

THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO (AMCNO)

PRACTICE MANAGEMENT MATTERS

SPRING EDITION 2012

Beginning in 2012, PRACTICE MANAGEMENT MATTERS will no longer be mailed and will be published ONLINE ONLY on the AMCNO website. Practice managers and physicians are welcome to visit the site on a regular basis to view the publication or follow us on Twitter to learn when new issues or topics have been posted.

**In this issue – Important CGS
Revalidation Information
AMCNO Launches New Website**

Medicare

AMCNO Physician Leadership Meets with CGS Representatives

Recently, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) physician leadership and staff were pleased to welcome key representatives from CGS to the AMCNO offices. The purpose of the meeting was to discuss recent issues that have arisen at both CGS and the Centers for Medicare and Medicaid Services (CMS). The CGS staff discussed claims processing issues, timely payment, customer service and other matters of importance to AMCNO members with the AMCNO physician leadership. On hand from CGS were Dr. Gary Oakes, Medical Director for CGS, Mr. Steve Smith President and COO of CGS, John Kimball, VP of Medicare Operations for CGS (via phone) and Vanessa Williams, CGS Provider Outreach.

The meeting was very productive with CGS representatives providing key updates and background information on how CGS and CMS have worked to resolve payment issues over the last few months. The AMCNO was pleased to learn that CGS plans to continue to work closely with us and meet with physician leadership and staff on a regular basis to discuss any problems or issues our members may be experiencing with CGS claims processing. Dr. Oakes also offered to prepare articles for upcoming issues of the Northern Ohio Physician magazine with an eye toward providing timely information on matters that could impact their practice.

The CGS representatives acknowledged that a strong relationship with the AMCNO is an important part of their success as a Medicare contractor and in the jurisdictions they serve. They also noted that they have long recognized the importance of establishing and cultivating relationships with key provider organizations like the AMCNO. CGS announced that going forward members of the CGS Provider Outreach and Education team will be meeting with AMCNO staff to discuss any questions our members may have with regard to CGS.

Several of the items discussed with the CGS representatives were:

Claims Processing

CGS has recognized that there have been problems with their claims processing operation specifically with automated documentation requests (ADRs) on claims requiring operative reports, radiology reports, etc. Inventories included claims well over their standard claim processing timeframe. The vulnerabilities identified with this process have been addressed and will not continue with additional documentation submissions.

Claims Requiring Additional Documentation

Previously, claims submitted without required information were pended and an ADR was sent to the provider requesting additional documentation. To assist physicians with this issue CGS is implementing a Fax Attachment Process over the next several months. Providers submitting claims for services that require additional documentation will have the option

to send that documentation via fax following submission of the accompanying electronic claim. The electronic claim will be flagged to alert claim processors that a fax has been sent to link to the claim.

Call Center Service Levels

The CGS representatives acknowledged the need to add more trained customer service staff. In addition, CGS has recognized the need for ongoing training of the CGS customer representatives and they plan to provide additional training on a regular basis to help ensure consistency and accurate responses are given to physician offices when they contact CGS for assistance. The wait times will also be significantly reduced and issues can be escalated up to other departments when necessary.

Self-Service Technology

CGS representatives were pleased to inform the AMCNO about the implementation of their Online Provider Services (OPS), a web portal used to perform online functions securely over the Internet. Special functions will include claim status and eligibility inquiries, the ability to view and order copies of remittance advices, as well as a number of provider financial inquiry options. This technology is expected to be launched within the next several months.

Revalidation of Physician Enrollment Information

Another item addressed during the CGS/AMCNO leadership meeting was revalidation of physician enrollment information. The CGS representatives noted that revalidation is necessary as part of the Affordable Care Act whereby all enrolled providers and suppliers have to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to all providers and suppliers that were enrolled prior to March 25, 2011. Between now and March 23, 2015, CGS will send out notices on a regular basis to begin the revalidation process for each provider and supplier.

