

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

## PRACTICE MANAGEMENT MATTERS

### Summer 2007

#### Medicare Update

Also Inside this Issue: AMCNO  
Solving the Third Party Payor Puzzle  
Seminar flyer – sign up today

#### **Centers for Medicare and Medicaid Services (CMS) Proposes Policy, payment changes and 10% payment cut for physician services in 2008**

CMS announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare Physician Fee schedule. The proposed Physician Fee Schedule shows Medicare's determination to continue the Physician Quality Reporting Initiative (PQRI) in 2008 by expanding the set of quality measures and warns that physicians are, indeed, facing a nearly 10% pay cut. It is IMPERATIVE that physicians voice their concern regarding these proposed payment cuts. The Congressional Budget Office (CBO) recently announced that Medicare physician payment rates would be reduced by 10% in 2008 under current law. The 110<sup>th</sup> Congress, under Democratic leadership, will again be reviewing the perennial issue of Medicare's annual payment update to physicians, which is controlled by the sustainable growth rate (SGR) formula. Late last year, Congress passed H.R. 6111, the Tax Relief and Health Care Act, which intervened to stop the impending 5 percent cut to Medicare physician reimbursement. Due to a myriad of federal budgetary rules, Congress decided to push the cut, scheduled for 2007, into 2008. This, of course, has resulted in physicians now facing a 10 percent payment cut in 2008 – the original 5 percent cut they faced under the SGR in 2007 along with the additional 5 percent SGR cut for 2008. The AMCNO president has sent a letter to all Congressional leaders from our area and we urge our members and their staff to do the same. Letters to Congress directly through the AMCNO website at [www.amcnoma.org](http://www.amcnoma.org) - click on the Legislation link then click on Find your Legislator/Eye on the Statehouse to find a sample letter to Congress. The AMCNO is also reviewing the need to send written comments on the CMS Proposed Rule. Comments are due by August 31, 2007. To view or download the proposed rule, visit <http://www.cms.hhs.gov/center/physician.asp>, click on CMS-1385-P. To send comments on the rule go to: <http://www.cms.hhs.gov/eRulemaking/>

#### **Clearinghouses May be Removing information from Medicare claims**

The Center for Medicare & Medicaid Services (CMS) has issued an alert that some Clearinghouses are stripping the National Provider Identifier (NPI) prior to submission of the claim to Medicare. If this occurs, it will adversely affect physicians that are participating in the PQRI program (Eligible Professionals) since these claims will not count toward PQRI participation. CMS urges Eligible Professionals that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the Eligible Professional determines that their clearinghouse is stripping NPIs from the claim, the Eligible Professional may want to consider other billing options. For information on how to use NPI correctly on claims go to <http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0725.pdf>. For more information on Physician Quality Review Initiative (PQRI) go to - <http://www.cms.hhs.gov/pqri>.

#### **CMS Proposes Policy and Payment Changes for Ambulatory Surgery Center (ASC) and Hospital Outpatient Services**

The Centers for Medicare & Medicaid Services (CMS) has issued a final rule revising the payment system for services furnished to people with Medicare in ambulatory surgical centers (ASCs) to better align payments for similar services furnished in a hospital outpatient department (HOPD) or a physician's office. CMS also issued a proposed rule that would update Medicare payment for services in HOPDs under the Outpatient Prospective Payment System (OPPS) and would set new payment rates for ASCs under the revised system effective for services in calendar year (CY) 2008. The ASC final rule expands beneficiary access to surgical procedures in ASCs and implements steps to make ASC payments more accurate, while aligning payments across Medicare's payment systems to encourage efficient and appropriate choices of outpatient settings for ambulatory surgical procedures. CMS expects to make payments of almost \$3 billion in CY 2008 to the approximately 4,600 ASCs that participate in Medicare. Comments on the

proposed rule will be accepted until September 14, and a final OPPS/ASC payment rule will be published later this fall. **For the text of the ASC final revised payment system rule see [www.cms.hhs.gov/ASCPayment/](http://www.cms.hhs.gov/ASCPayment/) For the text of the combined OPPS/ASC proposed rule, see:**

