

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

PRACTICE MANAGEMENT MATTERS

Winter Edition 2009

Medicare Update

In this issue – 2009 Medical Records Fact Sheet – What Your Practice Can Charge for Medical Records in 2009 AND Information on the AMCNO Legal Seminars in April – see pages 9 and 10

Centers for Medicare and Medicaid Services (CMS) Awards Medicare Administrative Contracts (MACs) - Highmark Medicare Services Chosen for Ohio Part A and B jurisdiction

The Centers for Medicare & Medicaid Services (CMS) has announced the final five contractors that will process and pay Medicare claims for health care services under the Medicare Fee-for-Service program. The new contracts that will be administered for up to five years will process and pay 36 percent of the national volume of Medicare Part A (hospital insurance) and Part B (medical insurance) claims payments. These are services furnished by hospitals, physicians and other health care providers to people with Medicare. CMS now has met its goal of awarding all 15 Medicare Administrative Contractor (MAC) contracts.

The competitive selection of the new Part A and Part B MACs was made on a “best value” basis. Primary consideration was given to the technical quality of the offerors’ proposals. CMS conducted a technical and past performance evaluation, performed a cost realism analysis and assessed overall cost reasonableness for each award.

The plan is to have the MAC contractors immediately begin their implementation activities and will assume full responsibility for the claims processing work in their respective jurisdictions no later than March 2010. During the implementation period, the Part A and Part B MAC contractors will be conducting extensive outreach to health care providers, medical associations and beneficiaries in their jurisdictions to provide education and information about the implementation.

Of importance to AMCNO members is the fact that PalmettoGBA was NOT awarded the MAC for Jurisdiction 15 (Ohio and Kentucky). Palmetto GBA partnered with another organization in a bid for Jurisdiction 15, but their bid was not successful. Instead, Highmark Medicare Services (HMS) has been awarded the contract for the combined administration of Part A/Part B Medicare claims payment in Jurisdiction 15 comprised of Kentucky and Ohio. HMS is headquartered in Camp Hill, Pa. HMS’s website is <http://www.highmarkmedicare.com/>.

Under the current system, fiscal intermediaries process claims for Medicare Part A providers, such as hospitals, skilled nursing facilities and other institutional providers. Carriers process claims for physicians, laboratories and other practitioners under Medicare Part B. The new system consolidates those contractors, making it simpler for practitioners to have a single point of contact with Medicare. The Part A and B MACs will be the contact for all Medicare providers and physicians. As a result of a full and open competitive procurement, the new contractors, will take over the claims payment work now performed by numerous fiscal intermediaries and carriers.

There is a possibility that protests may be filed regarding the awards and there is no additional information at this time regarding the transition period or changeover to the new intermediary. **The AMCNO will continue to share information with our members as more details become available regarding how these decisions will affect you.** For complete details regarding these most recent MAC awards go to: http://www.cms.hhs.gov/apps/media/press_releases.asp

Get information on how to transition to the new Medicare Administrative Contractor (MAC)

According to the Medicare Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) is required to more competitively select companies that process physician claims. A special edition of "MLN Matters," from the Medicare Learning Network, alerts fee-for-service physicians about what to expect as their carrier transitions its work to a new Medicare Administrative Contractor (MAC). Preparing for this process can help physicians minimize disruptions in their Medicare business.

"MLN Matters" is a series of national articles designed by CMS to inform physicians, providers and suppliers about the latest changes to the Medicare program. AMCNO members may want to access the above mentioned "MLN Matters" to garner additional information on what you need to know about changing to a new contractor since Ohio has been assigned a new MAC – Highmark Medicare Services (HMS) for the combined administration of Part A and Part B Medicare claims payments.

To view this special edition of MLN Matters go to:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0837.pdf>

Medicare publishes billing edits to reduce payment errors

The Centers for Medicare & Medicaid Services (CMS) recently announced its decision to publish most of the edits utilized in its Medically Unlikely Edit (MUE) program in order to improve accuracy of claims payments. The MUE program—implemented Jan. 1, 2007, and updated quarterly—was established to reduce payment errors for Medicare Part B claims. The latest program update, revealed Oct. 1, contains edits for about 9,700 Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT[®]) codes that have been assigned unit values for MUEs. Claims processing contractors utilize these edits to ensure that providers and suppliers do not report excessive services. MUEs were developed by CMS with the cooperation and participation of national health care organizations representing physicians, hospitals, nonphysician practitioners, laboratories and durable medical equipment suppliers. To learn more and view these edits go to http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage CMS will publish an update of most MUEs at the start of each calendar quarter.