Physicians should look for their revalidation letter to arrive in a distinct yellow envelope. CGS will send the revalidation requests to provider's/supplier's correspondence, special payment, or practice address identified in PECOS. Physicians are advised to WAIT to submit the revalidation application only after being asked by CGS to do so. For more information on the revalidation process, go to the provider enrollment section on the CGS website at www.cgsmedicare.com – posted here are many quick links to help guide providers through the enrollment process. AMCNO members that would like to receive more detailed information about the revalidation process should contact the AMCNO staff at 216-520-1000. **AMCNO members that are experiencing any claims processing problems with CGS should also contact the AMCNO staff for assistance.**

CGS Provider Enrollment Revalidation Resources

- **Why** revalidate - Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to all providers and suppliers that were enrolled prior to March 25, 2011.
- **When** to revalidate - Between now and March 23, 2015, CGS will send out notices on a regular basis to begin the revalidation process for each provider and supplier.
- **What** to look for –
 - A sample revalidation letter is available at <https://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf>
 - Revalidation letters will be mailed in yellow envelopes.
- **Where** revalidation request will be sent - CGS will send revalidation requests to provider's/supplier's correspondence, special payment, or practice address identified in PECOS.

- Reassignments – correspondence address
- Entities and sole proprietors – correspondence address and special payment addresses
 - If both are the same – correspondence/special payment address and practice location
 - If all three are the same – one letter is mailed
- **Wait** - Providers and suppliers should wait to submit the revalidation application only after being asked by CGS to do so.
- **Websites** –
 - The Provider Enrollment section at www.cgsmedicare.com has many quick links to help guide providers through the enrollment process.
 - Modules are available to assist providers in the enrollment process at the CGS Online Education Center located at http://www.cgsmedicare.com/medicare_dynamic/education/001.asp. Log in at this location and from the J15 Course menu choose “Provider Enrollment: An Overview”.
 - Revalidation checklists are available to help ensure all required sections of paper applications are completed. Checklists are available for 855I (individuals), 855R (terminations), 855B (entities & organizations) and 855B (IDTFs) revalidation applications and are located at <http://www.cgsmedicare.com/kyb/enrollment/checklists.html> (KY) and <http://www.cgsmedicare.com/ohb/enrollment/checklists.html> (OH).
 - Access <http://www.cms.gov/CMSForms/CMSForms/list.asp#TopOfPage> to ensure the most current version of the CMS 855 applications are completed. Mail the completed application, a copy of the revalidation request letter and any applicable supporting documentation to CGS Administrators, LLC.
 - To revalidate via the Internet-based PECOS, go to <https://pecos.cms.hhs.gov>. Review the information currently on file. The option to electronically sign the Internet-based PECOS enrollment is now available via E-Signature. If E-signature is not used print, sign, date, and mail the certification statement, a copy of the revalidation request letter and any applicable supporting documentation to CGS Administrators, LLC.
 - Institutional providers that submit enrollment actions using internet-based Provider Enrollment, Chain, and Ownership System (PECOS) pay the application fee during the online submission process. Providers which submit the CMS-855 paper application or providers that do not pay the fee during internet-based PECOS enrollment pay the fee at <https://pecos.CMS.hhs.gov/pecos/feePaymentWelcome.do>.
 - Providers/supplier can check online the status of their application. This search tool is located in the Provider Enrollment section at www.cgsmedicare.com or by accessing http://www.cgsmedicare.com/medicare_dynamic/PE/Login.asp. Two identifying items are required to search –
 - The reference number identified on the acknowledgement letter that is sent to the provider or designated contact person after receipt of the application in our office, and
 - The application’s contact person’s 5 digit zip code listed in Section 13 of either the CMS 855I or CMS 855B application, Section 7 of the CMS 855R application or Section 4 of the CMS 855O application.

- **Additional information –**

- The address to mail paper revalidation applications or Internet-based PECOS certification statements is:

CGS Administrators, LLC
P.O. Box 20003
Nashville, TN 37202-4011

- Applications received with incomplete or inaccurate information require development which will delay the processing of the application.
- Following are the current **top 10 reasons** identified requiring development of revalidation applications:
 - A newly signed and dated certification statement is not returned when corrections are made to the application.
 - The signer of the application does not submit a copy of a current passport or driver's license to confirm his or her identity.
 - Section 4C (practice location) of the CMS 855I is not completed. Sole owners and sole proprietors complete this section.
 - The individual's Medicare identification number (PTAN) is missing from Section 1A of the CMS 855I. PTANs are required for reassignments and the individual sole owner.
 - The individual's National Provider Identifier (NPI) is missing from Section 1A of the CMS 855I. NPIs are required for reassignments and the individual sole owner.
 - Section 4A (practice location) of the CMS 855B is not completed for all practice locations.
 - Section 4C (practice location) of the CMS 855I is missing date (mm/dd/yyyy) that provider first started rendering services to Medicare patients.
 - When required, the CMS 588 (EFT) application is not submitted.
 - The CMS 588 (EFT) application is missing the name of a contact person for the financial institution (bank).
 - When a CMS 588 (EFT) application is submitted the required original voided check or bank letter does not accompany the application.

