident to” rule

If you are considering to bill “incident to” the physician when a qualified nonphysician practitioner (NPP) performs the services for Medicare patients, please consider the following criteria before billing:

Did the primary care physician establish a plan of care?

To qualify for incident-to billing the physician must see Medicare patient during the initial visit and establish plan of care. Only then the NPP can continue the treatment plan set by the physician. However if the NPP during treatment found new problem that was not detected by physician, this finding cannot be reported as incident-to.

Is NPP Licensed?

Physician hiring NPP must be adequately sure that they have proper credentials to perform the service. The NPP could be a nurse practitioner or physician assistant, as long they meet state regulations and all federal requirements.

Did the visit meet all supervision requirements?

Medicare requires that physician provides direct supervision in order to bill incident-to. The physician doesn't have to be present in the same room as NPP but they must be available for immediate assistance.

Is patient's medical record keeping in order?

Experts recommend physicians to include in the plan of care that NPP is approved in involvement of this patient treatment. It seems important to show the link between the NPP and the patient. At least if random audit will show up, the patients chart will reflect the physician's decision to allocate continuation of care by NPP.

For more information refer to Office of Inspector General 2009 Review of Physicians Medicare Services Performed by NPPs.

Source of information obtained from: The Coding Institute, Part B Insider, January 19, 2009 Vol.10

Get Physical Therapy Care Without Referral

Under the new regulations 44 States and District of Columbia have allowed access to physical therapy treatment without referral. The Medicare Patient Access to Physical Therapy Act (HR 1829) would allow physical therapist to evaluate and treat Medicare Part B members that require outpatient physical therapy without a physician's referral.

For the New York State current provision state as follows: Treatment can be rendered by a Licensed PT without a referral for 10 visits or 30 days, which ever comes first. For access to other states provisions please visit:

<http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31262>

Source of information obtained from: APTA news release April 1, 2009

Upcoming Issue Discussions:

- **DME Vendor Certification**
- **Anti-Mark Up Rule Issued by Medicare for Diagnostic Testing**
- **IDTF Credentialing: Medicare & Commercial Issues**
- **WCH Electronic Superbill Implementations**

Please use next page for any suggestions, your feedback specific topics you would like us to discuss in the next issue in Summer 2009.

You can send your requests by email

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Have you visited our website recently?

WCH has relaunched its website, take a look at www.wchsb.com

