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

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In this issue –

Medicare

CIGNA Begins Transition to Medicare Carrier for Part A and Part B in Ohio

The Centers for Medicare and Medicaid Services (CMS) has officially announced the selection of CIGNA Government Services as the new Medicare Administrative Contractor (MAC) for Part A and Part B in Jurisdiction 15, which includes Ohio. CIGNA has stated that they have begun the implementation process in transitioning to become the Medicare Carrier for Part A and Part B in Ohio. Palmetto GBA currently administers Medicare payments in Jurisdiction 15. The transition from Palmetto GBA to CIGNA is expected to take the majority of 2011. CIGNA has developed a transition and implementation website to aid in this process. You may view the website by going to http://www.cignagovernmentservices.com/J15/

As the A/B MAC for Jurisdiction 15, CIGNA Government Services will perform a wide array of administrative services including claims processing, customer service, and provider education associated with Part A and Part B of the Medicare program. CIGNA has advised that physicians and their office staff may wish to reference the CMS MLN Matters article SE1017, "Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC." To view this article go to http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf

Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. CIGNA Government Services plans to communicate with the J15 provider community throughout the implementation process and will post timely implementation news and information on the website mentioned above. The AMCNO will also keep you informed as further information becomes available on the transition.

Jurisdiction 15 News from CIGNA Government Services

In November 2010, CIGNA Government Services (CGS) was awarded the contract for the Jurisdiction 15, A/B Medicare Administrative Contractor (J15 A/B MAC). At this time, the J15 MAC is not operational. CIGNA Government Services has recently begun to receive several requests for items such as provider address changes from J15 customers. We are unable to accommodate such requests until we are operational and officially assume the J15 workload. These types of misdirected requests will cause unnecessary delays in processing. All provider requests and inquiries must continue to be

directed to your current Medicare contractor for assistance at this time. CIGNA Government Services will notify our J15 providers via ListServ and Website messaging when you may begin to direct these requests to us.

Providers are strongly encouraged to continue to monitor the CGS J15 Webpage at: www.cignagovernmentservices.com/J15 for additional news and information as it becomes available.

One-year Medicare Payment Cut Reprieve

As you are probably already aware, Congress passed H.R. 4994, the "Medicare and Medicaid Extenders Act of 2010," which will stabilize Medicare physician payments at current rates for 12 months—through the end of 2011—and stop the 25 percent cut that was originally scheduled to take effect on Jan. 1. In addition to providing a 12-month reprieve from the Medicare physician payment cuts being produced by the sustainable growth rate (SGR) formula, the bill extends a number of other payment policies through 2011 that were originally set to expire at the end of this year, including:

- The "floor" on geographic adjustments made for the physician work component of the Medicare payment schedule.
- The 5 percent payment increase for certain Medicare mental health services.
- An exceptions process for the cap on Medicare outpatient therapy services.
- Payments for the technical component for certain pathology services.

The AMCNO continues to inform Congress that it is time to permanently replace the Sustainable Growth Rate (SGR) formula once and for all. The AMCNO will continue to ask Congress to take action on this issue before there is a need for yet another stopgap measure.

The Centers for Medicare and Medicaid Services (CMS) Introduces New Center for Innovation

The Centers for Medicare & Medicaid Services (CMS) has established the new Center for Medicare and Medicaid Innovation (Innovation Center). Created by the Affordable Care Act, the Innovation Center will examine new ways of delivering health care and paying health care providers that can save money for Medicare and Medicaid while improving the quality of care. CMS also announced the launch of new demonstration projects that will support efforts to better coordinate care and improve health outcomes for patients.

The Innovation Center will consult stakeholders across the health care sector including hospitals, doctors, consumers, payers, states, employers, advocates, relevant federal agencies and others to obtain direct input on its operations and to build partnerships with those that are interested in its work. The organization will also test models that include establishing an “open innovation community” that serves as an information clearinghouse of best practices in health care innovation. The Center will also work with stakeholders to create learning communities that help other providers rapidly implement these new care models.

CMS Announces New Initiatives to Strengthen Primary Care - New initiatives will test “health home” and “medical home” concepts:

Eight states have been selected to participate in a demonstration project to evaluate the effectiveness of doctors and other health professionals across the care system working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans. Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in the Multi-Payer Advanced Primary Care Practice Demonstration that will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries.

The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration will test the effectiveness of doctors and other health professionals working in teams to treat low-income patients at community health centers. The demonstration will be conducted by the Innovation Center in up to 500 FQHCs and provide patient-centered, coordinated care to up to 195,000 people with Medicare.

A new State plan option under which patients enrolled in Medicaid with at least two chronic conditions can designate a provider as a "health home" that would help coordinate treatments for the patient. States that implement this option will receive enhanced financial resources from the Federal government to support "health homes" in their Medicaid programs.

The Innovation Center also announced an upcoming opportunity for States to apply for contracts to support development of new models aimed at improving care quality, care coordination, cost-effectiveness, and overall experience of beneficiaries who are eligible for both Medicare and Medicaid, also known as "dual eligibles." The Innovation Center expects to award up to $1 million in design contracts to as many as 15 state programs for this work. More information on the CMMI and these initiatives is available at: http://www.innovations.cms.gov/

Changes Coming to Medicare Medical Equipment Program; What You Need to Know

Medicare patients who use durable medical equipment, prosthetics, orthotics or supplies (DMEPOS) items will soon see changes due to a new program that requires these items to be furnished by a Medicare contract supplier. Health care providers play a key role in helping their patients understand how they will be affected by this change and what they need to do in order to continue to receive the high-quality equipment and supplies they need. Starting Jan. 1, 2011, if your patients with Original Medicare live in Cleveland-Elyria or Mentor and they need to obtain any of the equipment or supplies included in the program (listed below), they will almost always have to use Medicare contract suppliers for Medicare to help pay for the item.