**[www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage) For Fact Sheets on the final ASC rule and the combined OPPS/ASC proposed rule, see: [www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp) .**

### **2007 PQRI Tool Kit – Five Steps for Success**

The Centers for Medicare & Medicaid Services (CMS) has developed a Tool Kit for the 2007 Physician Quality Reporting Initiative (PQRI) that will assist eligible professionals with successful reporting. This Tool Kit consists of some existing educational resources plus new measure-specific worksheets designed to walk the user step-by-step through reporting for each measure. The Tool Kit is now a featured section on the CMS PQRI Web page. To access the Tool Kit, visit, <http://www.cms.hhs.gov/PQRI>, and scroll down to the PQRI Tool Kit tab.

### **Revisions to the final 2007 PQRI Measure Specifications**

The Centers for Medicare and Medicaid Services (CMS) announces revisions to the final 2007 PQRI Measure Specifications, Version 1.1 to provide certain technical corrections. Please visit the "Measures/Codes" page of the PQRI Web site at [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri) for the updated measure specifications and release notes.

### **National Provider Identifier (NPI) Update - are you reporting you NPI on Medicare claims yet?**

Points to remember:

- ⇒ The Center for Medicaid and Medicare Services (CMS) contingency for covered entities are allowing Provider Transaction Access Numbers (PTAN) on Medicare claims for up to 12 months after the May 23, 2007 deadline.
- ⇒ CMS is working to develop a database of NPIs for the purpose of assisting providers in situations where NPIs are needed to declare referring or ordering physician information on the Medicare claim form.
- ⇒ Additional and updated NPI information is available at: <http://www.cms.hhs.gov/NationalProviderStand/> or at the Enumerator Web site: <http://www.nppes.cms.hhs.gov>

### **Important Information About Private Fee For Service (PFFS) Plans**

CMS has posted on its Web site contact information for most of the major Medicare Advantage PFFS plans to allow physicians easier access to the plans' terms and conditions. CMS compiled this information in response to physician complaints pertaining to difficulties accessing these plans' terms and conditions. Go to <http://www.cms.hhs.gov/privatefeeforserviceplans/> for more information.

## *Medicaid*

### **Ohio Dept. of Job and Family Services to Speed Up Enrollment in Medicaid Managed Care**

The recently enacted SFY 2008-2009 Biennial Budget included assumptions that the Ohio Department of Job and Family Services (ODJFS) will be working with counties to speed up enrollment of Medicaid consumers into managed care plans. Once an application has been submitted for Medicaid benefits, a notice will be generated to the applicant asking them to select a managed care plan. Regional managed care plan information will also be sent to the applicant. The applicant then will either select or be assigned to a managed care plan when the benefit determination is complete. The idea is to enroll applicants into the managed care plans 45 days sooner than is the current practice. Additional information on the Medicaid managed care plans may be obtained at <http://jfs.ohio.gov>

### **Medicaid Director Issues Information Regarding Theft of Confidential Data**

Physicians treating Medicaid patients have been informed by the Medicaid Director that the State of Ohio has confirmed that a data storage device stolen in June did contain confidential files that could impact Medicaid providers. The files contained provider names, address, tax ID number and bank account identifiers for Medicaid providers eligible to receive payment through electronic fund transfer (EFT). The Medicaid Director is of the opinion that it is unlikely that anyone will be able to access the data, however, they are suggesting that providers that may be affected contact their financial institutions to monitor their accounts and review accounts for accuracy. Details and further information for physicians and other health care providers may be found at [www.ohio.gov/idprotect](http://www.ohio.gov/idprotect)

### **Medicaid Managed Care Open Enrollment**

The Medicaid Managed Care Program is about to begin its annual open enrollment process. Managed care enrollees will receive "A Consumer's Guide to Medicaid Managed Health Care" via U.S. Mail. This information explains how to select a new managed care provider (MCP). It also lists contact numbers for each MCP in the region and the unique benefits each plan offers. Just as was done last year, Medicaid consumers that want to change MCPs must contact the Managed Care Enrollment Center at 1-800-605-3040 M-F between 8 a.m. and 8 p.m. or they may enroll via the Internet [www.ohiossc.com](http://www.ohiossc.com). Managed care enrollees who wish to remain

enrolled with their current MCP do not need to take any action. Open enrollment for the Northeastern Region of Ohio will be in October for the CFC Managed Care and in December for ABD Managed Care.

