

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

WINTER EDITION 2009/2010

Medicare

In this issue – AMCNO Medical Record Fact Sheet – timely information for your practice on the copying charges for medical records in 2010

Medicare Eliminates Consultation Codes

Effective January 1, 2010, the Centers for Medicare and Medicaid Services (CMS) are no longer paying for consultation services. As of that date, consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. For services furnished on or after January 1, 2010, physicians should code a patient evaluation and management visit with E/M codes that represents where the visit occurs and that identify the complexity of the visit performed.

Overview as provided by PalmettoGBA:

Effective for dates of service on or after January 1, 2010:

- CMS is eliminating all consultation CPT codes (inpatient and office/outpatient codes) for various places of services except for telehealth consultation G-codes
- Work relative value units (RVUs) will increase for new and established office visits, initial hospital visits and initial nursing facility visits
- Practice expense and malpractice calculations will incorporate increased use of the above visits
- Incremental work RVUs will increase for evaluation and management (E/M) codes that are built into the 10-day and 90-day global surgical codes

General information:

Be sure to select the correct code for E/M visits based on where the visit occurs and the complexity of the visit performed.

Inpatient Hospital and Nursing Facility Settings:

All physicians who perform an initial E/M may submit (depending on place of service):

- Initial hospital care CPT codes (99221-99223)
- Initial nursing facility care CPT codes (99304-99306)
- There may be multiple claims for these initial visits for one patient on the same date

HCPCS Modifier AI:

- Defined as “principle physician of record”
- Submitted by the admitting or attending physician who oversees the patient’s care
- Distinguishes admitting/attending physician services from the services of other physician performing specialty care
- Submit with the initial visit

All other providers who perform the initial evaluation:

Submit only the E/M code based on the complexity of the visit (do not submit HCPCS modifier AI)

Office or outpatient setting:

Submit CPT codes 99201-99215 depending on the complexity of the visit and whether the patient is new or established (within 3 years)

Resources:

MLN Matters Article: MM 6740 – Revisions to Consultations Services Payment Policy:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>

CMS Announces Updates

The Centers for Medicare & Medicaid Services (CMS) has announced updates to several 2010 PQRI and eRx measures-related documents. The updated documents are now available on the CMS PQRI webpage at <http://www.cms.hhs.gov/PQRI> and the CMS eRx webpage at <http://www.cms.hhs.gov/ERxIncentive> respectively on the CMS website.

2010 Measures Groups Specification Update

Version 3.0 of the Measures Groups Specifications Manual released in November 2009 for 2010 PQRI has been revised. Version 3.1 of the 2010 PQRI Measures Groups Specifications Manual and Release Notes reflects a change to the denial remark code note for several Measures Groups. Correct G-codes specific to each Measures Group have been replaced within this document. For further details, the updated “**2010 PQRI Measures Groups Specifications Manual and Release Notes**” is now available on the CMS PQRI webpage at <http://www.cms.hhs.gov/pqri>, on the CMS website. Click on the “**Measures Codes**” section page on the left.

2010 Measure Specifications Update

Version 4.0 of the Measure Specifications Manual and Release Notes, which was released in November 2009 for PQRI 2010, has been updated.

- Two updates were made to Version 4.1 of the Measure Specifications Manual
 - Measure #193: Additional information was added to the note for Numerator Coding option CPT II 4256F
 - Measure #94: CPT 92567 was added to the Denominator Coding
- Version 4.1 of the Release Notes was updated in several areas:
 - Two temporary measure numbers have been replaced with final measure numbers
 - Measure #21 and Measure #22: A CPT code that was listed as being deleted from the Denominator Coding was revised to reflect the correct code
 - Measure #48: CPT codes listed as being added and deleted from the Denominator Coding have been updated to reflect they were only added to the measure.

The updated version of the “**2010 PQRI Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes**” is now available on the CMS PQRI webpage at <http://www.cms.hhs.gov/pqri>, on the CMS website. Click on the “**Measures Codes**” section page on the left.

Final 2010 EHR Measures Specifications

The final “**2010 EHR Measures Specifications**” and “**2010 EHR Measures Specifications - Release Notes**” have been modified and are now available on the CMS PQRI website. Please note, changes were made to this document, as some encounter codes were identified as non-covered services under the Medicare Physician Fee Schedule and will not be counted in the denominator population for PQRI reporting calculations. To access these final documents, please visit the CMS PQRI webpage at <http://www.cms.hhs.gov/pqri>, on the CMS website. Click on the “**Alternative Reporting Mechanisms**” section page on the left.

