

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

PRACTICE MANAGEMENT MATTERS

Fall 2008 Edition

Medicare Update

AMCNO responds to Center for Medicare and Medicaid Services (CMS) special study to consider changes to geographic practice cost indices (GPCIs)

On behalf of our membership, the AMCNO has sent comments to CMS regarding a recent study conducted for CMS by Acumen LLC – “Review of Alternative GPCI Payment Locality Structures.” CMS contracted with Acumen, LLC to conduct a study of several options for revising the GPCI payment localities. The study was commissioned by CMS because of the myriad comments received from across the United States regarding the GPCI configuration.

The Medicare physician fee schedule adjusts physician fees for area differences in physicians’ costs of operating a private medical practice. Three separate indices, known as geographic practice cost indices (GPCI) raise or lower Medicare fees in an area, depending on whether the area’s physician practice costs are above or below the national average. These GPCIs adjust physician fees for variations in physicians’ costs of providing care in different geographic areas. The three GPCIs correspond to the three components of a Medicare fee: physician work, practice expense, and malpractice expense.

At this time, CMS uses 89 physician payment localities among which fees are adjusted. CMS recognizes that changing demographics and local economic conditions may lead to increased variations in practice costs in certain payment locality boundaries. Currently, the state of Ohio is designated as a statewide locality. Based upon the AMCNO review of studies on the GPCI calculations, a statewide locality in Ohio clearly does not accurately account for the variations in practice costs in certain payment localities – particularly in Northern Ohio.

The Acumen study demonstrates that there is a very real need to change the current GPCI locality configuration to reflect the area differences in the state of Ohio. In fact, the Acumen study showed that every alternative outlined for the state of Ohio would benefit physicians practicing in Northern Ohio.

Upon review of the study, the AMCNO board of directors opted for Option 1 – the CMS CBSA option. This option follows the approach CMS uses to develop geographic payment adjustments for other major Medicare providers. It is a preferable option because it utilizes Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) to form localities. Also, this option “allows for more stability in updates over time and data availability because of the use of MSAs.” The AMCNO believes that this option assures uniformity and provides for a common base for updates across all types of providers in Ohio. The AMCNO has urged CMS to carefully evaluate the Acumen study and consider including one of the options (preferably Option 1) in the 2009 physician update.

As the regional organization representing physicians in Northern Ohio the AMCNO continues to advocate for a change in the payment localities utilized in Ohio. The AMCNO will continue to follow-up with CMS in the future to assure that our comments have been noted. Any questions regarding this issue may be forward to E. Biddlestone at the AMCNO at 216-520-1000, ext. 100.

ICD-10-Clinical Modification/Procedure Coding System Fact Sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the Centers for Medicare

CMS Launches E-Prescribing Incentive Initiative

The Center for Medicare and Medicaid Services (CMS) will begin a new incentive program for eligible professionals who are successful electronic prescribers (E-Prescribers) beginning January 1, 2009. This new incentive program is in addition to the quality reporting incentive program known as the Physician Quality Reporting Initiative (PQRI). The e-prescribing incentive is similar to the PQRI incentive in that reporting periods are one year in length and the incentive is based on the covered professional services furnished by the eligible professional during the reporting year. In addition, MIPPA requires quality measures that can be reported for purposes of qualifying for the PQRI incentive payment not include e-prescribing measures. Reporting periods are for a calendar year, beginning with calendar year 2009 through 2013.

The e-prescribing incentive percent amount for reporting years 2009 - 2010 is 2.0 percent; for reporting years 2011 - 2012 is 1.0 percent; and for reporting year 2013 it is 0.5 percent. The incentive does not apply to eligible professionals, for the reporting period, if:

1. The Medicare allowed charges for all covered professional services for the codes to which the e-prescribing measure applies are less than 10% of the total of the allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional.

OR

2. If determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and non-electronically) a sufficient number of prescriptions under Part D.

CMS will describe which incentive limitation (either 1 or 2 above) will apply for the reporting year 2009 in the final 2009 Physician Fee Schedule rule that will be posted in the Federal Register no later than November 15, 2008.

For purposes of qualifying for the incentive, an eligible professional shall be treated as a successful E-Prescriber for a reporting period if the eligible professional meets the requirements under (1) below, or if determined appropriate by the Secretary, the requirement described in (2) below.

