THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO (AMCNO)
PRACTICE MANAGEMENT MATTERS

Winter Edition

Medicare Update

In this issue – 2008 Medical Records Fact Sheet – What Your Practice Can Charge for Medical Records in 2008

Medicare Payment Cuts Averted For Six Months -SCHIP Funding Extended

Congress has voted 411-3 to approve legislation that would delay for six months a 10% physician fee cut and extend SCHIP through March 2009. The bill would increase Medicare physician fees by 0.5% for six months and would extend several programs that provide higher Medicare reimbursement rates to rural health care providers and hospital laboratories. The measure also would extend SCHIP funding through March 31, 2009. The legislation is intended to provide enough funding for states to maintain their current enrollment levels. The legislation does not address future physician fee cuts, which means the 10% reduction will take effect when the delay expires in June 2008 unless additional legislative action is taken. The approved Medicare legislation does not include the adoption of health IT as a way for physicians to increase their reimbursements. The AMCNO believes that this six-month temporary fix is not the answer for Medicare patients and physicians. The AMCNO continues to advocate for elimination of the flawed SGR formula. AMCNO will keep our members apprised of any updates on this issue.

Physician Quality Reporting Initiative

The Tax Relief and Health Care Act of 2006 authorized the creation of the Physician Quality Reporting Initiative (PQRI), an initiative that pays physician practices a capped bonus for reporting validated quality measures during the last six months of 2007. In 2008, the PQRI initiative will continue, however, some of the 2007 measures have been deleted and over 70 new measures have been added. On January 23, 2008 the AMCNO and PalmettoGBA co-sponsored a teleconference on the 2008 PQRI initiative. The AMCNO organized this event in partnership with PalmettoGBA in an effort to clarify for our members and for physicians across the state PQRI's 2008 components and requirements. Our featured speaker, Dr. Daniel Green, of the Center for Medicare and Medicaid Services (CMS), clearly outlined the incentive structure and reporting details. Dr. Green explained that medical practices would be eligible for a 1.5 percent bonus under the Tax Relief and Health Care Act of 2006, which authorized the creation of the PQRI. The PQRI was first launched the last half of 2007 and will continue in 2008. The PQRI program will continue to pay physician practices a bonus payment in 2009 for reporting validated quality measures during 2008. This is a voluntary program that will provide a financial incentive not only to physicians, but many other eligible professionals who successfully report quality information related to services provided under the Medicare Physician Fee Schedule during the course of this year.

There are now 119 reportable quality measures posted at www.cms.hhs.gov/PQRI. The PQRI 2008 program began on January 1, 2008, however, it is not too late for physicians to begin participation in the 2008 program. For those that wish to participate you may gather information and educational materials, along with detailed measure specifications and instructions on the PQRI web page noted above. In addition, the American Medical Association has posted additional information on the measures and how to comply with the PQRI program – to view the AMA site go to www.ama-assn.org. Another helpful tool is the *Coding for Quality – A Handbook for PQRI Participation* – also contained on the PQRI website.

The same reporting requirement thresholds continue in 2008 -i.e. if there are no more than 3 measures that apply, each measure must be reported for at least 80% of the cases in which a measure is reportable; and if 4 or more measures apply, at least 3 measures must be reported for at least 80% of the cases in which the measure was reportable. To be included in the PQRI process, the claim must include an accurate use of the National Provider Identifier (NPI.) Participating eligible professionals who successfully report may earn a 1.5% bonus (there is NO CAP applied this year). The 1.5% bonus calculation is based on the total allowed charges for all Medicare patients seen in 2008 during the reporting period for professional services billed. Bonus payments will be made in a lump sum in mid-2009 and the bonus payments will be made to the holder of record of the Taxpayer Identification Number (TIN). Physicians will receive confidential feedback reports that will include reporting and performance rates by NPI or each TIN.

The form and manner of reporting will once again be claims-based using CPT Category II codes (or temporary G-codes where CPT Category II Codes are not yet available) for reporting quality data. The CPT II codes are included in the CPT codebook and these codes are also posted on the CMS web site. Some measures have a performance timeframe related to the clinical action that may be distinct from the reporting frequency. Each measure has a reporting frequency requirement for each eligible patient seen during the reporting period i.e. report one-time only, report once for each procedure performed, or report for each acute episode.