Time Limit for Filing Medicare Claims

Medicare law designates specific time limits for submitting claims for physician and other Part B services. The terms of the law require that a claim be filed no later than the end of the calendar year following the year in which the service was furnished, EXCEPT as follows:

- The time limit for filing claims furnished in the last 3 months of a year is the same as if the service had been furnished in the subsequent year. For example, **services provided October 1, 2006, through December 31, 2006, should have been filed by December 31, 2008.**
- Medicare claims for which assignment was accepted must be filed within one year from the date of service, or the payment will be reduced by ten (10) percent.
- Whenever the last day for timely filing a claim timely falls on a Saturday, Sunday, Federal non-workday or legal holiday, the claim will be considered timely if it is filed on the next workday.
- For dates of service from October-December 2006 claims had to be filed by 12/31/08
- For dates of service from January-September 2007 claims had to be filed by 12/31/08
- For dates of service from October-December 2007 claims must be filed by 12/31/09
- For dates of service from January-September 2008 claims must be filed by 12/31/09.

Note: The same time limit applies for filing Medicare Secondary Payer (MSP) claims. Medicare strongly recommends that you file MSP claims timely, even if you do not expect Medicare to make additional payment (secondary) payment.

Medicare's Guide to the E-Prescribing Incentive Program is available online

The guide explains the e-prescribing incentive program, how eligible professionals can participate, and how to choose a qualified e-prescribing system. By adopting e-prescribing through Medicare's program, eligible professionals can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care while earning incentives from Medicare. To obtain the guide go to

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Current%20News~Medicares%20Practical%20Guide%20to%20the%20E-Prescribing%20Incentive%20Program%20is%20now%20available%20online!?opendocument>

Flu and Pneumococcal vaccines get reimbursement increase

According to the Center for Medicare and Medicaid Services (CMS) Medicare Claims processing manual as of September 1, 2008 there was a slight increase for flu and pneumococcal vaccines. Payments increased slightly for the following codes: 90655, 90656, 90660 and 90732. To view the transmittal 1623 from CMS regarding this update go to www.cms.hhs.gov/Transmittals/downloads/R1623CP.pdf

For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, please go to

http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing go to

http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

Flu Season Still Upon Us – CDC Encourages Vaccination through February

Influenza season reaches its peak in January and February, so physicians are urged to protect as many of their patients as possible by continuing to administer vaccinations now through the end of next month. The Centers for Disease Control and Prevention (CDC) recommends that patients who fall into both “high health” and “no health risk” categories receive an influenza vaccination and that physicians encourage them to get vaccinated.

Visit the CDC web site for more information about influenza vaccination. http://www.cdc.gov/flu/?s_cid=internal6

Medicaid Update

Director of Ohio Department of Job and Family Services (ODJFS) resigns

Helen Jones-Kelley, the Ohio Department of Job & Family Services director who was suspended after the release of a critical inspector general's report, resigned her position this week. Ms. Jones-Kelley was suspended from her post because of questions about her involvement in database searches. Also resigning their positions were Assistant Director Fred Williams and Director of Child Support Doug Thompson. Mr. Williams has resigned effective Jan. 31 to provide enough time to help in the transition to new management, she said. Mr. Thompson's position has been “revoked” effective Dec. 22.

The situation involving searches of the databases involved Samuel Wurzelbacher, who came to be known as “Joe the Plumber,” in the media. These activities have caused legislators in Ohio to enact legislation that creates penalties for improper use of state databases.