## *Third Party Payors*

### **Bureau of Workers Compensation Adds NPI Information to Database**

As recently posted on the BWC web site, BWC will now allow providers to incorporate their National Provider Identifier (NPI) into the Bureau's billing processes. Providers may incorporate the NPI if it fits their business processes. BWC does not view the NPI as a replacement for the BWC provider rather BWC views NPIs as alternates or additional identifiers providers can use in Ohio workers' compensation billing. The Bureau is making changes to add NPI information to its database to cross-reference BWC provider numbers. Providers wishing to incorporate NPI into their workers' compensation billing must provide and verify their information with BWC's provider relations department. Providers should submit copies of their NPI confirmation from the enumerator (Fox Systems Inc.) along with their corresponding BWC provider number to the fax number or address listed here. Fax to: BWC Provider Enrollment (614) 621-1333 or Mail to: Ohio BWC Provider Enrollment P.O. Box 182031 Columbus, OH 43218-2031.

Once this process is complete, a provider may bill using either his or her BWC provider number or a combination of both the BWC provider number and NPI (and taxonomy code if applicable). Again, BWC does not require providers to use NPIs for billing. Providers who wish to transition to billing BWC using their NPI information only should first bill using both identifiers (the BWC provider number plus the NPI). BWC will add new explanation of benefit codes to remittances to confirm it has added NPI data to a provider's record. Once confirmed, the provider may choose to bill using the NPI rather than the BWC provider number. Please be aware that BWC can only accommodate NPIs on forms for the billing processes noted above. The bureau is looking to accommodate future use of NPIs on other medical documents but is not set up to do so at this time. BWC has instructed managed care organizations to identify medical providers using NPIs on any form other than a bill, attempt to cross-reference their information, and then inform the provider to use its BWC provider number until the bureau can accommodate NPI in other processes.

### **MMO To Begin Offering Personal Health Records**

According to *Health Care Data Management* Medical Mutual of Ohio plans to roll out a program this fall that will offer its members Medem's iHealth Personal Health Record, which automatically will be populated with members' claims data. Physicians using Medem Web sites can let patients enroll in a PHR when they are using the Web site to register for an appointment. Patients will be able to decide with whom to share their data. In addition, patients will own their PHRs, regardless of whether they switch physicians or insurers. However, Medical Mutual will be unable to populate a PHR with claims data if the member switches health plans (as reported in *Health Data Management*, 6/19).

### **Anthem Expands Transparency Initiative**

Anthem National Accounts has expanded its transparency initiative into four new markets, including Ohio. Anthem members will have access to Anthem's Care Comparison, an online tool that provides quality information, along with the total estimated costs associated with all aspects of nearly 40 specific medical procedures performed at local area hospitals. The cost information is facility specific, so members can compare the differences in cost among hospitals. In September 2006, Anthem unveiled the Anthem Care Comparison pilot in Dayton, Ohio, with partner General Motors, enabling thousands of Anthem members and GM employees in Dayton to participate in this transparency initiative. Since the rollout, Anthem has collected and analyzed member feedback to help enhance the effectiveness of Anthem's Care Comparison tool. More than 90 percent surveyed indicated the cost information provided by the tool is valuable, while 84 percent said it increases their ability to make good, informed decisions regarding where to have a medical service. Anthem plans to continue expanding the Care Comparison tool nationally.