Coding Tips for PQRI:
G-Codes – Use only if no CPTII codes are available; report with CPT and/or ICD-9; report alone with no modifier
CPT II Codes – Report with CPT and or ICD-9; Include on same claim form, Report alone (or) with Modifier
Modifiers: 1P – Medical Reasons: Not indicated; Contraindicated
2P – Patient Reasons: Patient Declined; Economic, Social, Religious; Other
3P – System Reason: Resources Not Available; Payer Limitation; Other
8P – Performance Measure Reporting – action not performed, reason not otherwise specified

To ensure success physicians should start reporting early to increase the probability of achieving the 80 percent rate of reporting during the reporting period. Also be sure to report on as many measures as possible to increase the likelihood of achieving successful reporting.

Included in the proposed rule for this year were additional reporting options that are now under review and testing by CMS. One is registry-based reporting – or the use of a data system that collects PQRI measure data and quality data codes for electronic submission to a CMS-designed clinical data warehouse using CMS-specific record layout based on PQRI specifications. The other is electronic health record (EHR) based reporting – or the use of specifications recently posted on the CMS website for testing electronic reporting of 5 measures. CMS is currently working with vendors and registries to see if these options may be successful.

Copies of the slides presented during the AMCNO/PalmettoGBA co-sponsored event are available on the AMCNO web site at www.amcnoma.org in the Practice Management link.

PalmettoGBA adds new information to website to assist providers and medical assistants

In May 2007, PalmettoGBA created dedicated Web pages for new providers, new medical assistants and new billers. This week, Palmetto added information to these Web pages. New items include:

Guide to Medical Record Requests, Terminology/Acronym Index, Direct links to CMS products: E/M Documentation Guidelines and E/M Services Guide, Medicare Physician Guide, Reference Guide for New Billers, and Understanding the Medicare Remittance Advice.

NPI – PalmettoGBA continues to receive many questions regarding NPI "informational messages" and claim rejections. Before, all of their NPI-related articles were posted under Resources/Provider Enrollment. NPI information is now available on the PalmettoGBA web page directly under Resources.

E/M Help Center: PalmettoGBA has also collected resources related to Evaluation and Management Documentation in the "E/M Help Center," located under Articles. All current published information is centralized in this location. From the E/M Help Center, you can access: CMS's E/M Documentation Guidelines, Frequently Asked Questions related to E/M services, peer comparison graphs that show aggregate claim submission data by specialty, tips for E/M coding by specialty, Palmetto GBA seminar handouts for E/M services and sample E/M "score sheets". Access the website at http://www.PalmettoGBA.com/boh

Other links to the PalmettoGBA site include"
New providers - http://www.PalmettoGBA.com/boh/newprov
New billers - http://www.PalmettoGBA.com/boh/newbill
New medical assistants - http://www.PalmettoGBA.com/boh/newasst

2008 Medicare Deductible, Coinsurance & Premium Rates

The Centers for Medicare & Medicaid Services (CMS) has announced changes for Deductible, Coinsurance and Premium Rates. More information regarding this matter can be found on the CMS Web site at:
http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2488.

Part B Deductible Information - Expenses count toward the deductible on the basis of incurred, rather than paid, expenses, and is based on Medicare allowed amounts. Non-covered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

Providers must collect the unmet deductible and coinsurance from the patient. Consistently waiving the deductible or coinsurance could be construed as program abuse. If the patient is unable to pay, the provider should have them sign a waiver outlining their financial hardship. If no waiver is signed, the patient's medical record should reflect that there were normal/reasonable attempts to collect from the patient prior to writing off the charge. Coinsurance - The patient or the patient's supplemental insurance company is responsible for paying the provider the coinsurance amount that Medicare will not pay.

CMS Announces Deadlines for NPI implementation:

- March 1, 2008—This deadline applies to Medicare claims only. Physicians will no longer be permitted to submit paper and electronic claims using just their legacy provider number. All claims must include the physician's NPI, with the option of also including the legacy provider number.
- May 23, 2008—This deadline applies to all public and commercial claims. Physicians will be required to use only their NPI on all electronic claims. Physicians who bill Medicare on paper must also use only their NPI starting on this date. No legacy numbers will be permitted on claims after this date.