1. The eligible professional reported the applicable e-prescribing quality measure (e.g., e-prescribing measure # 125) in at least 50 percent of the cases in which such measure is reportable by the eligible professional during the reporting year.

Note: Any updates to e-prescribing quality measures (specifications and/or reporting instructions) will be posted at <http://www.cms.hhs.gov/EPrescribing> on the CMS website.

OR

2. The eligible professional electronically submitted a sufficient number of prescriptions (as determined by the Secretary) under Part D during the reporting period.

CMS will describe the criteria (either 1 or 2 above) that will be used to determine a "successful E-Prescriber" for reporting year 2009 in the final 2009 Physician Fee Schedule rule that will be posted in the Federal Register no later than November 15, 2008.

Starting in January, Medicare will pay a 2% bonus to physicians who successfully e-prescribe under Part D. CMS will assess how often and how consistently physicians prescribe electronically to determine whether they qualify. The bonuses will phase down to 1% in 2011 and 0.5% in 2013 before ending. As noted above a final definition of successful e-prescribing will be issued later in November, along with the CPT codes that can be associated with paperless drug orders.

For a complete copy of the CMS fact sheet on this issue go to

www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf or visit <http://www.cms.hhs.gov/EPrescribing> to stay informed.

Guide Released to Help Physicians Make E-Prescribing Transition

The eHealth Initiative (eHI), in collaboration with the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the Medical Group Management Association, and The Center for Improving Medication Management (The Center), issued the first comprehensive, multi-stakeholder-informed "how-to" guide to help clinicians make informed decisions about how and when to transition from paper to electronic prescribing systems. *A Clinician's Guide to Electronic Prescribing* was released at the Centers for Medicare and Medicaid Services (CMS) National e-Prescribing Conference in Boston recently and follows the agency's decision earlier this year to offer financial incentives--beginning in 2009--to providers who adopt e-prescribing. To download a copy of the *Clinician's*

Guide to Electronic Prescribing, go to http://www.thecimm.org/PDF/Clinician's_Guide_to_e-Prescribing_Final_100708.pdf

Stark Rule Update

Effective October 1, 2008, if a physician is an owner in a physician organization that has a financial relationship with an entity that bills Medicare for designated health services, the Stark law will now regulate that relationship directly. The principal impact of this change is that hospitals and health systems will need to meet the more rigid formalities of having a written contract for services established in advance and limiting the compensation to fair market value when contracting through a physician organization for physician services.

CMS also finalized three changes that take effect next October so as to provide a long transition period. First, CMS will limit turnkey arrangements between hospitals and physicians whereby the physician group performs essentially all of the services relating to a service for which the hospital turns and bills Medicare. Hospitals can continue to lease equipment or obtain personnel and services from physician groups but the fine lines between the two will be established on a case-by-case basis. Also, leases between hospitals and physicians may need to be restructured before October, 2009. Certain types of rental payments to referring physicians based on a percent of revenue will be prohibited and, likewise, leases between a hospital and its referring physicians cannot have rental payments based on the number of procedures performed. In both cases, flat rate rental amounts will need to be established.

Physicians can also expect some additional changes that will go into effect on January 1, 2009, but CMS has not finalized those rules. The proposal would allow certain “gainsharing” arrangements whereby hospitals and physicians can financially align for hospital cost savings and quality improvement measures. The AMCNO will provide our members with additional information as it becomes available.

Medicare Provides Information on Flu Vaccine

Medicare asks that physicians encourage patients to get a flu shot as it is still their best defense against the influenza virus. Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug.

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 & Pneumonia Immunization Information

Palmetto GBA of Ohio and West Virginia has prepared a packet for health care providers who mass immunize their patients against influenza and pneumonia. The packet contains instructions on how to submit claims using the roster billing method. To access the Roster Billing Packet, go to:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf>

In addition, flu vaccine lots have been released by the FDA and are available for distribution by the manufacturers. For information on flu vaccine distribution schedules, please contact the manufacturers directly.