<http://www.bcbs.com/news/plans/anthem-national-accounts.html>

### **MMO announces laboratory network change**

Effective September 1, 2007, Laboratory Corporation of America (LabCorp) and its affiliates will no longer participate in the Medical Mutual/Consumers Life Network. All LabCorp services, including draw sites and analysis, will be affected. MMO will continue to contract with other national and local reference and specialty labs to ensure that patients have access to services. As a preferred option, MMO has stated that Quest Diagnostics, Inc., remains a national lab for all Medical Mutual and Consumers Life members. To view a list of network providers to go [www.medmutual.com](http://www.medmutual.com) or [www.consumerslife.com](http://www.consumerslife.com)

## NEWS YOU CAN USE

### **AMCNO Practice Management session planned for November**

Now in its 22<sup>nd</sup> year, the AMCNO Solving the Third Party Payor Puzzle seminar is planned for November 15<sup>th</sup> at the AMCNO offices. This excellent program was the first of its kind in the state to bring together representatives from the various payors to provide input and comments on up to the minute changes and issues from the health insurance companies. Represented at this year's event will be representatives from PalmettoGBA (Medicare), the Ohio Department of Job and Family Services (Medicaid), Medical Mutual of

Ohio, Anthem BC/BS and UnitedHealthCare. Registration fees for AMCNO members or their staff are only \$50.00 per person. To obtain a copy of the registration form go to [www.amcnoma.org](http://www.amcnoma.org) - or see the last page of this update for a copy of the form.

### OSHA unveils flu pandemic guidance

The U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) unveiled new safety and health guidance that will help health care workers and their employers prepare for a possible influenza pandemic. Pandemic Influenza Preparedness and Response Guidance for Health Care Workers and Healthcare Employers is a comprehensive resource for health care planners and practitioners. The document includes technical information on infection control and industrial preparations and planning issues; and OSHA standards that have special importance to pandemic preparedness planners and responders in the industry.

[http://www.osha.gov/Publications/OSHA\\_pandemic\\_health.pdf](http://www.osha.gov/Publications/OSHA_pandemic_health.pdf)

### AMCNO Physician representatives meet with Medicare Payment Advisory Commission

AMCNO board members Drs. James Taylor, Lawrence Kent, William Seitz, Jr., Paul Janicki, George Topalsky and Anthony Bacevice met in July with representatives from MEDPAC and Mathematica to discuss private plans usage of episode grouper (pay for performance) software as well as their interactions with and reactions from the physician community. The purpose of this meeting was to provide input into a study coordinated by Mathematica Policy Research. The final study will be provided to MedPAC – a congressional commission that advises Congress on Medicare payment issues. The Center for Medicare and Medicaid Services (CMS) is investigating the use of episode grouper software in the future as part of the Medicare program. The study group has met with other physicians and hospitals around the nation and plans to prepare a report for Congress in the near future based upon these discussions.

In response to questions regarding how quality information would be most useful to physicians, the group in general was of the opinion that, at the very least, the data should compare a doctor to a local peer group and a national benchmark. In addition, it was made clear that many physicians are already working with systems and programs and there is a real concern as to whether or not the data being input now into the systems is going to be compliant down the road – especially if CMS and the federal government start using software – this issue must be addressed.

Concerns were raised that if CMS were to add yet another layer of work on physicians under Medicare rules to track data for quality reporting, and continue to cut their pay and reimbursement it is not going to be workable. It is a known fact that specialty societies and other national organizations are involved in setting parameters for these type of programs, yet not all carriers are using this information, they are developing different criteria and their own tracking mechanisms. If CMS and Medicare determine that they “must” implement a program then the parameters and measurements used should be based upon input from physicians and their specialty societies. In addition, there should be one set developed and utilized by all insurance companies if possible. It was noted there is still the medical liability cost factor to consider as well as the issue of how physicians are supposed to pay for the electronic health systems to implement these programs. The group also agreed that a big factor is patient accountability and non-compliance – patient behavior does play a role in utilization of services.

The takeaway message from the AMCNO physician leadership to MedPAC was that it will be important to inform physicians regarding the parameters to be measured; what tools/software will be needed to provide the information on these measurements and will current systems be compliant; what will physicians need to document to comply, can the program be implemented reviewing a select number of procedures and in a pilot format; will the program be applied uniformly across health insurers and not only the Medicare program, and where will the money come from to pay for this program and will additional costs or reduced payments impact on physician practices. The AMCNO is in contact with MedPAC staff and a copy of the report will be provided to the AMCNO.