State Auditor Releases Medicaid Status Report

State Auditor Mary Taylor has released a Medicaid status report that found over \$300 million in potential savings in the Ohio Medicaid program have not been acted upon since 2006. Governor Strickland responded to the report by stating that his administration had cut costs in the entitlement by more than \$1.7 billion over the last two years. The auditor's conclusions were based on an update of the 2006 Medicaid performance audit conducted by her predecessor. The original review of the \$12 billion-plus annual program was mandated under legislation Ms. Taylor sponsored in 2005 while a

member of the House. The audit update showed that only 15 of 109 recommendations from the state auditor's office have been implemented. While administrators and the legislature made improvements estimated to save more than \$100 million under the recommendations, there has been a failure to fully pursue other initiatives that could have cut an additional \$300 million in costs. Ms. Taylor noted that Ohio could save \$156 million through a reorganization, \$128 million by increasing the generic drug dispensing rate from 60% to 67%, and \$60 million a year with an "e-prescribing" program. To view the performance audit report go to:

http://www.auditor.state.oh.us/AuditSearch/Reports/2008/Ohio_Medicaid_Program_Follow_Up_08_Performance-Franklin.pdf

Ohio Medicaid May be in Line for Increase

Ohio could be in line for more than \$1.4 billion in federal matching Medicaid money next year should a planned economic aid package include \$40 billion in spending on the entitlement, according to a recent study. The Medicaid bailout estimate is based on legislation that was recently introduced in the U.S. Senate. According to Families USA, the state would be in line for a Medicaid infusion totaling \$1.417 billion based on an average boost of \$40 billion in entitlement assistance for all states. In 2003, Ohio received about \$770 million over two years as part of a federal bailout ostensibly tied to Medicaid but used to bolster the state's general revenue fund under its block grant guidelines. The study said that if realized the latest proposal could help generate more than \$2.5 billion in economic activity in Ohio. To view the study go to

<http://www.familiesusa.org/assets/pdfs/a-painful-recession.pdf>

UNITEDHEALTH CARE

UnitedHealth Group to Settle Underpayment of Health Care Claims

One of the nation's largest health insurers has agreed to pay \$400 million dollars in a settlement after being accused of overcharging millions of Americans for health care. The New York attorney general's office launched an investigation after receiving hundreds of complaints about Oxford Insurance and its parent company, UnitedHealth Group, which claims to rely on "independent research from across the health care industry" to determine reimbursement rates. In actuality though, it relies on Ingenix, a research firm owned by UnitedHealth Group.

New York Attorney General Andrew Cuomo says Ingenix has been manipulating the numbers so insurance companies pay less. In a just-released report, he contends that Americans have been "under-reimbursed to the tune of at least hundreds of millions of dollars." Although UnitedHealth Group and Oxford Insurance were the only entities investigated, other major insurers use Ingenix, including Aetna, CIGNA and WellPoint/Empire BlueCross BlueShield. Cuomo is now investigating other insurance companies that use Ingenix's database to determine reimbursement rates for patients and taking steps to make sure this won't happen again in the future.

The company agreed to put \$350 million into a class-action restitution fund to pay physicians and policyholders for services provided by out-of-network providers. The other \$50 million UnitedHealth Group will pay in the settlement will be used to create a nonprofit organization that will determine reimbursement rates for patients.

In a statement the American Medical Association noted that "the settlement announced will initiate drastic change to the rigged system that allowed United Health Group to profit while shortchanging patients and physicians. While today's settlement is with UnitedHealth, circumstances suggest the scheme may extend to insurers across the nation and calls into question the validity of the system the insurance industry has used for years to pay for out-of-network care." The AMA and the AMCNO fully supports Attorney General Cuomo's decisive action to bring an end to this clear conflict of interest and lift the cloak of secrecy on the Ingenix database.

The AMA, along with the Medical Society of the State of New York and the Missouri State Medical Association, claimed victory with the settlement agreement in the lawsuit against United Health Group. The \$350 million settlement marks the largest monetary settlement of a class action lawsuit against a single health insurer in the U.S.

This lawsuit, pending since 2000, challenged the validity of the United Health Group owned Ingenix database to determine the reimbursement rates for out-of-network care. Today's settlement will ensure United Health Group is held accountable for reimbursing the patients and physicians it shortchanged through the use of this flawed database. The settlement supports the separate agreement between UnitedHealth Group and the New York Attorney General to trust the repair and operation of a new database to a not-for-profit institution.