- The following applications/supporting documents are not required when the CMS 855 revalidation application is submitted:
 - The CMS 588 (EFT) application is only required if the revalidating entity or sole proprietor is not current set up as EFT or a change is being made to existing banking information.
 - Degrees/diplomas
 - CMS 855Rs are not required when all active reassignments are identified in Section 4B of the individual's CMS 855I revalidation application.

- CMS 855Rs for reassignments when an entity submit the CMS 855B or a sole owner/sole proprietor submit the CMS 855I.

New CGS Mailing Addresses Now Effective

CGS consolidated their mailroom locations to coincide with the final transition of their J15 segments. The AMCNO has been notified by CGS that physicians and their staff continue to use the old mailroom locations and we have been asked to remind our members to please use the NEW mailing post office boxes listed below. The Chattanooga, TN addresses are no longer valid and in the future, mail sent to those locations may be returned to the sender. Also, please closely check that you are using the correct address for each inquiry type. When mail is sent to the wrong address for the inquiry type, it results in a delay in processing that inquiry/claim.

Inquiry Types	New Address Information
J15 Part B Claims/Adjustments	J15 Part B Claims CGS Administrators, LLC PO Box 20019 Nashville, TN 37202
J15 Part B Provider Enrollment Correspondence	J15 Part B Provider Enrollment CGS Administrators, LLC PO Box 20017 Nashville, TN 37202

Please make sure that your staff is aware of the new mailing addresses. Any questions please contact the J15 Part B provider contact center at 1-866-276-9558 from 8:00 a.m. to 5:00 p.m. EST.

Sign up for the CGS Provider ListServ

Has your practice registered for the CGS ListServ? If not, you may not have all the latest information concerning Medicare. The CGS ListServ is similar to the Palmetto GBA email messages you received prior to the transition. The CGS Provider Outreach & Education team wants to make sure you are receiving up-to-date information from CGS that will have a direct impact on your day-to-day operations. The only way to receive this information is by signing up for the CGS ListServ. To sign up for this free service go to https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp

The Centers for Medicare and Medicaid Services (CMS) Announces Another HIPAA 5010 Enforcement Delay

CMS has announced it would delay enforcement of HIPAA 5010 transactions to June 30, 2012. It's the second three-month delay on enforcement made by the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS). While the rule calls for compliance by Jan. 1, 2012, on Nov. 17, 2011, OESS announced it would not enforce the rule for another three months, referring to the move as "enforcement discretion."

According to OESS:

- The Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format.
- Commercial plans are reporting similar numbers.
- State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

OESS urged those covered by the rule to collaborate more closely on appropriate strategies to resolve remaining problems. The statement said the agency would step up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers.

CMS Releases Stage 2 Meaningful Use Proposed Rule

On February 22, 2012, the Office of the National Coordinator of HIT (ONC) and the Centers for Medicare and Medicaid Services (CMS) released the Notice of Proposed Rulemaking (NPRM) for two new rules relating to meaningful use (MU). The first rule, released by CMS, set the new standards for Stage 2 MU, due to go into effect in 2014. The second rule, released by ONC, established the permanent certification program for electronic health records (EHR) systems and changed some of the certification measures to more closely align with the Stage 2 MU standards.

The rules will be filed in the Federal Register on March 6, 2012. Both ONC and CMS are soliciting comments on the rules (both pros and cons). Both positive and negative comments on the proposed rules will be accepted for 60 days after their formal posting in the Federal Register. You can send comments electronically to <http://www.regulations.gov> or via mail to: CMS, Dept. of HHS, Attn: CMS-0044-P, PO Box 8013, Baltimore, MD 21244-8013. The final rules should be released by late summer. To view a fact sheet from CMS click [here](#).