<http://www.fda.gov/cber/flu/flu2008.htm>

FDA approves vaccines for upcoming flu season

This year’s seasonal influenza vaccines that include new strains of the virus likely to cause flu in the United States during the 2008–2009 season have been approved by the Food and Drug Administration (FDA). The vaccines contain three strains of the influenza virus that disease experts expect to be the most likely cause of the flu in the United States. The Advisory Committee on Immunization Practices recommends that anyone who wishes to be vaccinated for influenza receive the vaccination; physicians should not hold off on vaccinating patients if they have the vaccine in hand.

for more information, including a list of vaccines and their manufacturers go to

<http://www.fda.gov/bbs/topics/NEWS/2008/NEW01872.html>

National Recovery Audit Program

The Centers for Medicare & Medicaid Services (CMS) recently announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers; consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program.

As part of these enhanced efforts, CMS is consolidating its efforts with new program integrity contractors that will look at billing trends and patterns across Medicare. They will focus on companies and individuals whose billings for Medicare services are higher than the majority of providers and suppliers in the community. CMS is also shifting its traditional approach to fighting fraud by working directly with beneficiaries and ensuring they received the durable medical equipment or home health services for which Medicare was billed and that the items or services were medically necessary.

At this time, the state of Ohio is not scheduled for a RAC roll out until August 2009 or later. In addition, CMS has temporarily suspended work by the four recently named recovery audit contractors (RACs) after being informed by the Government Accountability Office (GAO) this week that two of the four contracts awarded are being protested by a pair of companies that bid on the work but were not selected. The GAO has 100 days to issue a decision about the protests, meaning one likely will be announced in early February. Prior to the protested contracts, CMS had been moving ahead with outreach to state hospital associations, as hospitals were expected to be the first Medicare providers audited under the program. The new national RACs can be found at www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf For more information, visit the CMS RAC Web site at: www.cms.hhs.gov/RAC.



AMCNO Attends ODJFS Listening Session Held in Cleveland

Recently, the AMCNO staff attended an Ohio Department of Job and Family Services (ODJFS) Listening Session regarding the Ohio Medicaid Managed Care Plans (MCPs). The session in Cleveland, Ohio was one of five sessions held across the state of Ohio during the summer months.

The Ohio Department of Job and Family Services (ODJFS) held five public sessions across Ohio seeking input on Ohio's Medicaid Managed Care Program in order to gain opinions and comments on how to improve Medicaid managed care. Session attendees were asked to offer ideas about how to:

1. Maximize the cost effectiveness of Medicaid managed care;
2. Improve the quality of services and/or health outcomes for Medicaid consumers enrolled in managed care;
3. Maintain or improve consumer access to needed medical services.

ODJFS plans to utilize comments from the sessions when developing their Medicaid initiatives in Ohio. Each session had a panel that included consumers and members of the ODJFS Medical Care Advisory Committee. Speakers were allotted three minutes to present comments. Presenters included consumers; Medicaid managed care plan representatives, members of the general public and Medicaid providers.

There were many suggestions made by the presenters including the following items:

- 1.) Simplify and streamline the enrollment process; the current process is too time consuming and costly.
- 2.) Hold managed care organizations accountable for adhering to plan requirements, increase prompt payment of claims; eliminate some of the red tape to gain prompt payment and resolve outstanding claims and work to obtain timely reimbursements for providers;
- 3.) Provide information to providers so that they may contact the appropriate person within ODJFS to discuss problem claims in an efficient manner and hold administrative staff accountable for doing their job in a timely fashion (one example was providers put on hold for over 45 minutes to talk to a representative).
- 4.) Be aggressive with working on preventative care issues, in particular for children in the Medicaid program.
- 5.) Enhance coordination of services to provide complete and timely care;

- 6.) There have been many changes in Medicaid Managed Care plans across the state since the inception of the program causing confusion, disruption of care, and inability to continue with a provider. Changes in coverage and contracts need to be better communicated to consumers (i.e. in particular when a large provider does not renew a MCP contract).
- 7.) Issues continue to arise when a Medicaid patient cannot see a physician of choice if the physician is not contracted with a particular plan.
- 8.) Review the importance of a medical home concept for Medicaid consumers.
- 9.) Any physician treating children in the MCP program should have access to patient records and the changes in healthcare plans cause confusion. Families of children with chronic health care problems in particular are impacted by these changes.