2010 PQRI Single Source Code Master Update

The “**2010 PQRI Single Source Code Master**” document released in November 2009 for PQRI 2010 has been revised to add CPT 92567 to the Denominator Coding for Measure #94. The updated document is now available on the CMS PQRI webpage at <http://www.cms.hhs.gov/pqri>, on the CMS website. Click on the “**Measures Codes**” section page on the left.

2010 eRx Measure Specifications Update

Version 1.0 of the 2010 eRx Release Notes released in November for 2010 eRx has also been revised. The updated Version 1.1 of the eRx Release Notes now correctly reflects a change in the Denominator Updates section of the document. To access this updated document, please see the “**2010 eRx Measures Specifications and Release Notes**”, which available on the CMS Electronic Prescribing Incentive Program (eRx) webpage at <http://www.cms.hhs.gov/ERxIncentive>, on the CMS website. Click on the “**E-Prescribing Measure**” section page on the left.

AMCNO Recovery Audit Contractors (RACs) and Medicare Seminar Overview - AMCNO May Act as Key Contact When Issues Arise with the RAC

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was one of the professional associations chosen to provide outreach training to physicians prior to the rollout of the recovery audit contractors (RACs) in Ohio. The AMCNO session was one of many conducted around the state of Ohio.

The purpose of the RAC program is to detect and correct past improper payments so that the Center for Medicare and Medicaid Services (CMS), Carriers, fiscal intermediaries (FI) and Medicare Administrative Contractors (MACs) will be able to develop corrective actions that will prevent future improper payments. All providers that bill Medicare fee-for-service Part A or Part B programs will be subject to RAC review.

The RAC that has jurisdiction for Region B is CGI. RACs use the same Medicare policies as FIs, Carriers, and MACs—Part A and Part B: national coverage determinations, local coverage determinations, and CMS manuals. RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician. RACs are also paid on a contingency fee basis which means they receive a portion of the funds they recover. If a RAC loses any level of appeal, they must return the contingency fee. Presenters noted that this is considered an incentive for the the RACs to check their work to assure accuracy. Since RACs review claims on a post-payment basis, they will not be able to review claims paid prior to October 1, 2007, but they will be able to look back three years from the date of the review. Presenters indicated that as of right now they have an 18 month look-back period. However, by 2012, they will have the full three years.

There are two types of reviews: Complex and Automated. Complex requires a medical record; automated does not require a medical record.

- **Complex Review Steps and Tracking**
 - Auditors will select cases for review and request the medical record; the request date and the requesting auditor is automatically recorded in CAS.
 - Medical record is received in CAS 5.0, and the received date is automatically recorded.
 - Auditor reviews the medical record and documents audit comments in CAS 5.0; the date is recorded in CAS 5.0. This is a way to give the provider customer service; if you call us and give us the name of the patient, you will be directed to the appropriate person so you can get an answer.
 - The physician’s comments are also documented in CAS 5.0; the date is recorded in CAS 5.0 automatically.
 - Letters are generated to providers at the end of the audit, and the date is recorded.

- Automated Review
 - Occurs when a RAC makes a claim determination at the system level without a human review of the medical record. When you look at the web site and the six (6) issues are automated, these are issues that we can make a determination that a service is not covered or incorrectly coded or supported by Medicare policy or coding guidelines.
 - Coverage/coding determinations are made through automated review.
 - The RAC may use automated review when making coverage and coding determinations only where BOTH of the following conditions apply:
 - there is certainty that the service is not covered or is incorrectly coded, AND
 - a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline (e.g. CPT statement, CPT assistant statement, coding clinic statement, etc.) exists.