### IRS Allowing Hospitals to Subsidize Health IT to Physicians

The federal government continues to promote health information technology (“Health IT”) through hospital financial assistance to physicians. On May 11, 2007, the IRS issued an internal memo on how a tax-exempt hospital may subsidize Health IT without jeopardizing its tax-exempt status or creating private inurement to the physician. Under the IRS directive, 501(c)(3) tax-exempt hospitals may enter into Health IT subsidy arrangements with medical staff physicians if the benefits are permitted under the HHS rules and meet the following IRS criteria:

- 1) **Both the hospital and the medical staff physicians are required to comply with the HHS rules on an ongoing basis;**
- 2) **The hospital makes the Health IT subsidy available to all medical staff physicians;**
- 3) **The amount of the subsidy is either the same for *all* physicians or varies according to criteria for meeting the health care needs of the community; and**
- 4) **To the extent permitted by law, the hospital must be able to access all of the electronic health records created by the subsidized physicians.**

The first three criteria must be understood in light of the HHS rules allowing a subsidy of up to 85% of the donor's costs for interoperable software that is necessary and used predominantly to create, maintain, transmit, or receive electronic health records. The IRS has acknowledged the impracticality of implementing the program for all physicians at once and that phased implementation for only those physicians interested would be acceptable. For example, a hospital might design an implementation plan to address unique health conditions, serve indigent populations or connect large off-site clinics.

The model for cost-sharing amounts paid by physicians must have a reasonable and verifiable basis, and the IRS wants to see whether a flat subsidy amount is used or any differences are explained by community need. From a practical point of view, how the hospital determines costs often will be driven by how it has structured its license fees with vendors. Variations in subsidy amounts should be related to improving community benefit and promoting health without directly rewarding referrals.

The final criteria must be understood in light of medical privacy laws, including HIPAA. Under HIPAA, a physician may disclose protected health information to a hospital only if an exception permits the disclosure. So while physicians may allow access when making a referral to the hospital or when the hospital is involved in treatment, HIPAA requires the physician to limit the information disclosed outside of treatment purposes to that minimally necessary to accomplish the purpose of the disclosure. Examples of proper avenues would be disclosures necessary for software maintenance and sharing insurance coverage for payment purposes.

These criteria are not absolute requirements for EHR donations. Rather, the directive sets forth a safe harbor under which the IRS agents will not find an impermissible private benefit or private inurement if followed. Otherwise, the IRS may review arrangements on a case-by-case basis to ensure that the subsidy promotes the needs of the community, and not to benefit an individual physicians. While the IRS has not opined on what tax consequences to the physician may be incurred, if any, more hospitals are reviewing whether and how to structure health IT subsidies under the new rules.

**Reprinted from the Northern Ohio Physician magazine – submitted by Amy S. Leopard , Walter & Haverfield LLP.**

#### **AMCNO Physician Leadership Participate in UnitedHealthCare Physician Advisory Committee (PAC)**

As a follow up to the AMCNO board meeting with the new Northern Ohio Medical Director for UnitedHealthCare, the AMCNO was invited to send physician representatives and staff to the Physician Advisory Committee (PAC) meeting of UHC. In June, the committee met to discuss the laboratory referral matter, the UHC Practice Rewards Program and the UHC radiology notification program. **The AMCNO continued to advocate for our members by offering our opinion that physicians should not be subject to a change in rating or a penalty by an insurance company if the patient makes a decision to use a non-network lab. The AMCNO also questions the authority of UHC to require financial penalties against physicians as well as how these penalties would be applied.** During the course of the PAC meeting representatives from UHC indicated that, to date, no fines have been implemented but stated that the action was meant to be less drastic than contract termination if needed in response to substantial and continued use of non-par labs. UHC plans to take action with respect to lab referrals only when physicians make continued, material use of non-par laboratories and then only after discussions with those physicians. In addition, UHC claims that they will not attempt to hold physicians accountable when their patients independently use out-of-network lab providers. The last item noted on this issue was that UHC subscribers will be receiving written notification in the mail in the near future about utilizing non-par labs and the consequences for same so physicians may expect to get questions from their patients. **AMCNO representatives noted that any letters sent out to UHC subscribers should also be sent out to UHC contracted physicians as well – inclusive of detailed information as to where UHC subscribers and physicians could obtain the list of regional labs so that physician staff can respond to any questions that may arise from the UHC members – since this could offset additional work on the part of the physicians. The AMCNO did not believe that it should not be left up to the physicians to respond to questions from patients. The AMCNO plans to continue to monitor this activity by UHC. If any member of the AMCNO has a concern about the lab protocol please contact us.**