The AMCNO urges physicians and their office staff members to review the following points:

- Begin using your NPI immediately—begin first by sending a few claims through to ensure they process correctly. Doing so now allows time to correct any problems Medicare may encounter when matching your legacy number to your NPI. If these first few claims are rejected, first validate your NPI information in the NPI system. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do or call (800) 465–3203 to access the system. Once there, ensure that the correct legacy number appears in the "Other Provider Identification Numbers" field. If the information in the NPI system is correct, contact your contractor and ask they validate what appears in their system.
- If required, re-enroll in Medicare immediately. Expect the enrollment process to take some time, so consider starting the above NPI verification process early to ensure meeting the March 1, 2008 deadline. For more information go to: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf

CMS Reviewing ICD-10 Codes

The Center for Medicare and Medicaid Services (CMS) has begun to review the implementation of ICD-10 codes. CMS has announced a one-year contract with the American Health Information Management Association to start to assess the impact on CMS if ICD-9 code sets, currently used in U.S. healthcare claims, are replaced with ICD-10 versions. Full use of ICD-10 codes is still in the future, however, the CMS acting administrator has noted that this "contract reflects CMS' commitment to ensuring that the transition from ICD-9 to the ICD-10 code sets will be thoughtfully planned." Under the contract AHIMA will analyze CMS' systems, policies and operations to determine the potential effects of the transition. At a recent AMCNO seminar, representatives from PalmettoGBA provided an overview of what changes could be expected in the future when and if the ICD-10 codes are implemented. These changes included: more information relevant to ambulatory and managed care encounters; expanded list of injury codes; combination diagnosis/symptom codes, 6th digit, more 4th and 5th digit codes, and more specific codes. Again, use of the codes are still planned for the future, and the AMCNO will keep our members apprised of any new information on this initiative.

Medicaid

Medicaid Reimbursement Boost Stalls at Statehouse

Gov. Strickland has stopped plans to boost reimbursements for hospitals and clinics due to escalating Medicaid caseloads. Gov. Ted Strickland decided it would be prudent to delay the increased health care spending in light of the fact that Ohio's Medicaid caseload has increased steadily during each of the past three months. Gov. Strickland's executive budget allowed for a 3.2% increase in Medicaid reimbursements for hospitals and 3.0% for community providers, such as doctors' offices and clinics that participate in the Medicaid Managed Care program. The Ohio Department of Job and Family Services is of the opinion that implementing the increases as scheduled would have cost about $26 million for community providers and $24 million for hospitals. Beginning in mid-December 2007, the Office of Budget and Management started to evaluate caseload figures on a quarterly basis to determine whether the state can afford to implement increased Medicaid spending for hospitals, community providers, and dental services. House Finance & Appropriations Chairman Matt Dolan (R-Novelty) said the decision to stop the reimbursement rate increases was quite a surprise, given that Medicaid caseloads are close to projections offered during the conference committee stage of deliberations on the executive budget. Rather than going into effect in January 2008 as planned, the state will recalibrate Medicaid reimbursements in April 2008, allowing hospitals to retain roughly a quarter of the estimated $13 million in payment reductions. Little more than a week after the administration moved to delay some Medicaid expansions, officials announced that other health care programs called for in the biennial budget would go into effect by late January 2008.

Plans to increase Medicaid eligibility for pregnant women earning up to 200% of the federal poverty level and to cover individuals aging out of foster care up to 21 years of age will go into effect on or before January 31, 2008 according to the Department of Job and Family Services (ODJFS). A buy-in program for disabled adults will by implemented by April 1, 2008. ODJFS is still awaiting approval from the federal Centers for Medicare & Medicaid Services (CMS) for another initiative that would expand the State Children's Health Insurance Program (SCHIP). Lawmakers approved the governor's proposal in the executive budget to boost eligibility for children from families earning 150% FPL to 200% FPL. The delay from the federal government is expected since CMS normally takes 90 days to approve changes to the state Medicaid plan, she said. Meanwhile, Congress has failed to reauthorize SCHIP due to wrangling with the president over proposals to increase spending.

Process to Resolve Medicaid Disputes Established by State – AMCNO Resources Also Available for Insurance Dispute Resolution

The Ohio Department of Job and Family Services (ODJFS) has established a process to assist healthcare providers in pursuing unresolved concerns with Medicaid managed care plans. This process is to be used after exhausting the existing processes. If after utilizing the processes, providers can complete a complaint form at http://jfs.ohio.gov/ohp/bmhc/pro-man-care.stm.
Once a provider has completed and submitted the form, ODJFS staff will work with the provider and the Medicaid managed care provider (MCP) to address the issues and ensure that the MCP is in compliance with their contract. MCPs have 15 days to respond to ODJFS. The only exception is if the complaint is related to a Medicaid consumer's access to care. Those issues require a two working day response time.