For automated reviews, these are black and white issues such as duplicate claims or pricing mistakes. These errors do not have a policy or a guideline to support it; you could detect it by looking at the claim. The RAC may use automated review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often don't exist for these situations. For an automated review:

- The RAC will not request medical records from the provider.
- The RAC makes a claim determination. (Same as for Carrier, FI and MAC identified overpayments, but the demand letter comes from the RAC.)
- If the claim is denied, the RAC sends the claim information to the FI or the MAC.
- The FI or MAC issues a remittance advice with the code N432: Adjustment Based on Recovery Audit.
- At the same time, the RAC issues an overpayment demand letter (date = day 1) that includes the recovery amount and the provider's appeal rights.
- If the provider agrees with the RAC's determination, the provider may pay by check; allow recoupment from future payments; or, request or apply for extended payment plan.
- Providers have two options when they disagree with the RAC findings, the "discussion period" and the "formal appeal". In an automated review, the time frames for both the discussion period and the formal appeals process begin with the date of the demand letter.

Presenters at the AMCNO seminar encouraged providers to call as soon as possible to initiate the discussion period and send a letter with supporting documentation to refute the improper payment with the RAC. If the RAC agrees with the provider, the findings are reversed and the provider doesn't have to appeal. The appeals process, which is the same as for FI or MAC denials, needs to move forward at the same time as the discussion period. Providers must file an appeal before the 120th day after the date of the demand letter. If an appeal is not filed within 40 days, the FI or MAC begins recouping by offset on day 41. For more information on Appeal Timeframes go to:

<http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf>

Underpayments:

CGI receives the same contingency fee for over and under payments. It does not make a difference because they are contracted to review both. They can identify them at the line level. If it was billed at a low level of payment but should have been a high level of payment, the RAC will make sure the claim is adjusted accordingly.

For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that were billed at a low level of payment, but should have been billed at a higher level of payment. The RAC will include review for underpayments as a part of our auditing process.

- Upon identification, the RAC will communicate the underpayment finding to the appropriate affiliated contractor.
- Neither the RAC nor the AC may ask the provider to correct and resubmit the claim.
- The affiliated contractor validates the underpayment occurrence, adjusts the claim and pays the provider.
- The RAC will issue a written notice to the provider, via the Underpayment Notification Letter.
- Provider inquiries are answered by the RAC call center.

Record request limits:

- Inpatient Hospital, IRF, SNF, Hospice – 10% of the average monthly Medicare claims (max 200) per 45 days per NPI
- Other Part A Billers (HH) – 1% of the average monthly Medicare episodes of care (max 200) per 45 days per NPI
- Physicians (including podiatrists, chiropractors)
 - Sole practitioner: 10 medical records per 45 days per group NPI
 - Partnership 2-5 individuals: 20 medical records per 45 days per group NPI
 - Group 6-15 individuals: 30 medical records per 45 days per group NPI
 - Large Group 16+ individuals: 50 medical records per 45 days per group NPI
- Other Part B Billers (DME, Lab, Outpatient hospitals) – 1% of the average monthly Medicare services (max 200) per NPI per 45 days

Chief Medical Director (CMD) Assigned to Region B

During the RAC demonstration project, providers felt that the lack of a physician presence at the RAC equated to claims being erroneously denied. Due to this problem, CMS implemented a change to the RAC program, namely that each RAC had to hire a medical director to oversee the medical review process to assist nurses, therapists and certified coders upon request, to manage procedures, and to inform provider organizations about the RAC program to be sure providers know how and why the RAC program will effect them. During the AMCNO presentation, Dr. Percival Seaward outlined his role and responsibilities as the CMD for Region B.

CMD responsibilities:

- The CMD is expected to have an understanding of National Coding Determinations, Local Coding Determinations and other Medicare policies – with the intent to provide clinical expertise and judgment.
- Readily available; the RAC staff must always have easy access to the regional CMD. They must be able to walk into the CMD's office or call when they need information. The CMD must be able to eliminate as many gray areas as possible from the auditing process.
- Questionable claim review situations; the CMD must be able to make decisions on questionable decisions and must be available for one-on-one discussions with physicians. Remember – discuss before you appeal – you may not have to appeal.
- Claim adjudication briefing and advising of personnel.
- Correct policy applications – use of written guidelines.
- The CMD must review corrective actions and recommend provider education if necessary. The CMD will be involved in claim adjudication briefings which will entail having a discussion with relevant personnel in the review process.

CGI plans to maximize transparency through communication. Physicians and their staff may contact CGI through the following avenues:

CGI web site: If you do not know anything about the RAC program, you can visit their web site. There are also links to the CMS web site there as well. The web site address is <http://RACB.CGI.com>.