The AMA has noted that the settlement is subject to preliminary approval by a federal district court in New York. No distribution of the settlement fund can take place until final court approval has been obtained following a "fairness" hearing. Details of the settlement and formal notice will be provided to affected members of the subscriber and the healthcare provider classes.

UnitedHealth Group released a statement indicating that they "believe that the agreement will enhance the transparency of information related to physician fees for out-of-network services." UHG noted that the agreement commits UHG to fund a qualified, independent not-for-profit entity to help develop and own a new, independent database product to replace the Prevailing Health Charges System (PHCS) and Medical Data Research (MDR) database products own by UHG's subsidiary, Ingenix, Inc. UHG noted that when the new database product is ready, Ingenix will close the PHCS and MDR database products. The UnitedHealth Group's class action settlement "contains no admission of wrongdoing" according to a statement related by UHG. To view the news release from NY Attorney General Cuomo go to:

http://www.oag.state.ny.us/media_center/2009/jan/jan13a_09.html

UnitedHealthCare (UHC) Releases Annual United Health Premium Physician Designation Program Assessment Results

UHC has recently completed their annual UnitedHealth Premium physician designation program quality and cost efficiency assessments. Designation letters were sent out by UHC to physician offices last week. The letters notify physicians if they have met the criteria necessary for a specific designation under the program. UHC plans to make the results available to the public no earlier than March 4, 2009. Physicians can access their performance assessment report online through a specific link provided by UHC and with a user ID and temporary password provided in the correspondence sent out to physicians by UHC.

For physicians that are notified that they have successfully achieved a UHC designation, they still have the option of reconsideration to address concerns they may have with the data contained in their assessment. Physicians that are notified that they did not meet the program's criteria to obtain a specific designation by UHC also have the opportunity to review their assessment report, seek clarification and, if necessary, request reconsideration of their designation. If a physician does not receive the Premium program's designation, it could be for various reasons, including insufficient UnitedHealthCare paid claims volume (sample size) for analysis, having a specialty that is not evaluated or practice patterns that did not meet the program's criteria. A physician may request reconsideration at any time during the designation cycle.

However, if the physician does not want their new designation to display on UHC Web sites until they receive the outcome of the reconsideration, their request for reconsideration with all supporting information they want considered had to be postmarked by January 27, 2009, email and fax must have been received by January 27, 2009 as well.

If UnitedHealthcare received the request by this date, they will display the physician's designation results **only after** completing their reconsideration. However, if the request and all information physicians would like considered in the review **were not received by January 27, the designation will be displayed according to the timetable noted above.**

UHC states that they utilize national industry, evidence-based and medical society standards with a transparent methodology and data sources to evaluate physicians across 20 specialties. A summary of the methodology and frequently asked questions about the program are included with the UHC mailing to physicians.

Included with the UHC mailing to physicians are important links and resources to obtain additional information on the program. Physician reports can be accessed through a specific link provided in the letter <https://ereports.uhc.com/ReportCard> but you must have your user name and password provided in the letter from UHC to access your specific report. Other resources available from UHC on the program are available online at

www.UnitedHealthcareOnline.com >Clinician Resources >UnitedHealth Premium >UnitedHealth Premium Designation. UHC is also offering an interactive online UnitedHealth Premium Designation course through their website.

BUREAU OF WORKERS' COMPENSATION **Bureau of Workers' Compensation (BWC) Refiles Rules**

Recently the BWC filed a letter of intent to re-file rule 4123-6-08. This action removed from the Joint Commission on Agency Rule Review's (JCARR) agenda the consideration of the 2009 BWC Proposed Provider Fee Schedule. The impact of this action will be the delay of the implementation of the 2009 BWC proposed provider fees until the second week of February 2009 for selected BWC provider service codes.

The action to remove the rule from JCARR on Monday was taken as a result of a recent determination of a potential technical conflict if vocational rehabilitation services fees were included under rule 4123-6-08. Although there were differing perspectives relative to the potential conflict, BWC determined that the removal of the vocational rehabilitation services from this particular rule was the best approach to reduce the delay in implementing all other 2009 proposed fees.