AMCNO members should remember that the AMCNO staff and physician leadership have developed working relationships with all of the third party payors in our area and we meet or conference with them on a regular basis. The AMCNO will assist our members and their staff if they have complaints or problems with insurance companies. Our insurance complaint form is posted on our website at www.amcnoma.org or you may call the AMCNO at 216-520-1000 for more information.

Medicaid Managed Care in Ohio

MCP prompt payment: MCPs must comply with federal prompt pay requirements. The prompt pay requirements for MCPs is as follows:

MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract.

Clean claim definitions have the same meaning as used in the fee-for-service program. A clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse; or a claim under review for medical necessity. Claim means 1) bill for services; 2) a line item of service, or 3) all services for one recipient within a bill.

Key contacts within the Medicaid system for Providers

Provider assistance can be obtained from Medicaid from various sources.

- The Interactive Voice Response System (IVR) provides a 24-hour, 7-day a week access to information regarding: client eligibility, claim status, payment status, prior authorization, drug and procedure codes, provider information and managed care eligibility information. The IVR can be accessed at 1-800-686-1516 or at http://jfs.ohio.gov/ohp/providers/assistance.stm
- Provider services staff is available Monday-Friday from 8 a.m. to 4:30 p.m.
- Ombudsman/Technical Assistance (FFS) – 614-752-9551 or at http://jfs.ohio.gov/ohp/providers/assistance.stm
- Bureau of Managed Health Care – 614-466-4693 or at email: bmhc@odjfs.state.oh.us

Anthem Partnership Plan Covered Families and Children (CFC) State Contracts Will Not Be Renewed

The Bureau of Managed Health Care (BMHC) has notified the AMCNO that Anthem Blue Cross/Blue Shield (BC/BS) intends to end its provider agreement with the Ohio Medicaid Program and will no longer serve Medicaid consumers in the Covered Families and Children (CFC) managed care program effective March 31, 2008. However, Anthem will continue to serve Aged, Blind and Disabled (ABD) Medicaid consumers without any interruption.

This change WILL IMPACT physicians and their Medicaid patients in Northeast Ohio region because currently Anthem has 87,011 Medicaid consumers listed as members in this region. Other regions affected include the Central and Northwest regions of the state. Plans are underway by the Ohio Department of Jobs and Family Services (ODJFS) to notify Anthem members to assist them in transitioning to new health plans in their region. ODJFS plans to send a notification letter to the 87,011 Northeast Ohio Anthem members on February 25, 2008, with a reminder letter to be sent out on March 10, 2008. The anticipated enrollment transition date is April 1, 2008.

For members that do not make an affirmative choice of a new managed care plan, ODJFS will automatically assign them to the managed care plan (MCP) with the best overlap with their historic relationships with primary care providers. Any member who is dissatisfied with the auto-assignment to an MCP may switch within 90 days by contacting the Ohio Medicaid Managed Care Enrollment Center at 1-800-605-3040. Currently there are two other MCPs operating in the Northeast Ohio region that Anthem Medicaid consumers may choose from at this time – CareSource and WellCare. Anthem has issued a news release indicating that continuity of care will be the responsibility of the receiving MCP. The new MCP and providers may contact the Anthem Partnership Plan for assistance with CFC Medicaid patients who require a continuity of care plan for qualifying conditions. Contacts may be made to the Anthem Utilization Management Department at 1-866-896-6580.

Anthem will continue to reimburse providers for eligible CFC Medicaid claims with dates of service up to and including midnight of March 31, 2008. Service dates beginning April 1, 2008 will be the financial responsibility of the members' newly assigned MCP.

If you have Medicaid patients in your practice that are currently enrolled in Anthem you may wish to review whether or not your practice is also contracted with one of the other MCPs still operating in the Northeast Ohio region. The AMCNO will continue to monitor this situation and provide any updates as necessary.