CGI Call Center: You are guaranteed to get a response within 24 hours of your request. The call center phone number is 877-316-racb or 877-316-7222.

CGI Email: CGI has an email and encourages your point-of-contact person to use it. They plan to send all correspondence to this one point-of-contact. You also can use the email to send a question or concern that you may have. If CGI does not have the answer, they have an excellent relationship with CMS. CGI has weekly meetings with them and all questions will get an answer. The email address is racb@cgi.com.

CGI has agreed to establish and maintain relations with associations. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has reached out to CGI and they will continue to foster a relationship. If at any time the AMCNO has questions, they can contact CGI directly – the AMCNO is a key contact – CGI will send emails to the AMCNO and will keep the lines of communication open. In the event the three (3) keys to successful communication fail (i.e. web site, email and call center), members may contact the AMCNO and ask for assistance.

Editor's note: An AMCNO prepared transcript outlining the presentation by CMS and CGI at our Third Party Payor seminar is posted on our web site along with complete copies of the slides provided by both CMS and CGI at www.amcnoma.org.

Recovery Audit Contractor – Region B – Posts sample demand letter on web site

The Centers for Medicare and Medicaid Services (CMS) has retained CGI Federal to carry out the Recovery Audit Contracting (RAC) program in Ohio. The RAC program is mandated by Congress and meant to identify Medicare improper payments. CGI Federal has now posted on its website a sample of the updated automated demand letter and a sample of the envelope that CGI will use for all correspondence sent by RACB. The RACB website is <http://RACB.CGI.com>. To go directly to a sample of the demand letter go to <http://racb.cgi.com/Docs/Automated%20Demand%20letter.pdf>

Any questions can be addressed to the RACB Call Center at 877-316-RACB or by email to RACB@cgi.com.

Nineteen New Issues Posted on RAC Website

Any issues that are to be reviewed by Recovery Audit Contractors (RACs) must be approved by the Center for Medicare and Medicaid Services (CMS) prior to widespread review by the RAC. All approved issues are posted on a RAC website before review begins. New issues are sent to the CMS New Issues Review Board which is made up of subject matter experts. The AMCNO has been informed that 19 new issues (two automated and seventeen complex) have been approved by the Center for Medicare and Medicaid Services (CMS) and have been posted to the RACB Web site effective Monday, January 18. To view all issues go to <http://racb.cgi.com/Issues.aspx>

CMS Extends Annual Participation Enrollment Program

CMS has extended the 2010 Annual Participation Enrollment Program end date from January 31, 2010, to **March 17, 2010**— therefore, the enrollment period now runs from November 13, 2009, through March 17, 2010. The effective date for any Participation status change during the extension, however, remains January 1, 2010, and will be in force for the entire year. Contractors will accept and process any Participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

CMS and ONC Issue Regulations Proposing a Definition of ‘Meaningful Use’ and Setting Standards for Electronic Health Record Incentive Program

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released regulations that lay a foundation for improving quality, efficiency and safety through meaningful use of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of “meaningful use” of EHR technology. An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. Numerous public meetings to solicit public comment were held by three Federal advisory committees: the National Committee on Vital and Health Statistics (NCVHS), the Health IT Policy Committee (HITPC), and the Health IT Standards Committee (HITSC). HITSC presented its final recommendations to the National Coordinator in August 2009. These recommendations, along with all other input were considered to help inform the development of the regulations announced today.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange healthcare information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information using the Internet.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations, and sets forth criteria required for an EHR technology to be certified. These standards will support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS was required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an opportunity for public comment and refinement over the next 60 days. A final rule will be issued in 2010. The Recovery Act established programs to provide incentive payments to eligible professionals and eligible hospitals participating in Medicare and Medicaid that adopt and make “meaningful use” of certified EHR technology. Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

The proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery, reduces health care disparities, engages patients and families, improves care coordination, improves population and public health, and ensures adequate privacy and security protections for personal health information.

The proposed rule would define meaningful use for the Medicare EHR incentive programs. It proposes one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advantage EHR incentive programs as well as a proposed definition that would apply to eligible hospitals and critical access hospitals. These definitions also would serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional meaningful use measures, as appropriate, but could not request approval of fewer or less rigorous meaningful use measures than required by the rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for meaningful use based on currently available technological capabilities and providers' practice experience. CMS will establish stricter and more extensive criteria for demonstrating meaningful use over time, as anticipated developments in technology and providers' capabilities occur. CMS provides a 60-day comment period on the proposed rule.