In addition, CliniSync has prepared a summary of the Stage 2 Meaningful Use Proposal Rule. Details of the proposed rule are as follows:

For eligible professionals (EPs) the following changes are proposed:

- Regardless of when a physician meets MU, he/she will have two years of Stage 1 measures (those currently in effect) until needing to move to the increased Stage 2 standards. For those physicians meeting MU in 2011, they will not need to meet Stage 2 until 2014.
- Physicians will still be required to meet 20 MU measures: 17 Core and 3 Menu measures. Many of the menu measures from Stage 1 have been moved to Core measures for Stage 2. Physicians will still attest to meeting MU measures; however, starting in 2014, they will be required to submit the clinical quality measures (CQM) to CMS or other data registries as recognized in the rules. The rules have tried to realign the CQM reporting to match submission requirements for other programs, such as PQRS. CQM reporting will increase from 6 CQM measures in Stage 1 to 12 CQM measures in Stage 2. The proposed list of potential CQMs to select from for reporting is increased to 125 measures to accommodate specialists' practices.
- Physicians will be required to provide patient portals for patient access to their medical records. The proposed rule requires the physician or other eligible professional (EP) to give access to at least 50% of their patients seen during the reporting period to results within four days of the report being available to the EP. Certain information may be withheld at the EP's discretion. At least 10% of the patients need to view, download or transmit their information to a third party.
- Physicians meeting MU by 2013 will not be subject to any payment penalties. If they meet MU in 2014, they will need to attest to 90 days of MU by October 1, 2014 in order to avoid any penalty in 2015. This means that physicians will need to begin their 90 day reporting period for MU no later than July 2, 2014 to avoid payment penalties in 2015. Physicians not meeting MU by 2014 will be subject to a 1% decrease in Medicare Part B payments in 2015, 2016 and 2017 (for a total of 3%) until MU is met. Further payment penalties after 2017 will depend on the rate of adoption of MU nationally. Hardship exemptions will be reviewed on a case-by-case basis in the following circumstances: 1) no internet access for two years prior to the reporting period; 2) new physician practicing within the past two years; and 3) extreme circumstances (e.g., vendor going out of business, natural disasters).
- The computerized physician order entry (CPOE) measure has been expanded from just medication orders to include laboratory and radiology orders. The MU threshold for CPOE rises to 60% of all orders from 30%.
- Percentages for Stage 1 meaningful use measures have been increased to reflect greater activity by practices on EHR.
- Measures are now more responsive to specialists' workflow issues: one of the menu measures includes online imaging results for one of the menu measures. Also, the vital signs measure is divided into blood pressure and height and weight, so if a physician's scope of practice would include taking blood pressure but not height and

weight, the physician can still meet that MU measure. The certification of EHR systems is more streamlined. The protocol for certifying systems (Certified EHR Technology, “CEHRT”) would be based upon the needs of the practice and would not require every element of certification in the system to be standard for all practices. This new level of certification, part of the permanent certification program ONC is adopting, will be effective in 2014 at the same time as the Stage 2 rules.

- Public health reporting: EPs are required to do ongoing public health reporting and not just test the connection. In Ohio, this would mean doing immunization reporting for EPs to the Ohio Department of Health’s Impact SIIS program.
- The overall thrust of Stage 2 is actual exchange of clinical information. This definition requires the EPs’ practice to be engaged with some type of Health Information Exchange (HIE) so that the exchange of information can occur across different EHR systems and outside of one specific organization’s structure, be that a physician network or a hospital network. Emphasis is given to the electronic exchange of a continuity of care document (CCD) in at least 10% of the transitions of care or referrals. The rules were filed in the Federal Register on March 6, 2012. Comments on the proposed rules will be accepted for 60 days. You can send comments electronically to <http://www.regulations.gov> or via mail to: CMS, Dept. of HHS, Attn: CMS-0044-P, PO Box 8013, Baltimore, MD 21244-8013. The final rules should be released by late summer.

CMS Delays Medicare RAC Pre-Review Demonstration Project

The Centers for Medicare and Medicaid Services (CMS) has announced that it will delay the implementation of the Medicare Recovery Audit Prepayment Review Demonstration, originally scheduled to begin Jan. 1. The demonstration, once implemented, will allow Medicare recovery audit contractors to conduct prepayment reviews of some inpatient hospital claims in 11 states, including Ohio. CMS did not announce a new start-up date for the demonstration project, but they will provide a 30-day warning before they begin the demonstration project in Ohio and the other targeted states. CMS also is delaying until further notice the Prepayment Review and Prior Authorization for Power Mobility Devices Demonstration originally scheduled to begin Jan. 1.