The second topic of discussion, was UHC's Premium Designation Program and Practice Rewards program (see article by Dr. G. Greene elsewhere in this newsletter). Of note to our readers were comments made by physicians at the PAC meeting, specifically concerning the lack of information on the criteria used by UHC in these programs, the fact that information was not readily available about how the program functioned – specifically on the UHC web site, and that physicians had to talk to the UHC medical directors to obtain information. The AMCNO responded to UHC by stating that there is a great deal of frustration on the part of physicians concerning ease in accessing information from the UHC on this program. Based upon comments made at the AMCNO board meeting as well as during the PAC the AMCNO questions whether data that would be a useful tool for physicians is available on the UHC Web site or whether certain data can only be obtained by contacting a medical director from UHC. **The AMCNO has asked UHC to develop an informational piece outlining the details of what information is available on the UHC Website inclusive of links as to where it can be viewed. In addition, the AMCNO has asked that UHC consider providing ongoing updates to physicians via push emails or other resources to keep physicians and their staff up to date on any new information or changes.**

Physicians and their staff may obtain additional information regarding these programs at <http://www.unitedhealthcareonline.com> If any AMCNO members have specific issues with either of these programs, please email your comments to [ebiddlestone@amcnoma.org](mailto:ebiddlestone@amcnoma.org)

**Article about UnitedHealthCare program reprinted from the Northern Ohio Physician Magazine**

**UnitedHealth Premium<sup>®</sup> Designation Program and UnitedHealth Practice Rewards<sup>SM</sup>**

**By: Giesele Robinson Greene, M.D., - Market Medical Director Northern Ohio UnitedHealthcare**

Today's health care system is fraught with wide variation in medical practices that often leads to inconsistent clinical outcomes, inefficient care delivery for consumers and increased costs for employers. As those health care costs continue to rise, significant pressure is placed on benefit leaders to identify solutions aimed at limiting their companies' financial exposure while providing affordable health care to their employees. Most are looking to the vendors of health care to develop strategies that promote high quality and efficient care, build consumer trust and enhance the personal experience, while managing total health care spend.

UnitedHealth Premium designation is a consumer information tool recognizing physicians and hospitals for their adherence to evidence based medicine and delivery of cost efficient care. This tool is internet based and can be viewed by the public and United HealthCare members at the internet site [myuhc.com](http://myuhc.com). Physicians designated as Quality or Quality & Efficiency are represented for ease of consumer identification by one star for quality, or two stars for quality & efficiency in the UnitedHealthcare online directory.

The UnitedHealth Premium<sup>®</sup> designation program administered by UnitedHealthcare is a physician performance assessment initiative that uses evidence and expert based physician consensus standards to evaluate network physicians in 21 specialties for quality and efficiency of clinical care. Incorporating extensive and continuing input from physicians and state and medical professional societies, this program is available in 94 markets including the Cleveland Market. The UnitedHealth Premium program is a resource for practice improvement providing evidence-based guidelines, physician data sharing and data driven clinical management to reduce variability and enable high quality and affordable outcomes. The primary focus of the designation program is the evaluation of the quality of care delivery as measured against evidence based and expert physician approved standards. The program specifically incorporates "industry standard" criteria such as those approved by the Ambulatory Care Quality Alliance (AQA) which enjoys the considerable input of more than 35 leading medical societies, specialty society and external expert physician advisory committee input.