The CMS proposed rule and fact sheets may be viewed at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp

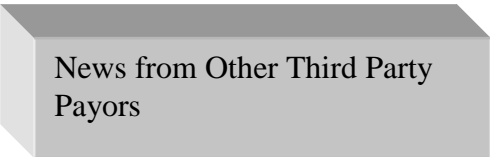
You can download the Federal Register document at: <http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>

ONC's interim final rule may be viewed at <http://healthit.hhs.gov/standardsandcertification>.

In early 2010 ONC intends to issue a notice of proposed rulemaking related to the certification of health information technology.

CMS has proposed stages for the meaningful use criteria with Stage 1 meaningful use criteria focusing on electronically capturing health information in a coded format, using that information to track key clinical conditions and communicating that information for care coordination purposes. It also calls for implementing clinical decision support tools to facilitate disease and medication management and reporting clinical quality measures and public health information.

CMS officials recommend Stage 2 criteria proposed by the end of 2011 and the Stage 3 definition proposed by the end of 2013.



News from Other Third Party
Payors

MEDICAID

Ohio Department of Job and Family Services Provides Information Regarding Changes to Coverage of Prescription Drugs for Members of MCPs

Beginning with date of service February 1, 2010, prescription drug coverage for members of Medicaid MCPs will transfer to the Medicaid fee-for-service (FFS) program. This change means that all Medicaid consumers will have the same list of covered drugs and same prior authorization policy. Medicaid MCPs are no longer responsible for prescription drug coverage for their members. This change is only for prescription drugs that are administered in the patient's home, not for any drugs that are administered in a provider setting such as physician office, hospital outpatient department, clinic, dialysis center, or infusion center. Drugs

administered in a home health setting should be billed through the fee-for-service pharmacy program. Some medical supplies, such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers, and peak flow meters, will only be able to be billed by pharmacies (including hospital pharmacies) and will no longer be covered when billed by any other provider type, including durable medical equipment (DME) dealers, clinics, or individual physician offices. ODJFS also has issued information about CyberAccess, a secure web site that allows Ohio Medicaid providers to review the Medicaid prescription claims history for their patients, review prescription prior authorizations, and send electronic prescriptions (eprescribe) for their Medicaid patients. Prescriptions billed through the FFS program may be subject to co-payments. In addition, the federal requirement for tamper-resistant prescription pads will now include prescriptions for members of MCPs because they will be billed to the FFS program. Each of these topics is explained in more detail in a letter issued by the ODJFS. To view the letter go to: <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=MAL561>

Ohio Department of Job and Family Services Ohio Medicaid Preferred Drug List

The newest phase of the Ohio Medicaid Preferred Drug List (PDL) became effective on October 1, 2009. The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization. A "quick list" of preferred drugs is available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm> This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have ODJFS-approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://jfs.ohio.gov/ohp/bmhc/> for information about Medicaid MCP.

Please note that while most of the preferred drug categories have been part of the PDL in the past, the preferred drugs in each class may have changed. A summary of changes, though not all-inclusive, may be found at <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=MAL557>

UnitedHealthcare Announces Change in Radiology Notification Program for 2010 ***By Laurie A. Paidosh and Giesele Greene, M.D.***

To help ensure that patients are receiving the *right imaging study for the right reason the first time*, UnitedHealthcare is expanding its Radiology Notification Program in February 2010, to include all network physicians -- including those physicians who have received the Premium Quality and Efficiency designation. This program requires prior notification for the following outpatient imaging procedures: CT scans, MRIs, MRAs, PET scans, and nuclear medicine studies, including nuclear cardiology.

This change is based on our concern for patients who are subject to preventable radiation exposure, the need to improve compliance with evidence-based and professional society guidance in the use of these expensive health care assets, and direct feedback from practicing physicians and office managers, who, while appreciating the exemption for UnitedHealth Premium designated physicians, have also reported additional administrative complexity in managing these exemptions.

Since the inception of the Radiology Notification Program, UnitedHealthcare has more effectively promoted quality and safety by encouraging efficient utilization of advanced imaging services consistent with evidence-based clinical guidelines. This patient-centered approach ensures the most appropriate imaging service will be considered to aid in the clinical diagnosis.