The Recovery Audit Prepayment Review demonstration will allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration will also help lower the error rate by preventing improper payments rather than the traditional “pay and chase” methods of looking for improper payments after they have been made. **This demonstration project has been delayed until further notice.**

CMS in November announced this demonstration project along with a Part A to Part B re-billing demonstration, which allows selected hospitals to re-bill for up to 90% of the Part B outpatient payment after a Part A inpatient short-stay claim is denied on the basis that the inpatient admission was not reasonable and necessary. This initiative will allow hospitals to rebill for 90 percent of the Part B payment when a Medicare contractor denies a Part A inpatient short stay claim as not reasonable and necessary due to the hospital billing for the wrong setting. Currently, when outpatient services are billed as inpatient services, the entire claim is denied in full.

This demonstration will be limited to a representative sample of 380 hospitals nationwide that volunteer to be part of the program. This demonstration will allow hospitals to resubmit claims for 90 percent of the allowable Part B payment when a Medicare Administrative Contractor, Recovery Auditor, or the Comprehensive Error Rate Testing Contractor finds that a Medicare patient met the requirements for Part B services but did not meet the requirements for a Part A inpatient stay. **The Part A to Part B re-billing Demonstration was not delayed and began Jan. 1.** For more information on this announcement from CMS to go to: https://www.cms.gov/CERT/02_Demonstrations.asp

The Department of Health and Human Services (HHS) Proposes Delay in ICD-10 Implementation

HHS has announced a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). The ICD-10 compliance date change is part of a proposed rule that would adopt a standard for a unique health plan identifier (HPID), adopt a data element that would serve as an “other entity” identifier (OEID), and add a National Provider Identifier (NPI) requirement. The proposed rule was developed by the Office of E-Health Standards and Services (OESS) as part of its ongoing role, delegated by HHS, to establish adopt standards for electronic health care transactions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). OESS is part of the Centers for Medicare & Medicaid Services (CMS).

The proposed rule, CMS-0040-P, may be viewed at www.ofr.gov/inspection.aspx.

A news release on the proposed rule may be viewed at <http://www.hhs.gov/news>.

News from Other Third Party
Payers

MEDICAID

Ohio Medicaid Chooses Five Managed Care Organizations

Ohio has chosen five managed care organizations to provide services for Ohioans served by Medicaid - the tentative selections allow current Ohio plans CareSource, Paramount Advantage and United Healthcare Community Plan of Ohio to operate under new contracts while also introducing Aetna Better Health of Ohio and Meridian Health Plan to the program. The managed care overhaul will reduce the eight Covered Families and Children and Aged, Blind and Disabled regions to three combined regions where the MCOs will operate, and all five plans will serve in each area. Current MCOs working in the state that did not make the list include Amerigroup Ohio Inc.; Buckeye Community Health Plan Inc.; Molina Healthcare of Ohio Inc.; and Wellcare of Ohio Inc. The Ohio Department of Job and Family Services (ODJFS) have indicated that these selections are preliminary and those that were not chosen can protest the decision.

The MCOs that have been selected must meet expectations through readiness reviews to be held through July, and the state could opt to take the next best applicant if a plan fails to progress as expected. Final provider agreements are set to be signed at the end of August with plans scheduled to enroll Medicaid members in January. The plans were selected through open application process and the ODJFS used a scoring methodology based on applicants’ past performance in coordinating care and providing high-quality health outcomes. The contracts Ohio Medicaid signs with the selected plans will require the plans to more national performance standards in order to receive financial incentive payments. Ohio’s Medicaid managed care program serves about 1.5 million individuals enrolled in Ohio’s CFC program, 129,000 enrolled in the state’s ABD program, and 37,000 children with special needs. Ohio’s Medicaid program serves more than 2.1 million low-income Ohioans.

Medicaid Open for Attestation

Medicaid Meaningful Use opened for attestation on Monday, April 2. Medicaid will be accepting attestations both for Adopt/Implement/Upgrade (A/I/U) for Year 1 incentives as well as for Year 2 Meaningful Use incentives. For Year 2 attestation for Meaningful Use, it will be necessary for Eligible Professionals to attest to 90 days of MU for the calendar year 2012.