On January 5, 2009, BWC re-filed the revised rule with JCARR, which will, by virtue of the filed letter of intent, maintain JCARR jurisdiction over the rule for an additional 30 days. JCARR will hold a hearing on the rule within the 30 days of the re-filing with an effective date 10 days thereafter. The revised rule will not contain local codes related to vocational rehabilitation services. Vocational rehabilitation service fees will be addressed pursuant to the resolution of the rule interpretation conflict. If you have any questions regarding this announcement, please submit them to the following email address: medpol@bwc.state.oh.us



NEWS YOU CAN USE

HHS Releases ICD-10 code set with new compliance date

The Department of Health and Human Services has released the long-awaited ICD-10 code set and set a new compliance date of Oct. 1, 2013. The new date gives providers, now using the ICD-9 code set, an additional two years to prepare for compliance. HHS also released an updated X12 standard, Version 5010, for certain electronic healthcare transactions; an updated version of the National Council for Prescription Drug Programs (NCPDP) standard, Version D.0, for electronic pharmacy-related transactions; and a standard for Medicaid pharmacy subrogation transactions. HHS extended the deadline for X12 standard, Version 5010 by 21 months from the date set in the proposed rule, to Jan. 1, 2012. Small health plans have a compliance deadline for X12, Version 5010 of Jan. 1, 2013. To view the final rule go to <http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=482116279223+0+2+0&WAIAction=retrieve>

CMS Updates the Stark Physician Self Referral Rule - By Amy S. Leopard, Esq., Walter & Haverfield LLP

The Center for Medicare and Medicaid Services (CMS) revised the Stark II physician self-referral rule twice this year -- once with the Inpatient Hospital Final Rule and more recently with the Medicare Physician Fee Schedule (PFS) Rule. While some joint ventures and leasing arrangements will no longer be allowed, CMS has also provided some leeway with alternative methods of compliance when providers need a reprieve from the harsh demands of the rule.

The Stark law prohibits physician referrals to an entity for certain "designated health services" covered by Medicare if a financial relationship exists between the referring physician (or an immediate family member) and the entity, unless the arrangement meets an exception. An entity furnishing services pursuant to a prohibited referral may not bill Medicare for the services and, along with the physician, may be subject to civil monetary penalties and exclusion. Many of the changes under way will affect indirect relationships with hospitals, either through affiliated entities, joint ventures or physician organizations.

October 2008 Changes to Compensation Relationships

Under the "stand-in-the-shoes" requirement adopted last year, CMS presumes a financial relationship with each of the referring physicians in a physician organization when an entity that bills Medicare enters a financial relationship with the physician organization itself. CMS delayed application of the rule to academic medical centers and certain 501(c)(3) integrated healthcare

system arrangements due to industry concerns that it would unnecessarily stifle the use of support payments from hospitals to affiliated physician practices.

Effective October 1, 2008, CMS narrowed the stand-in-the-shoes rule to those organizations with physician owners having profit distributions and investment returns. CMS specifically excluded physicians with only a titular interest (e.g., holding shares in trust for the benefit of a hospital) and physicians covered by the current academic medical center exception.

If a physician is eligible for profits and distributions as an owner in a physician organization having a financial relationship with an entity that bills Medicare for designated health services, the Stark law will now regulate that relationship directly and require a specific exception. As a result, most of these financial relationships will require a written agreement of at least one year that is commercially reasonable, signed by both parties in advance, and including payment terms consistent with fair market value for rent or any items and services provided.

In a brief respite, CMS created a grace period for arrangements that otherwise meet an exception but are missing the signatures required by the applicable exception. If the written agreement is missing the necessary signature, it can be obtained within 90 days if inadvertent (and within 30 days if non-inadvertent) so long as the other conditions are met and this alternative method has not been used within a three-year period.

Hospitals are also preparing for CMS to implement new Disclosure of Financial Relationship Reports (DFFR), requiring the hospital to furnish information to CMS within 60 days on all ownership and compensation arrangements with physicians. As a result of these changes, physicians and physician organizations can expect increased emphasis on both the disclosure of these relationships as well as the documentation required to pass muster and more rigid formalities when contracting with hospitals and health systems.

October 2009 Changes to Joint Ventures and Leases

CMS finalized to expand the types of entities regulated by the Stark law beyond simply those entities that bill Medicare directly and to tighten up the compensation methodologies that can be used in leases and certain compensation arrangements. Anticipating that the industry would need time to implement these structural changes, CMS allowed a grace period for transitioning to the new rule and it will not take effect until next October.