While implementing this enhanced Radiology Notification Program, UnitedHealthcare will continue to evaluate mechanisms that appropriately and transparently distinguish physicians who demonstrate adherence to evidence-based guidelines for ordering advanced imaging services and who could therefore qualify for a reduction in the administrative notification requirements in the future. UnitedHealthcare is actively consulting with medical societies, experts and its scientific advisory board in working toward this goal.

Physicians and other health care professionals ordering advanced imaging services should complete prior notification online at UnitedHealthcareOnline.com. As a reminder, advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay do not require notification. This change does not affect physicians' current UnitedHealth Premium designation status.

UnitedHealthcare has sent physicians reference materials regarding the program change. For more information, visit UnitedHealthcare's physician Web site, UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification > Reference Materials. For notification questions, contact your UnitedHealthcare Network Management representative, or call 800-637-5792, or email radiology@customerelation.com.



Red Flags Rule Delayed Yet Again

The commission's "red flags" rule requires entities that regularly extend credit or defer payment for services to implement a formal policy for detecting and preventing identity theft. Despite repeated objections from physician organizations, the FTC counts physician practices as creditors if they bill patients for past services or allow patients to set up payment plans.

The pushback by physicians has once again prompted the Federal Trade Commission (FTC) to delay enforcement three times. A fourth postponement -- from Nov. 1, 2009, to June 1, 2010 -- came at the request of congressional lawmakers and could be followed by enactment of a new bill that would exempt practices with 20 or fewer employees. That measure passed the House on Oct. 20 and awaits action by the Senate Committee on Banking, Housing and Urban Affairs.

Other provisions would exempt entities that:

- Know all of their customers individually.
- Only perform services in or around their customers' residencies.
- Have never experienced incidents of identity theft or are in an industry where such occurrences are rare.

Recently the U.S. District Court for the District of Columbia blocked the FTC from applying the red flags rule to attorneys, noting that the agency may have overstepped its bounds. The suit was brought by the American Bar Association. A final court order is pending.

The AMCNO has provided our members with detailed information on Red Flags rule compliance in past issues of the Northern Ohio Physician and our Practice Management Matters publications. Physicians are urged to continue to review their practices for identity theft issues and review the AMCNO information on adoption of compliance plans in the event it is finally required in June 2010.

The AMCNO sent out detailed information regarding compliance with the Red Flags Rule that was to become effective on May 1, 2009 in the Spring 2009 Practice Management Matters newsletter. Physician

offices are urged to retain this information or, to obtain a copy go to the AMCNO website: www.amcnoma.org and access “information on red flag rules” within the Practice Management link.

Additional information is also available on the FTC web site at www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm, and at another link on the FTC site at www.ftc.gov/redflagsrule. The FTC is currently working on a compliance template and the AMCNO will inform our members as soon as that information becomes available on their site.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) encourages our members to simplify work and gain savings through the multi-payer web portal

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO), as a part of a statewide initiative between AHIP, the Blue Cross and Blue Shield and eight leading health plans in Ohio, is encouraging members to explore [Availity](#), a multi-payer web portal solution for:

- researching a patient’s eligibility and benefits coverage,
- managing referrals to specialists,
- clearing authorizations for treatment, and
- submitting and reviewing the disposition of claims.

The Availity health information network and web portal will help The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) members achieve administrative savings by simplifying the exchange of information between providers and payers.

Our role at the Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

The Ohio portal initiative is a one-of-a-kind collaborative effort between health plans, medical providers and professional associations to deliver immediate efficiencies and cost savings across the continuum of care. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to support such a solution.

Consistent usage and early adoption of the Availity portal as a savings tool will give Ohio a greater voice in defining best practices in health care administrative processes—and gives our physicians, health plans and patients the benefit of immediate cost savings.

Health plans participating in the multi-payer portal include:

- [Aetna](#)
- [Anthem Blue Cross and Blue Shield](#)
- [CIGNA](#)
- [Humana](#)
- [Kaiser Permanente](#)
- [Medical Mutual of Ohio](#)
- [UnitedHealthcare](#)
- [WellCare Health Plans, Inc.](#)

The portal is easy to use; health care providers can start saving time and money with minimal training and without changes to their expensive office systems. World-class support teams help users online and via telephone.