For MU attestation for both Medicare and Medicaid, at this time Eligible Professionals should exclude Menu Measure 9: Immunization Reporting - until the Ohio Department of Health is ready to test interfaces for reporting into the Impact SIIS system (see below for additional information on this issue as outlined from the Ohio Department of Health).

Immunization Reporting – Information from Ohio Department of Health - Overview of the Program

The goal of the Ohio Department of Health (ODH) Immunization Program is to reduce and eliminate vaccine-preventable diseases among Ohio's children, adolescents and adults. To assist in reaching this goal a web-based statewide immunization information system was developed. ImpactSIIS collects immunization and other health and demographic information from doctor’s offices, hospitals, insurance carriers, public health clinics, and other health care

providers. Records for Ohio's citizens are then visible to other health care providers around the state, including forecasting of next doses due for administration. An increasing percentage of this information is sent electronically in HL7 messages.

Federal Requirements

Meaningful Use Stage 1 objective: Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.

Meaningful Use Stage 1 measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the eligible professional, eligible hospital or critical access hospital submits such information have the capacity to receive the information electronically).

Policy for MU

The ODH Immunization Registry is currently not accepting test files for MU.

Meaningful Use Exclusions for Eligible Professionals (EPs) for Immunization Reporting:

Eligible professionals who do not administer any immunizations during the EHR reporting period may claim an exclusion. Eligible professionals who do administer immunizations may claim an exclusion at this time. Any updated information on testing of immunization files for MU will be posted on this website.

However, eligible hospitals can submit test files for either ELR or Syndromic Surveillance.

Contact information: impactEMR@odh.ohio.gov or call 1-866-349-0002.

UnitedHealth Care

UHC Implements Advance and Admission Notification Requirements

UHC will begin expanding their medical necessity criteria to additional benefit plans. UHC notes that although services on the Advance Notification list have not changed, physicians may be asked to provide additional clinical information to support a medical necessity coverage review for certain members and certain services on the advance notification list. The list has been updated to include these additional services that require notification and the new list became effective April 1, 2012. The additions have been published in the 2012 UHC Administrative Guide. For more information, access the frequently asked questions and recourse tools on the UHC website at www.unitedhealthcareonline.com – clinician resources.

UHC Announces New Mobile App for Patients

UnitedHealthcare is providing its plan participants a new mobile app – Health4Me. The app is available for the Apple iPhone and iPad – and coming to the Android soon. Health4Me enables users to manage their health and interact with UnitedHealthcare. The free app provides employer plan participants 24/7 access to a nurse call line, enables them to locate a nearby in-network physician, hospital or other medical facility and gives them access to their personal health benefits information.



Do You Need Help in Your Practice with Health Information Technology?

Cuyahoga Community College Continues to Train HIT Professionals through 2013

If you or your practice needs an intern, new staff or training for your existing staff, please contact the HIT project lead at Tri-C to discuss your needs. By the end of this month the Health Information Technology (HIT) training program at Cuyahoga Community College (Tri-C) will have graduated over 275 students prepared to assist primary care physicians, hospitals and community health organizations deploy and meaningfully use Electronic Health Records for patient benefit. In order to fill the growing Health IT employment demand and support timely transition to EHRs, the ONC has identified six workforce roles intended to support primary care physicians on the road to meaningful use:

- Practice workflow and information management redesign specialists

- Clinician/practitioner consultants
- Implementation support specialists
- Implementation managers
- Technical/software support specialists
- Trainers

The AMCNO is pleased to be assisting Tri-C in bringing this program to the attention of our members. If you are looking for HIT help in your practice or hospital and would like more information about the HIT program at Tri-C, go to www.tri-c.edu/hit or call 216-987-2723 and ask for Ronna McNair - the program manager of the Health Information Technology program.

AMCNO Encourages Physicians to Consider Utilizing Ohio's EHR Learning and Action Network

At no cost, physicians can be part of a learning network that allows you to work with others who are going through similar experiences with the same goals as you. Our organization is working alongside KePro to support Ohio's EHR Learning and Action Network. What will this network give you?