The ODJFS has published the comments made at all five listening sessions on their web site at <http://jfs.ohio.gov/>

Ohio Department of Job and Family Service (ODJFS) Changes to Fee-For-Service Pharmacy Program

Effective October 1, 2008 ODJFS began full implementation of the federal requirement for tamper-resistant prescription forms. Beginning October 1, 2008, a prescription is required to have three tamper-resistant characteristics in order to be reimbursed by Ohio Medicaid. All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy via telephone, fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper resistant a prescription form must contain ALL of the following three characteristics:

- One or more features designed to prevent unauthorized copying of a completed or blank prescription form
- One or more features designed to prevent the erasure or modification of information written on the prescription by the provider
- One of more features designed to prevent the use of counterfeit prescription forms

For printing purposes, you may access the Acrobat version of the pharmacy update from ODJFS Legal/Policy Central at: <http://www.odjfs.state.oh.us/lpc/calendar/index.asp>.

Third Party Payors

UNITEDHEALTH CARE

Feet on the Street...and in Physicians' Offices

By: Dr. Giesele Robinson Greene Health Plan Medical Director for Northern Ohio for UnitedHealthcare

Recognizing the complexity of the daily workings in a physician's office, UnitedHealthcare is gearing up to provide some help. Physicians and their staffs are central to the delivery of health care and UnitedHealthcare recognizes the role it must play in supporting physicians and their staffs.

As UnitedHealthcare rolls out the new Provider Advocacy Program, physician offices in Ohio can expect to see a Physician Advocate visiting the office to ask, "What can I do to help?" Physician Advocates will work primarily with the practice manager to assist with reducing administrative burden, but will be available to anyone in the office who needs assistance or training.

United is working to earn and sustain a trusted clinical and business relationship with physicians and their staffs to facilitate optimal health status for our members. Through this relationship we can help with:

- Resolution of outstanding claims issues
- Train staff to utilize United's on-line tools to streamline administrative tasks
- Educating new providers on billing and reimbursement practices
- Conduct periodic training programs

Our goal is to build relationships and drive simplicity in our interactions with physician offices. We ultimately want to be the easiest health care organization to deal with and be sensitive to the financial aspects of a medical practice – promoting timely, accurate and fair payment.

UnitedHealthcare understands the administrative burdens on a physician's practice and is constantly implementing new methods of increasing efficiency and quality. Our Provider Advocates are available to physician offices to help them best utilize our changes and improvements.

UnitedHealthcare is currently piloting this program in several markets including Cincinnati and Rhode Island. Both markets have demonstrated good strides in building better relationships. Our local Provider Advocates proactively visit with physician offices to help them resolve any issues and to help them learn about the technology and tools that can make their office administration more efficient.

For example, in northern Ohio, only a small percentage of physician offices submit claims online. On line claims submission utilizing the provider portal at:

<https://www.unitedhealthcareonline.com>

eliminates hassle, is more efficient and speeds reimbursement. The Provider Advocate can demonstrate this website in the office and immediately increase office productivity.

The northern Ohio market has also been making strides in converting facilities and physicians groups to Electronic Payment and Statements (EPS). Over the month of August there was a strong push in a "GO GREEN" marketing campaign resulting in six new facilities and several physician offices starting to utilize the electronic payment system for the first time.

We are committed to continuously visiting physicians' offices to help them better utilize the tools we offer as well as our policies and procedures. Our goal is to build personal relationships with our physicians and network providers, and make interactions with UnitedHealthcare smoother and more efficient.

A similar program, the Specialized Oncology Service Team, implemented a similar program earlier this year and provider satisfaction has improved from 64.88 % to 92.60%.

UnitedHealthCare Begins Review Cycle for the UnitedHealth Premium Designation Program.

UHC has sent out an introductory letter to practice administrators regarding the process for the new UHC Premium Designation Program assessment period. The assessment reports for the next designation cycles are based on refreshed paid claims data and was sent to physicians in October 2008. Comprehensive information about the program is available on UnitedHealthcare's physician web site located at www.UnitedHealthcareonline.com. Materials available at this web site are the UnitedHealth Premium detailed methodology which provides a complete description of the 2008 program methodology, the UHC Premium reconsideration process, commonly asked questions, and the UHC principles for transparency-consumer disclosure.

Physicians are encouraged to access this information in order to prepare for the review of their individual data when the reports are issued in October. UnitedHealthcare will notify physicians of their individual designation status at least 45 days prior to any public disclosure of the results to give physicians the opportunity to seek clarification and, if necessary, to request reconsideration.