Third Party Payors

Anthem and NPIs

Effective May 23, 2008, Anthem BC/BS will begin accepting only NPI numbers on electronic claims and other transactions requiring a provider number to meet required HIPAA compliance. Currently, Anthem accepts electronic transactions with NPIs and Anthem provider numbers ("legacy Ids"). Anthem will continue accepting electronic transactions with NPI numbers only, Anthem provider numbers or both until May 23, 2008. On May 23, 2008, the 10-digit NPI numbers will become the only compliant provider number Anthem will accept. The requirement effective May 23, 2008 only impacts electronic transactions. However, Anthem also encourages providers to file paper claims with NPIs in lieu of the legacy ID for consistency in claims filing. To register an NPI with Anthem, providers may go online at https://npi.wellpoint.com

Anthem Offers Web Based service

Anthem has partnered with Electronic Network Systems (ENS), an Ingenix company that is a clearinghouse for electronic claims submission via the Internet. This service offers a way to submit secure transactions electronically while complying with HIPAA requirements. Providers can access a suite of ENS' web-based services via the Anthem web site at www.anthem.com to submit electronic claims directly to Anthem. The service is available at no charge to providers who submit claims to Anthem, and the only requirement is a personal computer with Internet access. Providers may enroll online at www.edi.anthem.com or by phone – general questions may also be answered at 1-800-341-6141.

CIGNA Offers Online Precertification

CIGNA providers can now go online to submit and check the status of precertification requests for covered inpatient services, certain outpatient services (when required by a Cigna HealthCare plan) and injectable medications (when covered under the medical plan). Once you enter basic information, providers will receive a response to the precertification request such as: approved – includes a precertification tracking number to use for future inquiries; service does not require precertification – no precertification needed for this service or pended – includes the reason the request is pended, and a precertification tracking number to use for further inquiries. This service can be accessed through the CIGNA healthcare professionals website at www.cignaforhcp.com.

Medical Mutual (MMO) Referrals

Effective January 1, 2008, HMO and POS members no longer need a referral from their primary care physician (PCP) before seeing an in-network doctor or health care professional. Members will receive a new certificate book reflecting the benefit change at the time of their employer's benefit renewal. On or after the effective date, members may seek services from in-network doctors and other healthcare professionals without a referral and the claim for such services will be processed at the referral benefit level. Members still need a referral from their PCP or specialist for out-of-network services. Medical Mutual must be provided with information indicating the necessity of arranging care outside of the network at the time of the request, and MMO retains the right to approve or deny the out-of-network services.

UnitedHealth Care Phone Directory Information

Provider Central Service Unit (PCSU) – 1-800-521-2603
Cleveland Network Management office – 1-800-468-5001
Radiology notification program – by phone: 1-866-889-8054 or by fax: 1-866-889-8061
www.unitedhealthcareonline.com Help Desk – 1-866-842-3278

UnitedHealthcare National Imaging Accreditation Program Extended

Last year, UnitedHealthcare(UHC) announced a new quality initiative that recognized the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC) standards and enlisted their expertise in facilitating accreditation. UnitedHealthcare provided notice at that time of their intent to incorporate these accreditation requirements into their outpatient reimbursement policy and set a date for March 1, 2008, as the date that freestanding radiology facilities and physician offices that use a CMS 1500 claim form and are performing CT, CTA, MRI, MRA, PET, Nuclear Medicine, Nuclear Cardiology and Echocardiography outpatient imaging studies to obtain accreditation as a condition for reimbursement.

Based upon physician input and feedback, UnitedHealthcare has decided that the imaging accreditation implementation date affecting reimbursement will be extended from its original March 1, 2008 effective date to the third quarter of 2008. This decision was based, in part, on a telephone survey UHC conducted in November & December 2007. UHC will notify all free standing radiology providers and physician's offices performing these advance imaging service a minimum of 30 days before accreditation becomes effective in their area, or as otherwise required by regulation. Additional information about the imaging accreditation initiative is available online *www.UnitedHealthcareOnline.com*

If you have specific questions about the application process for accreditation, contact the ACR at *www.acr.org* or 1-800-770-0145 or the IAC at *www.intersocietal.org*

or 1-800-838-2110. For general questions about the UnitedHealthcare accreditation initiative, call 1-800-637-5792 .

NEWS YOU CAN USE

Get your office ready for 2008

Use the check-off list below to help your practice continue to run smoothly in the New Year.