- Assistance with successful submission of data for quality improvement incentive programs including EHR Meaningful Use and Physicians Quality Reporting System (PQRS).
- The ability to partner with and connect to other organizations and individuals with similar goals.
- Identification of best practices, including EHR implementation strategies and quality improvement initiatives.
- Access to aggregate local, regional and national data for benchmarking, as well as resources developed by the Quality Improvement Organization network.
- Access to information and tools from the Prevention National Coordinating Center via the Quality Improvement Organization network.

Designed specifically for providers, the network includes IT experts, vendors, community organizations and patient representatives. This collaborative is part of a national initiative by the Centers for Medicare & Medicaid Services (CMS) and is coordinated by the Quality Improvement Organizations in each state and territory. In Ohio, the founders include the Academy of Medicine of Cleveland & Northern Ohio, HealthBridge, Ohio Academy of Family Physicians, Ohio Department of Health, Ohio Department of Job & Family Services, Ohio Health Information Partnership and the Ohio Hospital Association. The network's mission is to provide an environment for shared learning, and in association with the Regional Extension Centers, to assist providers in achieving meaningful use of health information technology.

To join Ohio's EHR Learning and Action Network, please visit www.ohiokepro.com and click on **Ohio's EHR Learning & Action Network**.

CliniSync Provides HIE Physician and Hospital Brochures

CliniSync, the statewide health information exchange, has created several tri-fold brochures that now are on their website so interested healthcare professionals can download them. These include:

- **Overview of HIE Services for Physicians:** This overview introduces physicians to CliniSync and describes the suites of services offered, including a CliniSync Direct Suite and a more integrated CliniSync Community Health Suite.
- **Direct Suite:** This suite of services is for physicians and other healthcare providers who are predominately paper-based and may not have an EHR system. The Direct Suite is an application that is installed on a local PC in the physician's office and connects with the CliniSync network. Once installed and configured, the Direct Suite offers these modules: Referral Management, Direct Messaging, Inbox and Straight-to-EHR.
- **Community Health Suite:** This more integrated suite does everything above, but it also allows you to search for available information on a patient. The modules include: Straight-to-EHR, Community to-EHR- Delivery and Practice-to-CliniSync Publishing.

- **Hospital Suite:** These services include project management, assessment of the existing system, custom-developed interfaces, rigorous testing and a community roll-out of electronic results to the physician community, including interfacing.

To view the CliniSync brochures go to www.clinisync.org

AMCNO Lawyer Referral Brochure Now Available to AMCNO Members and Staff

If you are in need of legal counsel in a specific area of expertise this brochure could be of assistance to you. When legal questions or issues arise, the AMCNO believes it is important for its members to obtain sound advice from legal counsel who are knowledgeable in relevant areas of the law and who have a commitment to the effective representation of physicians and their practice groups. This brochure is the product of our effort to identify such attorneys. We encourage our members to make use of these lawyers (or other practitioners similarly qualified) whenever they encounter significant legal issues. **If you would like a FREE copy of the AMCNO Lawyer Referral Brochure go to our website at www.amcno.org or contact the AMCNO staff at 216-520-1000, ext. 101.**

Discounted Classes at Tri-C for
AMCNO members

Cuyahoga Community College AMCNO Discounted Medical Practice Management Seminars

The AMCNO is pleased to partner with Cuyahoga Community College (Tri-C) Center for Health Industry Solutions to offer certification courses and continuing education unit seminars at discount prices for AMCNO members and staff.

Take advantage of discounted classes for AMCNO Members and staff, call 216-520-1000 to obtain your AMCNO discount code, registration and CEU information

Spring-Summer Term 2012

05/22/12 – 7/03/12 **Medical Terminology** (6 pm – 9 pm T-TH) \$315 at CCW

6/11/12 – 7/25/12 **Medical Terminology** (9 am-12 pm M-W) \$315 at UTC

7/9/12 – 8/8/12 **Fundamentals of Billing Reimbursement** (9 am – 12 pm M-W) \$338 at UTC

7/10/12 – 8/21/12 **Medical Terminology** (6 pm – 9 pm T-TH) \$315 at CCE

8/7/12 – 9/6/12 **Fundamentals of Billing Reimbursement** (6 pm – 9 pm T-TH) \$338 at CCE

9/15/12 - 11/10/12 **AAPC Accelerated Professional Medical Coding Curriculum** (9 am – 1 pm Sat) \$902 at CCE

Course Locations:

CCE Corporate College East 4400 Richmond Rd, Warrensville Hts, OH 44128

CCW Corporate College West 25425 Center Ridge Rd., Westlake OH 44145

UTC Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 44115

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Launches New Web Site

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to announce the launch of their new and improved website: <http://www.amcno.org>. The website features a new design with a fresh look, and is more focused on the needs of our members.