Portal launch partners will capture portal usage information for the next 12 months, and identify the merits of a collaborative service among Ohio physicians for a potential expansion to other states and addition of other services. The information will be used to define best practices in health care administration, among stakeholders nationwide. Physicians interested in using the portal should begin by registering for Availity at <http://www.availity.com/providers/registration-details/>.

Upon completing and returning your signed application, Availity will send your login information to you within a few days. It's that simple. Once you login to the secure portal, you'll have access to free live training, help, and other resources to ensure you get the most out of your Availity experience. Client service representatives are available Monday through Friday to help answer your questions at 1.800.AVAILITY (282.4548). For more information about Availity and to see a demonstration of the portal, go to <http://www.availity.com/demo/> No log-in is required.

There is Still Time to Get a Quote from the AMCNO Workers Compensation Group Rating Plan

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to offer a workers compensation group rating plan to our members that can help you save money on the premiums you pay to the Ohio Bureau of Workers' Compensation. This plan is made possible through our **longstanding** partnership with CompManagement, Inc., (CMI) a Sedgwick CMS Company. CMI has begun the review process for 2010 group participation, which means you can find out how much you can save! AMCNO practices already enrolled in the AMCNO Group Rating Program will receive a letter regarding review for renewal with the program as well as contact information for CompManagement.

Practices not currently enrolled can receive a free quote by completing an application for the 2010 program one of three ways:

FAX: Go to www.amcnoma.org and download a copy of the application form posted on the front page of the website. Complete the form and fax it back to CompManagement at (866) 567-9380.

ONLINE: Go to <http://resources.compmgt.com/AC3/GroupRating.aspx?Organization=AMCNO> to access and complete the application online.

PHONE: Complete the application over the telephone by contacting the CompManagement Customer Support Unit at (800) 825-6755, option 3.

CompManagement will review the application, determine your potential savings and contact you with a cost analysis. If you decide you want to participate, all you need to do is sign and send in the enrollment paperwork included in your cost analysis. This is a no-cost, no obligation review. If you are currently a member of another medical association in the state and participating in a group rating plan other than through the AMCNO you are probably paying higher member dues to remain in that plan. Upon review, you may find that the AMCNO dues are substantially less per member and we provide group discounts which cost effectively enables our physician members to take advantage of the worker's comp group rating program along with other AMCNO benefits and services at reduced cost. If you have questions regarding the program contact Ms. Linda Hale at the AMCNO offices at 216-520-1000, ext. 101.

Discounted Classes at Tri-C for
AMCNO members

Cuyahoga Community College
Discounted Medical Practice Management Seminars

CODING SEMINARS: Professional CEUS: AAPC and PMI-1 CEU per hour

For your AMCNO member discount promo code: Contact Linda Hale AMCNO at 216-520-1000.

For class information: Contact Barbara Neilsen at 216-987-3187 or barbara.neilsen@tri-c.edu

Date	Course/Seminar	
2010		
Seminars at: Corporate College East, 4400 Richmond Road, Warrensville Hts, OH 44128		
March 24	Compliance Update:	
8:30am-11:30am	Preparing for RAC/MIC Audits	\$139
April 14	ICD -9-CM Fundamentals and More	
9:00am-3:30pm		\$179
May 5	CPT Fundamentals and More	
9:00am-3:30pm		\$179
May 19	ICD-10 Preparation: Part 1	
8:00am-12:30pm	Fundamentals of ICD 10 Structure	\$120
	Anatomy, Physiology & Terminology Review	
May 19	ICD-10 Preparation: Part 2	
1:30pm-4:30pm	Preparing the Practice	\$105
	Timelines, Checklists and Staff Training	

Medical Terminology: Cost \$253 and **Medical Billing Reimbursement: Cost \$282** are also offered at various times and at various Tri-C campus locations. Please call the AMCNO, Linda Hale 216-520-1000 to obtain course details, location, times, cost and discount promo code.

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

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

www.amcnoma.org

216.520.1000 Executive Offices 216.520.0999 Facsimile

Medical Records Fact Sheet Update Effective January 2010

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 2010, 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:** \$2.73 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: \$1.86 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 \$16.78 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: \$1.86 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.