As expected, CMS finalized restrictions on “per click” and percentage-based leases governed by the Stark rule based on the concern that physicians will be rewarded for referrals (i.e., the rental charges reflect services provided to patients referred by the lessor physician to the hospital lessee based on a per-use or per-service fee). Rental payments for office space and equipment cannot be based on a percent of revenue or the number of procedures performed even if the payment is considered to be at fair market value. Office and equipment leases that are not based on a set, fixed-in-advance rental payment should be reviewed before the October 1, 2009 deadline and may need to be restructured if the leasing arrangement violates the new conditions.

In an about face, CMS reversed its previous position allowing “under arrangements” alignment models with hospitals. An “under arrangements” alignment model is a structure through which referring physicians provide goods and services to a hospital directly, or through a joint venture with the hospital, and the hospital then bills Medicare “under arrangements” and pays the joint venture for the services provided (e.g., imaging, outpatient services, cardiac cath labs). CMS considers turnkey arrangements whereby the joint venture performs essentially all of the services relating to the hospital service a business model fraught with problems and will begin to regulate the joint venture entity under Stark effective October 1, 2009. Outside the wholesale turnkey approach, hospitals can continue to obtain personnel and services from physician groups under the personal services exception and can lease space and equipment by avoiding per-click and percentage based rentals as set forth above, but the fine lines between the two business models must be analyzed on a case-by-case basis.

Amy S. Leopard is a partner at Walter & Haverfield LLP who represents health care clients on business and transactional issues, regulatory compliance and government investigations. She may be reached at (216) 928-2889 or aleopard@walterhav.com.

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. The AMCNO Practice Management Department is available to address or investigate any claim issue as well. Call us at 216.520.1000 or email concerns@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*

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Discounted Classes at Tri-C for AMCNO members

Cuyahoga Community College--AMCNO Discounted Classes and Seminars Spring 2009

To obtain your AMCNO discount code call 216-520-1000

Medical Billing Reimbursement

Gain proficiency in insurance verification, eligibility and billing for Medicare, Medicaid and commercial insurance covered medical services. *Note* required textbook is Medical Insurance an Integrated Claims Process Approach; ISBN 9780073256450 and the Workbook to accompany the text ISBN 9780073402109

CRN: 17020 UTC 2/10/09 – 3/5/09(T,R only) 9:00 am-Noon \$282

CRN: 17022 CCE 3/4/09 – 4/22/09(W only) 6:00 pm – 9:00 pm \$282

Effective Documentation: The Ultimate Chart Auditing Guide

This workshop will provide the experienced coder with innovative concepts to help assure your records and audit processes are compliant with current federal guidelines.

CRN: 18413 CCE Feb 11 9:00 am-Noon \$249

Emergency Procedures: What Practice Coders Need to Know

Review all E&M CPT codes for physicians' billing for private specialty practices and emergency rooms. Discussion of codes that are often missed and why. The class will include a discussion of the importance of modifiers--when and why they should be used.

CRN: 17740 CCW Mar 11 8:30 am-11:30 am \$139

Cardiology Coding

Students will be given examples of specific coding scenarios and the common modifiers used in cardiology coding. Common cardiac-related conditions will be addressed as well as the types of non-invasive and invasive testing used to diagnose and/or treat these conditions.

CRN: 17738 CCW Mar 20 8:30 am-11:30 am \$139

Denials and Appeals: An Interactive Discussion for Medical Coders

Have you been denied? Would you like to know the proper way to appeal and have the denial reversed? Come and listen in as your peers discuss best practices using real situations. Bring your questions.

CRN: 18870 CCE Apr 1 9:00 am-Noon \$139

Emergency Procedures: What Practice Coders Need to Know

CRN: 17742 CCE Apr 22 8:30 am-11:30 am \$139

General Medicine Coding and Non-Invasive Testing

An in-depth look at the Medicine Section of the CPT-4 manual, including a look at some invasive coding procedures such as immunizations and vaccinations. Emphasis will be placed on non-invasive diagnostic testing.