The new website offers a wealth of information and extensive background about the Academy of Medicine of Cleveland & Northern Ohio - including our rich history dating back to 1824 as well as information on current board members and committees. Take a moment to review the work of the AMCNO over the past year or learn more about the governance and mission of the organization.

Physicians now have the ability to join or renew their membership online – and learn more about the AMCNO member benefits including our advocacy and legislative activities. Our Advocacy page contains information outlining the legislation currently under review by the AMCNO, background on amicus briefs filed on behalf of our members with the Ohio Supreme Court, a detailed advocacy tool kit which provides information on how to contact and write your legislators, background on current Ohio legislation as well as details on how to donate to the AMCNO political action committee - NOMPAC.

The AMCNO Practice Resources page contains a detailed information of use to physicians and practice managers such as insurance company contact information, how to deal with Medicare audits, coding information, tips on adopting electronic health records, information on HIPAA regulations, data and security issues and much more. Members will also find the AMCNO lawyer referral brochure online along with the AMCNO community resources list.

The website also provides details about the AMCNO's work on regional and state issues along with information on the various community committees, boards and groups the AMCNO physician leadership and staff interacts with on a regular basis. In addition, members can now browse through past issues of the Northern Ohio Physician magazine, our Practice Management Matters newsletter and view more information on education and events supported by the AMCNO.

The website also provides detailed information about another important component of the AMCNO – our foundation the Academy of Medicine Education Foundation (AMEF). This foundation provides medical student scholarship funding and supports many other Northern Ohio community activities.

The website provides a plethora of information for the public – including links to recordings of the AMCNO award winning Healthlines radio program, Find a Physician look up which includes an online listing of all AMCNO active members, and daily AMCNO pollen counts. The public is also invited to follow us on Twitter where the AMCNO plans to “tweet” daily pollen counts, provide callouts when Healthlines programs are posted as well as other tidbits of importance to the community.

Members are also welcome to follow us on Facebook and Twitter where you can learn more about the activities of your regional organization – the Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Beginning in 2012, the AMCNO publication, PRACTICE MANAGEMENT MATTERS will no longer be mailed and will be published online only on the AMCNO website. Practice managers and physicians are welcome to visit the site on a regular basis to view the publication or follow us on Twitter to learn when new issues or topics have been posted.



Medical Records Fact Sheet Update Effective January 2012

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Current Opinion **7.05**. Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.742** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2012, the maximum fees that may be charged, are as set forth below.

- (1) The following maximum fee applies when the request comes from a patient or the patient's representative.
 - a) No records search fee is allowed;
 - b) **For data recorded on paper:** \$2.92 per page for the first ten pages; \$0.61 per page for pages 11 through 50; \$0.25 per page for pages 51 and higher
For data recorded other than on paper: \$2.00 per page
 - c) Actual cost of postage may also be charged

- (2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.
 - a) A \$17.97 records search fee is allowed;
 - b) **For data recorded on paper:** \$1.18 per page for the first ten pages; \$0.61 per page for pages 11 through 50; \$0.25 per page for pages 51 and higher
For data recorded other than on paper: \$2.00 per page
 - c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the adjustment to be not later than January 31st of each calendar year, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext 102.

Practice Management Matters

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) can provide you information on topics from balance billing to managed care to terminating the physician/patient relationship.

The AMCNO Practice Management Department is available to address or investigate any claim issue as well.

Visit *Practice Management* at www.amcno.org
For a “Third Party Payor Review Form”.

Call us at 216.520.1000 or email amcno@amcno.org

The AMCNO Practice Management Matters newsletter includes links that provide direct access to Internet sites other than our own. The AMCNO takes no responsibility for the content or the information obtained on other Web sites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our Web site at www.amcno.org

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

www.amcno.org

216.520.1000 Executive Offices 216.520.0999 Facsimile