Check-off list

- ☐ Ensure staff is checking eligibility, especially on Medicare and Medicaid patients.
- ☐ Ensure that front-end staff are asking for a copy of the insurance card on the first visit of the New Year and compare it to the old card. Also, deactivate old information in the system and add new information. The insurance company may stay the same, but the product, co pays and deductibles may have changed.
- ☐ Begin putting together tax information for your practice.
- ☐ Send out 1099s to independent contractors. (Make sure you have W-9 information in your file prior to sending.)
- ☐ Review your staff salaries and health insurance, if it is done on a calendar basis.
- ☐ Send out W-2s to your staff on or before January 31, 2008.
- ☐ Order 2008 chart labels.
- ☐ Formulate the 2008 weekend on-call calendar.
- ☐ Update your files (staff, patients, vendors, etc.) for changes in their names, insurance, addresses, phone numbers, dependent care, immunizations, etc.
- ☐ Update codes to ensure that the 2008 CPT, ICD-9 and HCPCS codes are in the system. This also includes deleting codes that are no longer usable in 2008.
- ☐ Educate your staff on the changes.
- ☐ Load the Medicare 2008 fee schedule into your system.
- ☐ Check Medicare and Medicaid for any 2008 policy changes.
- ☐ Assess billed charge fee schedule for appropriate changes.
- ☐ Reformat super bills, encounter forms, etc., by adding new codes and deleting old codes.
- ☐ Review your insurance contracts and fee schedules to ensure they are appropriate for your business.
- ☐ Review all forms, standardized letters and any other documents for needed updates (i.e., change date from 2007 to 2008).
- ☐ Update office policies and procedures and educate your staff.
- ☐ Check HIPAA, OSHA, and OIG compliance for updates and have your staff review and sign.
- ☐ Check all your insurance policies for renewal (medical liability, workers' compensation, general/commercial liability, E&O/D&O, etc.).

Usage of Tamper Proof Rx Pads Delayed Until April 1, 2008

Strong advocacy by the AMCNO and other organizations, in particular the Ohio Pharmacy Association, helped secure a six-month delay of a federal requirement that handwritten Medicaid prescriptions must be written on tamper-resistant prescription pads. Efforts included a letter, signed by the AMCNO president to Congressional representatives urging the passage of legislation to delay the mandate, which originally was to have taken effect October 1, 2007. The new deadline for usage of the tamper-resistant drugs pads is April 1, 2008. The AMCNO has been monitoring the development of this issue and how it could impact a physician practice. Physician offices and staff should be aware that even though there is a six-month delay now in effect, offices should start now to get acquainted with what the new rule will require once implemented. Listed below is a short synopsis of what physicians and their staff may expect once this requirement is in full effect on April 1, 2008:

Overview of tamper resistant prescription pad law to become effective tentatively April 1, 2008

In order for Medicaid outpatient drugs to be reimbursable by the federal government, all written, non-electronic prescriptions must be executed on tamper-resistant pads. To be considered tamper resistant a prescription pad must contain at least one of the following:

- one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
- one or more industry-recognized features designed to present the use of counterfeit prescription forms.

In addition, at a point one year after the implementation date, in order for prescriptions pads to be considered tamper resistant, a prescription pad must contain all three of the foregoing characteristics.

The requirement, once implemented, will apply to:

- All written prescriptions presented at the pharmacy on or after the published implementation date regardless of when the prescription was written;
- Written prescriptions for all outpatient drugs, including controlled, non-controlled, and over-the-counter drugs;
- Written prescriptions for drugs provided in a long-term care facility;
- Written prescriptions when Medicaid pays any part of the claim, including when Medicaid is not the primary payer, and
- Written prescriptions billed to Medicaid after the date of service due to retroactive eligibility.

The requirement, once implemented, DOES NOT apply to:

- Orders for medications administered in a provider setting (e.g., physician office or hospital outpatient or emergency department) and billed by the administering provider.
- Refills of written prescriptions presented at a pharmacy before the implementation date;
- Electronic, faxed or telephoned prescriptions; and
- Prescriptions for which payment will be made by a Medicaid managed care entity (i.e., this requirement applies only to prescriptions written for patients who receive a monthly paper Ohio Medicaid card, not to prescriptions written for patients enrolled in a Medicaid managed health care organization).
- Physician offices are NOT exempt.
- In addition, prescriptions will be covered if the physician provides the pharmacy with a verbal, faxed, electronic, or tamper-resistant written prescription within 72 hours of the date the prescription was filled.

Physicians interested in obtaining compliant prescription pads prior to the revised implementation date may want to contact the following vendors for more information:

- MediScripts can provide pads for individual physicians in all specialties, except surgery, where special group requirements apply. They do NOT provide individual pads for APNs or PAs. Call them at 1-800-387-3636 for more information.
- For those physicians who are used to printing their own prescriptions and prefer customized, non-commercial pads, another possible source is Rx Pads, Inc. This company has the tamper proof "security" pads that meet all the standards and offers pads in varying quantities with greater discounts the more you order. For example, they charge $33.95 plus shipping for 10 pads. For more information check their website at www.rxpads.com/2007/Index.aspx or call 800-307-7717.
- ScriptShield is offering a 10% discount for its HologramRx scripts and 5% off of National RxSecurity script prices for pads ordered between now and the end of the year. To receive an order form, call either HologramRx at 1-866-356-1050 or 1-800-510-1050. or visit their website at www.scriptshield.com or www.nationalrx.net.