Only those physicians who meet the quality standards will proceed to the evaluation for efficiency of care. The efficiency of care criteria for UnitedHealth Premium incorporates the AQA definition of efficiency, and is calculated by comparing a physician's actual episode of care costs against the geographic norm specialty specific case mix, risk, and severity adjusted market average episode costs. Physicians whose performance meets or exceeds the national consensus standards for quality, and the geographic area norms for efficiency, are designated Premium providers. As further national evidence-based consensus standards in more specialties become available, they will be incorporated into the designation program. Physicians who have successfully met the quality criteria or the quality and efficiency of care criteria will receive the designations and will be identified to consumers in online directories by the one or two star designation. Narrative information is provided in the directory explaining that physicians who are non-designated may be non-designated for many reasons, the most common being insufficient information due to low volume or an a specialty not evaluated under the program. On a national basis, 56% of physicians eligible for designation status have received the UnitedHealth Premium designation for quality and/or quality & efficiency.

Unlike many other programs, the UnitedHealth Premium<sup>®</sup> Designation Program does not require physicians to administratively participate in data gathering for the purpose of designation. Physicians receive written documentation from UnitedHealthcare confirming their UnitedHealth Premium designation status. Physicians may view their detailed results of the assessment analysis by accessing a secured website using the user ID and password provided to them by UnitedHealthcare. Physicians have the opportunity to review the data and provide clarification and provide additional self-reported data prior to publication of results in the on-line directory. Based on additional self-reported data, quality and efficiency determinations will be recalculated and may result in revised designation status based on the additional self-reported information.

UnitedHealth Practice Rewards<sup>SM</sup> is the financial recognition for designated physicians meeting additional specified criteria beyond quality and efficiency. UnitedHealth Practice Rewards<sup>SM</sup> is an innovative approach that recognizes and rewards physicians who meet defined quality, efficiency and administrative criteria by providing them with an enhanced fee schedule. This is not a bonus program. Rather, it is a financial recognition of physician performance. Eligibility for UnitedHealth Practice Rewards begins with physicians who have received the quality and efficiency designation through the UnitedHealth Premium designation program. Medical Groups are also eligible as long as one or more of the group's physicians have received the quality and efficiency designation.

In addition to considering performance against quality and efficiency criteria, UnitedHealth Practice Rewards considers a practice's use of eligible standard contract templates, reimbursement schedules and efficiency use of technology in areas such as electronic claims submission. Eligibility for UnitedHealth Practice Rewards fee schedule adjustments occurs annually for all physicians, regardless of specialty, who bill at the contract level. Physicians who do not meet the criteria will continue to be reimbursed in accordance with the terms of their existing contracts and fee schedules. Physicians and medical groups will have access to detailed assessment reports and communication advising the physicians and groups of the results of the UnitedHealth Practice Rewards assessment as well as the availability of their detailed assessment analysis. UnitedHealthcare believes that quality and efficient health care depends on the effective engagement and performance of all participants: physicians, consumers, employers, and health plans. Advocacy for the practice of evidence medicine as the most affordable plan of care, is integral to improving health care in America.

### CUYAHOGA COMMUNITY COLLEGE

#### Discounted Continuing Education Classes for AMCNO Members and their Staff

Take advantage of local professional education on medical practice management issues!

Members and/or their staff will need an exclusive AMCNO course number to register and obtain the discount. For course numbers, call Linda Hale of AMC/NOMA at 216-520-1000, ext. 101, or e-mail [lhale@amcnoma.org](mailto:lhale@amcnoma.org). Once you have obtained your discount course number, call Cuyahoga Community College to register at 216/987-3075.