From October 8th through December 1st UHC will take input from physicians on their data and recalculate scores if necessary and based on new information. Physicians are provided with passwords to the UHC site to review their designation status and their ratings. There have been some changes to the program – for example the sample size was increased – a minimum of 30 rules among 5 patients are needed to be evaluated for quality. In addition, there is now a wider set of rules applied to certain specialties.

New designations will be available on UHC's consumer web site by the end of 2008. UHC Premium program advisors are available to answer questions toll-free at 866-270-5588 or via email at unitedpremium@uhc.com

ANTHEM

Anthem Claims Processing Issue

The AMCNO has received contacts from our members that have been experiencing problems with claims payments from Anthem. While we realize that Anthem has been working to address problems within physician practices, we are also aware that problems persist. If your practice is experiencing problems with reimbursements from Anthem please contact the AMCNO offices at 216-520-1000, ext. 102 in order to obtain additional information on how to submit a complaint to the AMCNO.

Anthem begins move to standardized ID cards

During the fall months, Anthem BC/BS began the transition to a new standardized format for member ID cards. The national BC/BS association has mandated the adoption of these standardized ID cards beginning January 2009. The plan is to provide for a uniform format on the ID cards on a national basis.

BUREAU OF WORKERS' COMPENSATION

AMCNO Offers Workers' Compensation Group Rating Plan for Members

As a member benefit, The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) offers a Workers' Compensation group-rating plan to our members that can help save money on premiums. The majority of our participants are able to save a large percentage on their Workers' Compensation premiums. This savings is made possible through our partnership with CompManagement, Inc. (CMI), a Sedgwick CMS Company, our third-party administrator, and alliance with the North American Employers Council. CMI was founded in 1984 to provide employers with professional and personalized cost control services in the areas of workers' compensation and unemployment compensation, and has grown to providing administrative service to over 21,000 employers in Ohio. By grouping several companies together, CMI can offer a **group-rating discount**. Even if an organization already pays a *small* premium, they may qualify for a CMI group program to get *an even lower* rate. In a letter sent earlier this year, AMCNO informed its members that CMI has begun the review process for **2009** group participation, which means that your practice can find out just how much you can save. Whether you are currently in another group or did not qualify in the past, we strongly urge you to participate in the AMCNO group-rating review.

Though this is a *no-cost, no-obligation, no risk* review, should you decide to take advantage of the significant savings, *all of the physicians in your group* will need to become members of AMCNO. Bear in mind, however, that if you are currently enrolled in a group plan with another medical association in a state other than the AMCNO plan, **you are probably paying higher dues**. AMCNO's dues are *substantially* less per member *and* we provide discounts for groups with over 10 members. This enables our physician members to take advantage of the Workers' Compensation group-rating program along with other AMCNO benefits and services. To find out more about the plan or AMCNO membership dues, please contact Linda Hale at AMCNO, 216-520-1000, ext. 100.

NEWS YOU CAN USE

FTC "Red Flag" Rules Delayed until Next Year

The Federal Trade Commission (FTC) has announced that it would delay enforcement of its "red flag" rules until May 1, 2009, six months after the original compliance date of Nov. 1. The rules require creditors—broadly interpreted by FTC staff to include physicians who accept deferred payment—to establish programs that can detect, prevent and mitigate medical identity theft. To view the FTC announcement go to: <http://www.ftc.gov/opa/2008/10/redflags.shtm>

The announcement states that the FTC will suspend enforcement of the new "Red Flags Rule" until May 1, 2009, to give creditors and financial institutions additional time in which to develop and implement written identity theft prevention programs. The Red Flags Rule was developed pursuant to the Fair and Accurate Credit Transactions (FACT) Act of 2003. Under the Rule, financial institutions and creditors with covered accounts must have identity theft prevention programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The Rule applies to creditors and financial institutions. Federal law defines a creditor to be: any entity that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who is involved in the decision to extend, renew, or continue credit. The regulations are somewhat vague on the issue, but it would appear that the FTC has informally interpreted the rules to

include health care providers, including physicians in all practice settings. The FTC is basing this interpretation on the term “creditor” stating that a physician is a “creditor” if the patient is billed after services are rendered, instead of demanding payment in full beforehand. It would also apply if the physician bills the patient’s insurance first, but holds the patient ultimately responsible for any non-covered amount. The AMCNO will continue to follow how this rule develops and report back to our membership if there is a need for physicians to comply with this rule.