The AMCNO will continue to provide our members with input on this issue as information becomes available.

AMCNO Asks Ohio Attorney General to Review New York State Attorney General Insurance Agreements

New York State Attorney General Andrew Cuomo (D) has signed onto an agreement with CIGNA, which will require CIGNA to provide its members with more information on how it ranks physicians. In August 2007, the New York AG warned Aetna and CIGNA that their physician ranking programs likely would confuse or mislead members because of problems with the information used to rank physicians. In addition, the New York AG had also asked UnitedHealth Group to cancel their launch of a similar program or face possible legal action. Under the agreement, CIGNA will divide its preferred physician list into three lists -- one that ranks by cost, one that ranks by quality and one that uses a combination of both measures. CIGNA said that it always has used both cost and quality measures to rank physicians, but the insurer in the agreement pledged to make its ranking data more transparent to members. The agreement will require that CIGNA report to the attorney general every six months and that it use an outside monitor. Aetna and other carriers have said they will work with the NY AG on the issue and have worked out agreements in the state and UnitedHealth Care has signed onto a national agreement.

Medical groups including the AMCNO have expressed concerns that doctor rankings can be confusing and could be used to steer patients to the least-expensive health care providers, rather than being based on quality. The AMCNO physician leadership has been reviewing this issue since the New York AG first issued the warnings to the insurance companies this summer to determine if this is a matter for review in Ohio. Physician ranking and rating is an issue of importance to our members based upon our recent membership survey. It will be important that the insurance companies are truly reviewing quality issues versus cost and claims data, and the data must be accurate with the ability of physicians to appeal the their data. Based upon the AMCNO review and discussion of the recent events in New York, the physician leadership of the AMCNO has requested the review of the Ohio Attorney General's office regarding the agreements reached in New York with the insurance companies. Although New York law clearly differs from the law in

Ohio, the AMCNO has asked for a meeting with the Ohio AG Marc Dann to discuss whether or not similar agreements and laws can be pursued in Ohio.

House Bill 125 – the Healthcare Simplification Act

As noted last issue, the Ohio House of Representatives passed, by a vote of 91-5, House Bill 125 - the Healthcare Simplification Act, which was supported by the Academy of Medicine of Cleveland & Northern Ohio, however, the AMCNO does believe that the bill as it is written now needs further improvement. The AMCNO lobbyists attended the interested party hearings on this legislation – a bill that was designed to provide remedies for many of the excessive administrative demands faced by doctors in their interactions with health plans. Of note, the language concerning insurance company usage of a most favored nation clause in insurance contracts was completely removed from the Bill in favor of a joint legislative committee to be formed to review this topic in the future. The 15-member Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts is to be chaired by the Superintendent of Insurance and is charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly. During the work of this Commission, there is a Moratorium on Most Favored nation Clauses (MFNs). HB 125, was meant to address the most favored nation clause along with other health care insurance related matters. The AMCNO is somewhat concerned, however, that the legislation does not go far enough in that the insurance companies are not completely prohibited from using an all products clause, and that the bill does not completely prohibit insurers from including a most favored nation clause in contracts. Instead, at the present time the latest version of the bill calls for a two-year moratorium on the usage of a most favored nation clause while a joint legislative review committee reviews the matter, and the bill would "restrict" the use of all products clauses. Other states have already prohibited the use of such clauses and we feel that Ohio should follow suit. These clauses are unfair and would never be allowed in other business practices.

The AMCNO has also informed the legislature that we would also have preferred that language were included in HB 125 that addressed the definition of what constitutes "medical necessity." Often insurance companies make decisions relative to medical necessity matters that are inappropriate and not in the best interest of patients. Insurance companies routinely deny access to benefits guaranteed by their contracts, and this denial of payment for medical care can result in a patient receiving inadequate or delayed treatment. Physicians should be in control of what is deemed medically necessary for a patient – not an insurance company. The AMCNO would favor inclusion of a definition of medical necessity in this legislation along with consideration of the legislature requesting that the Ohio Department of Insurance create a healthcare panel inclusive of physician representation that would review and comment on health insurance company practices. The AMCNO has articulated these concerns to the members of both the Ohio House and Senate that are reviewing this legislation.