CRN: 17736 CCE May 1 8:30 am-11:30 am \$139

ICD-9-CM Fundamentals and More

Strengthen your ICD-9-CM diagnostic coding skills & reduce your claims denials when coding for compliance. Work on multiple coding exercises & have your coding questions answered. Bring: 2008 ICD-9-CM Coding Manual & medical dictionary

CRN: 17727 CCE May 6 9:00 am-3:30 pm \$179

CPT Coding Fundamentals and More!

This CPT coding seminar will strengthen your procedural coding skills and reduce your claims denials. Bring: 2008 CPT-4 Coding Manual to class; a medical dictionary would also be helpful.

CRN: 17715 CCE May 20 9:00 am-3:30 pm \$179

CCS Certification Exam Review

Prerequisite: Hospital Coding experience or academic coursework, in hospital/technical coding. An intensive review of the CCS exam using timed mock test questions and answer review. Focus on your exam preparation while you learn from your coding errors. This workshop will supplement your studies and help you tie together the important elements of this Certification Exam preparation. *Note required text:* Current Year Professional Review Guide for CCS Exam/CD ROM Current Year CPT Coding Manual and ICD-9-CM Volumes

CRN: 17015 CCE Jan 31 9:00 am – 2:45 pm \$120

CCE – Corporate College East, 4400 Richmond Road, Warrensville Heights, OH 44128

CCW – Corporate College West, 25425 Center Ridge Road, Westlake, OH 44145

UTC – Unified Technologies Center, 2415 Woodland Avenue. Cleveland, OH 44115

For more information, contact Linda Hale at AMCNO at lhale@amcnoma.org

Or by calling AMCNO at 216/520-1000

Medical Records Fact Sheet Update Effective January 2009

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 §**3701.74** 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 2009, 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:** \$2.84 per page for the first ten pages; \$0.59 per page for pages 11 through 50; \$0.24 per page for pages 51 and higher
For data recorded other than on paper: \$1.94 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 \$17.48 records search fee is allowed;
 - b) **For data recorded on paper:** \$1.15 per page for the first ten pages; \$0.59 per page for pages 11 through 50; \$0.24 per page for pages 51 and higher
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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 8, 2009 – Lakewood Country Club, or
Wednesday, April 15, 2009 – Mayfield Country Club
5:00 p.m. – 8:30 p.m.

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Program Format

5:00 p.m. – 6:00 p.m. -
Dinner

6:00 p.m. – 6:30 p.m.
Top Ten Medical Malpractice
Issues That Lead to
Malpractice Lawsuits (i.e.
anonymous horror stories,
lessons learned, and how to
prevent such lawsuits).

Edward Taber, Esq.
Tucker, Ellis & West, LLP

6:30 p.m. – 7:00 p.m.
Apologizing to Patients for
Complications and Medical
Mistakes, the legalities involved
and how to prepare for these

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

7:00 p.m. – 7:30 p.m.
eHR Adoption Issues and the HIT
Stimulus Package, eHR License
Agreements, and an Update on
HIT Donation Rules.

Amy Leopard, Esq.
Walter & Haverfield LLP

7:30 p.m. – 8:00 p.m.
The Impact of Never Events on
Medical Claims.

R. Mark Jones, Esq.
Cheryl O'Brien, Esq.
Roetzel & Andress, LPA

Meet the Presenters

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.

R. MARK JONES is a partner in the law office of Roetzel & Andress, LPA. Mr. Jones practices in both medical malpractice defense and civil litigation, focusing on representing hospitals and physicians in a variety of medical defense matters. Mr. Jones has handled more than 90 civil jury trials to verdict.

CHERYL O'BRIEN is a partner in the law office of Roetzel & Andress, LPA. Ms. O'Brien practices in the area of medical defense and civil litigation, focusing on hospital and medical defense claims. Her clients include local hospitals and physicians. Ms. O'Brien is a registered nurse with extensive experience in the areas of nursing home care, pediatrics, and pharmacology.

REGISTRATION FORM

I will attend the following
session:

April 8, 2009

Lakewood Country Club
2613 Bradley Road
Westlake, Ohio 44145

April 15, 2009

Mayfield Country Club
1545 Sheridan Road
S. Euclid, Ohio 44121

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FEES:
\$15.00 – Residents/Medical Students
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