#### Wednesday Seminar Series at Corporate College East; 4400 Richmond Road, Warrensville Heights, Ohio 44128

Sept. 12 <sup>th</sup>	Physician Quality Review Initiative (PQRI) Introduction \$149	8am-12:15pm
Sept. 26 <sup>th</sup>	Compliance and Advanced Chart Auditing \$159	8am-12:15pm
Oct. 10 <sup>th</sup>	Revenue Cycle Management Strategies \$159	8am-12:15pm
Oct. 10 <sup>th</sup>	Advanced ICD-9CM Coding Update \$159	1:30pm-4:30pm
Oct. 24 <sup>th</sup>	Appeals and Denials- Panel \$99	11:30am-1:30pm
Dec. 5 <sup>th</sup>	Instituting a Coding Compliance Program in the Practice \$120	8am-11:00am
Dec. 5 <sup>th</sup>	Advanced CPT Coding Updates \$159	12:30-3:30pm

#### *Courses and Certifications:*

- **Certified Medical Coder (CMC) by PMI:** Wednesdays, Sept. 19-Oct. 24<sup>th</sup>. 8:30am-4:30pm. \$899
- **AAPC Professional Medical Coding Curriculum (CPC-A):** Evening Courses start in August- 6:00pm-9:00pm; Corporate College East and Westlake. \$1650
- **CPC Certification Exam Review:** Saturday, Dec. 1. 9:00am-2:45pm. \$120
- **Medical Terminology/Anatomy and Physiology:** day and evening courses; various times and locations. \$216

#### **Practice Management MATTERS**

*The Academy of Medicine of Cleveland & Northern Ohio can provide you information on topics from balance billing to managed care to terminating the physician/patient relationship. Whatever your question or concern, the Practice Management Department is available to address or investigate any issue left unresolved.*

*Call us at 216-520-1000 or email [concerns@amcnoma.org](mailto:concerns@amcnoma.org)*

6100 Oak Tree Blvd. Suite 440  
Independence, Ohio 44131  
[www.amcnoma.org](http://www.amcnoma.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.amcnoma.org](http://www.amcnoma.org)*



The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)  
is pleased to present:

**“Solving The Third Party Payor Puzzle”**

**WHEN:**

Thursday, November 15, 2007

**TIME:**

8:30 a.m. - 9:00 a.m. Registration

9:00 a.m. – 3:30 p.m. Seminar

<BOXED LUNCHES WILL BE PROVIDED>

**WHERE:**

AMCNO Executive Offices

**Park Center Plaza I**

6100 Oak Tree Blvd Independence, Ohio 44131

Lower Level Meeting Room

**COST:**

AMCNO Members and their staff - \$50 per participant

Non-Members - \$100.00

**PURPOSE:**

This seminar is intended to educate physicians and their office staffs regarding the many third party payor claims and managed care issues.

**Featured Speakers:**

Palmetto GBA Medicare Part B

Ohio Department of Job and Family Services (Medicaid)

Medical Mutual of Ohio

United Health Care

Anthem Blue Cross and Blue Shield

*All speakers will be afforded time to answer general questions.*

**TO REGISTER, fill out and return the form below or contact Bette C. Robinson at:  
216-520-1000, Ext. 102 or E-mail: brobinson@amcnoma.org**

**PLEASE COMPLETE AND RETURN WITH YOUR PAYMENT**

Enclosed is my check (if completed by mail) in the amount of \$ \_\_\_\_\_ for \_\_\_\_ attendees.

Name(s) of Attendee(s): \_\_\_\_\_

Physician(s) Name(s): \_\_\_\_\_

Office Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

**Please mail your registration form along with your check made payable to:**

**The Academy of Medicine of Cleveland & Northern Ohio**

PO. Box 901724, Cleveland, Ohio 44101-9932; or if paying by credit card, fax to (216) 520-0999,

**ALONG WITH YOUR CREDIT CARD AND**

**NUMBER: \_\_\_\_\_, Exp. date: \_\_\_\_\_ Attn:**

**Bette C. Robinson**

DEADLINE IS NOVEMBER 7, 2007. THERE IS A LIMIT OF TWO PEOPLE PER OFFICE AND  
CUTOFF WILL BE 75 PEOPLE. YOU MUST REGISTER PRIOR TO THE DAY OF THE SEMINAR  
AS SEATING IS LIMITED.

**PAYMENT WILL BE ACCEPTED DURING REGISTRATION THE DAY OF THE SEMINAR.**