AMCNO Discounted Classes Available at TriC

CUYAHOGA COMMUNITY COLLEGE

Discounted Continuing Education Classes for AMCNO Members and their Staff

Take advantage of local professional education on medical practice management issues! AMCNO members/staff can take these courses at Tri-C and obtain a 25% discount on the cost of the course. The costs for the courses outlined below include the 25% AMCNO discount – take advantage of this membership benefit today!!!

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. Once you have obtained your discount course number, call Cuyahoga Community College to register at 216/987-3075.

February 6th	Advanced ICD9-CM Coding Update	1 pm – 4 pm	$159.00*
February 6th	ICD-10 – How will it affect me?	9:30 am-11:00 am	$159.00*
March 5th	Advanced CPT Coding Workshop	1 pm-4pm	$159.00*
Apr. 2nd	Compliance Program Effectiveness	9am-12:00pm	$139.00*
Apr. 16th	Managed Care Updates	8am-11:00am	$120.00*
Apr. 16th	Appeals and Denials: Discussion for Coders	11:30am-1:30pm	$ 99.00*

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

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

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

Medical Records Fact Sheet Update Effective January 2008

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 tine 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 §**3701.74** 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 2008, 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:*** $2.74 per page for the first ten pages; $0.57 per page for pages 11 through 50; $0.23 per page for pages 51 and higher
For data recorded other than on paper: $1.87 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 $16.84 records search fee is allowed;

b) ***For data recorded on paper*****:** $1.11 per page for the first ten pages; $0.57 per page for pages 11 through 50: $0.23 per page for pages 51 and higher
For data recorded other than on paper**:** $1.87 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.

How to Manage Legal Issues

Impacting the Practice of Medicine

Wednesday, April 2, 2008 – Lakewood Country Club, or
Wednesday, April 9, 2008 – Mayfield Country Club
5:00 p.m. – 8:30 p.m.

Jointly sponsored by:

amcno THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

AMEF Academy of Medicine Education Foundation

Program Format

5:00 p.m. – 6:00 p.m.
Dinner

6:00 p.m. – 6:30 p.m.
Current trends in Malpractice Allegations
and Risk Management
Joe Farchione, Esq
Sutter, O'Connell and Farchione Co.

6:30 p.m. – 7:00 p.m.
Practice Pitfalls – HIPAA

7:00 p.m. – 7:30 p.m.
Electronic Health Records/Technology Issues and Patient Communication
Amy Leopard, Esq.
Walter & Haverfield LLP

7:30 p.m. – 8:00 p.m.
Stark III Compliance
Marilena DiSilvio, Esq.
Reminger & Reminger Co.,

Call (216) 520-1000 for more information or to register by phone or visit our Web Site at www. amcnoma.org.

Meet the Presenters

JOE FARCHIONE has been defending health care professionals for over twenty years. His firm is dedicated exclusively to the defense of medical malpractice claims and suits.

EDWARD E. TABER is a partner in the Cleveland office of Tucker Ellis & West LLP. His focus is on litigation including medical malpractice, pharmaceutical litigation, products liability, business litigation, toxic tort and legal malpractice.

AMY S. LEOPARD is a partner at Walter & Haverfield LLP and a member of its management committee. She counsels physicians, group practices, and entrepreneurs on licensing, payment, regulatory and technology issues.

MARILENA DISILVIO began her career as a registered nurse, which makes her an invaluable leader in Reminger & Reminger Co., LPA's Medical Malpractice and Healthcare Law Practice Group. Marilena has significant experience in the representation of healthcare providers and healthcare facilities.

REGISTRATION FORM

following session:

___ April 2, 2008
Lakewood Country Club
2613 Bradley Road
Westlake, Ohio 44145

___ April 9, 2008
Mayfield Country Club
1545 Sheridan Road
S. Euclid, Ohio 44121

Name_____
___

Address_____
___

City

FEES:
$15.00 – Residents/Medical Students
$35.00 – AMCNO Members
$50.00 – Non-member Physicians/Staff

___

Fax_____
___

Return this form with your check made payable to The AMCNO and mail to: AMCNO, 6100 Oak Tree Blvd, Ste. 400, Independence, Ohio 44131

You may also fax back this form with a credit card payment. Fill in the