The Ohio Department of Insurance (ODI) Launches New Web Site

The ODI has been working for several months with staff from professional organizations, inclusive of the AMCNO, to garner input concerning the materials included on the ODI web site. The ODI was asking for input on the web site with regard to the ease in which a user could lookup information, what are the most frequently searched items, and was the website easy to navigate. Based upon input from various sources, and with changes made to the site to conform with other Ohio government web sites the site is now easier to navigate and provides clear information on how to file a prompt pay complaint, where to look for Ohio Revised Codes and statutes pertaining to insurance issues, information on medical malpractice closed claim data, as well as detailed consumer information.

According to the ODI, there are plans to add other items to the web site in the future such as additional consumer information outlining how consumers can file health insurance company inquiries and complaints. The ODI is also considering feedback from stakeholders groups with regard to the ODI prompt pay and independent review process to consider changes to the ODI web site that would provide specific health insurance company information with regard to complaints filed, the types of complaints filed and the geographic location where complaints are filed. ODI plans to reconvene the stakeholder groups which include the AMCNO to further discuss these issues. To view the web site go to www.ohioinsurance.gov

AMCNO Spearheads Legislation to Address Physician Ranking in Ohio

After several months of working with the AMCNO leadership and lobbyists, legislators in both the Ohio House and Ohio Senate have introduced SB 355 and HB 622. The purpose of this legislation is to provide patients with accurate information when selecting a physician. This legislation would prevent health insurance companies from ranking physicians solely based on specific criteria to persuade a consumer to choose one physician over another. The designations would be made based on cost efficiency, quality of care or clinical experience. This legislation will establish standards for the physician designations. It stresses that health plans must use risk-adjusted data, base grades, and ratings at least in part on nationally recognized quality of care measures. The legislation also allows physicians the right to review and appeal their ratings prior to the ratings being released to the public.

The issue of physician ranking has been hotly debated for several years. The crux of the debate is balancing the rights of physicians to have accurate and relevant reporting of their practice with the desire of health insurers and consumers to have access to information about their treating physician.

In 2007, the New York Attorney General became active on the issue of insurance company doctor ranking programs. In 2007, New York State Attorney General Andrew Cuomo reached agreements with insurance companies operating in New York to provide members with more information on how companies rank physicians. Cuomo said the deal could set a national standard for physician ranking systems. Cuomo warned insurance companies that their physician ranking programs likely would confuse or mislead members because of problems with the information used to rank physicians. Under the agreements, the plans will divide their 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. The agreements also require that the plans report to the NY Attorney General every six months and use an outside monitor.

The AMCNO along with other medical groups including the American Medical Association have expressed concern 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. It is 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 their data.

The legislation stresses that health plans must use risk-adjusted data, and base grades and ratings at least in part on nationally recognized quality of care measures and not on cost alone. The legislation also provides physicians with the right to review and appeal their ratings. Although the legislation will more than likely not pass in this General Assembly, the AMCNO plans to reintroduce the legislation in 2009.

How to File a Prompt Payment Complaint with the Ohio Department of Insurance

By: Mary Jo Hudson, Director, ODI

Medical providers dissatisfied with the time it takes to be reimbursed or due to improper reimbursements made by an insurance company can lodge a complaint with the Ohio Department of Insurance. Since its launch in 2003, the Department's Ohio Complaint Handling and Monitoring Program – called OCHAMP – offers providers a secure, web-based appeal process to resolve prompt payment disputes in a timely fashion.

The system – the first of its kind to be implemented in the country – has fielded a total of 10,160 complaints since its inception. There were 2,174 provider prompt payment complaints last year. The majority of the complaints have been about slow reimbursement and denied or partially paid claims. Self-funded entities, Medicare and federal employee benefits plans, all are outside the scope of Ohio's prompt payment law due to federal preemption.

To access OCHAMP, providers need to visit the Department's web site at www.ohioinsurance.gov and click the "File a Complaint with ODI" link, located under the "Quick Links" section of the home page. Next, click the "Provider Complaint Information Page" to submit a complaint and to review information on the prompt payment law, frequently asked questions, and other information especially tailored to providers. A hard copy complaint form can also be obtained in this area to be mailed or faxed to the Department. Providers should note that they are to first follow all contract grievances and appeal procedures with an insurer before filing a complaint with the Department.

After these steps are completed, OCHAMP electronically forwards the complaint to the insurer for a response. The insurer will be directed to resolve the complaint directly with the provider and notify the Department and the provider of the resolution of the complaint. Meetings were recently held at the Department with providers, insurers and businesses to ensure that the Department is effectively addressing needs of stakeholders involved in this process. The discussions were informative, productive and insightful. The Department is currently reviewing the prompt payment complaint processes and procedures in light of the feedback provided.

A sampling of the topics discussed were: different ways to file a complaint and collect and share prompt payment complaint data, retaliation issues, and the Department's enforcement authority of prompt payment violations. For a complete summary of the topics discussed and responses provided by the Department, please visit the "Prompt Pay-IRO Meetings" link, located in the "Quick Links" section on the Department's web site.

How to Navigate OCHAMP:

1. OCHAMP can be accessed by visiting the Department's web site at www.ohioinsurance.gov.
2. Click the "File a Complaint with ODI" link in the "Quick Links" area, located at the bottom right of the home page.
3. Click the "Provider Complaint Information Page" link. The prompt payment web page can be accessed directly at www.ohioinsurance.gov/Company/insprmp5.htm.
4. Next, click the "Prompt Payment Complaint Form" link in the first paragraph. Select the option to "Fill this form out Online."
5. Scroll down, then either use your User ID and Password or if you are a new user, select Healthcare Provider in the "New Users" section.
6. You will receive the necessary log-in information via email. Use that information to log-in the "Registered Users" area.
7. Select the company you wish to file a complaint against from the selection list provided.
8. A one page form will appear and you need to populate all fields on the form within a 20-minute timeframe and submit.
9. You will receive a pop-up complaint number assigned automatically and a copy of the email that goes to the company notifying them of the complaint.
10. The company has 21-days to respond and you will be notified by email when a response has been provided. The email will include instructions on how to retrieve the response electronically.

To access detailed instructions for submitting complaints on OCHAMP please visit www.ohioinsurance.gov/Company/INS0505Instructions.pdf.

Anyone with prompt payment questions or providers who can only file a paper complaint can contact the Department's Tate Chaney at 614-644-3428 or Julie Phillips at 614-644-3411. Emails can be sent to PromptPayComplaints@ins.state.oh.us. Please fax hard copy complaints to 614-644-3327. The Department's mailing address is 50 W. Town St., Suite 300; Columbus, OH 43215.

HB 125's New Credentialing Provisions – Effective September 25

On September 25, 2008, the new credentialing provisions of HB 125 went into effect for health care providers in Ohio. Under the law, all physicians and other health care providers will be subject to only one credentialing process for insurance credentialing purposes. Therefore, all insurers must use the Council for Affordable Healthcare (CAQH) form developed for credentialing purposes. Insurers will not be allowed to add additional questions. Physicians will only have to fill out one credentialing form with CAQH and then provide access to insurers. The form can be accessed electronically through the Ohio Department of Insurance (ODI) web site at www.ohioinsurance.gov or directly through CAQH at www.caqh.org/credapp. Paper credentialing is also available.

The new law imposes time limits on insurers in their credentialing process, and if the time limits are not met the insurers will face penalties. A brief outline of the process is as follows:

- Physicians can submit their credentials to CAQH when requested by an insurer and do not need to wait until their employment has started.
- If there is a question or problem with the physician's credentials, the insurance company must notify the physician within 21 days from the date the credentials were submitted.
- The insurance company must either accept or deny the physician's credentials within 90 days.
- If the insurance company takes more than 90 days to credential a physician, the insurance company must either 1) pay the physician \$500/day for every day over 90 days, including weekends; or 2) reimburse the physician under the terms of the contract for any services provided after 90 days until the insurance company finishes the credentialing process. These penalties accrue whether or not the physician's credentials are accepted by the insurer. It is up to the insurer which penalty the insurer will pay.

This new insurer credentialing process does not apply to hospitals that credential physicians so physicians must continue to work directly with any hospital when asked for credential information. In addition, for Medicaid managed care programs the credentialing time lines do not begin to run until the National Provider Identification Number (NPI) is submitted along with the credentialing form.

AMCNO Seminars

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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

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