The products and equipment included in the program are:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only)
- Mail-order diabetic supplies
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (Group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach only)

If your patients currently rent oxygen or certain other items such as Continuous Positive Airway Pressure (CPAP) machines, they may be able to continue renting these items from their current supplier when the program takes effect, if the supplier decides to participate in the program as a "grandfathered" supplier.

Medicare has resources to help your patients understand the new program, including 1-800-MEDICARE and www.medicare.gov. Consumers can also call their local State Health Insurance Assistance Program (SHIP) for free health insurance counseling and personalized help understanding the program. If your patient is in a Medicare Advantage Plan (like an HMO or PPO), their plan will notify them if their supplier is changing. They should contact their plan for more information.

Consult the list of contract suppliers on www.medicare.gov (or request a list through 1-800-MEDICARE) to determine whether their current supplier has been approved as a Medicare contract supplier for their area and may continue to supply the equipment and services they need with Medicare coverage. If their current supplier is a contract supplier for their equipment, they don't need to do anything.

Auto Denial of Claims Submitted With a GZ HCPCS Modifier

Medicare contractors that process both institutional and professional claims have discretion to automatically deny claims billed with the GZ HCPCS modifier. The GZ HCPCS modifier indicates that an Advance Beneficiary Notice (ABN) was

not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Medicare contractors will automatically deny claim line(s) items submitted with a GZ HCPCS modifier, effective for dates of service on or after July 1, 2011.http://www.palmettogba.com/palmetto/providers.nsf/ls/OWV~8DVPE58261?opendocument

CMS Expands Healthcare Provider Directory

The Centers for Medicare & Medicaid Services has enhanced the Physician Directory tool at www.Medicare.gov with new information about physicians and other healthcare workers in their communities and the services those professionals provide. The new feature, called Physician Compare, expands and updates CMS's Healthcare Provider Directory, which has helped millions of beneficiaries find Medicare-participating doctors online for over a decade. The new tool expands the doctor-specific information into the suite of informational tools for Medicare beneficiaries and other consumers.

The new site, at www.Medicare.gov/find-a-doctor, which was required by the Affordable Care Act of 2010, contains information about physicians enrolled in the Medicare program, which include Doctors of Medicine, Osteopathy, Optometry, Podiatric Medicine, and Chiropractic Medicine. The site also contains information about other types of health professionals who routinely care for Medicare beneficiaries, including nurse practitioners, clinical psychologists, registered dietitians, physical therapists, physician assistants, and occupational therapists.

The Physician Compare website is designed to be consumer-friendly and help all patients – whether on Medicare or not – locate health professionals in their communities. The information on the site includes contact and address information for offices, the professional's medical specialty, where the professional completed his or her degree as well as residency or other clinical training, whether the professional speaks a foreign language, and the professional's gender. The tool can also help Medicare beneficiaries identify which physicians participate in the Medicare program.

In addition to information about the physician's practice, Physician Compare also shows consumers whether the practice reported certain data to CMS through the Physician Quality Reporting System, formerly known as the Physician Quality Reporting Initiative (PQRI). Currently, the PQRI reporting system is a voluntary reporting program that rewards physicians and other eligible healthcare professionals for reporting data on quality measures related to services furnished to Medicare beneficiaries. These quality measures are based on the best available medical evidence and designed to help professionals improve care for patients. In 2009, more than 200,000 professionals reported data to CMS through the Physician Quality Reporting System. Later in 2011, CMS plans a second phase of the website which will indicate whether professionals chose to participate in a voluntary effort with the Agency to encourage doctors to prescribe medicines electronically, rather than through traditional paper-based prescription methods.

To learn more about the quality information CMS already collects through Medicare's Physician Quality Reporting System, visit http://www.cms.gov/pqri. To visit the Physician Compare website, visit www.Medicare.gov/find-a-doctor or click on the "Compare" tab at www.Healthcare.gov.

Medicare Fee Schedule Now Available

Palmetto GBA, the Medicare Carrier for Part A and Part B in Ohio, has released an updated Medicare Part B fee schedule for 2011. This fee schedule is available at http://www.palmettogba.com/boh/fees

AMCNO members will also recall from previous notices that the CMS has officially announced the selection of CIGNA Government Services as the new Medicare Administrative Contractor (MAC) for Part A and Part B in Jurisdiction 15, which includes Ohio. The AMCNO has received an official notification from CIGNA that they have begun the transition process. Physicians can review information regarding the transition on their web site at http://www.cignagovernmentservices.com/J15/

News from Other Third Party Payors

Ohio Medicaid Delays Implementation of MITS

Ohio Medicaid has delayed the implementation of its newly developed Medical Information Technology System (MITS) for claims processing, provider enrollment, and prior authorizations. The new system was scheduled to go live on December 7th 2010; however, due to issues with the implementation process, Ohio Medicaid delayed the go live date to a time yet to be determined. Although there is a delay in implementation it is still important for you and your staff to sign up to use the MITS system in order to become familiar with the new format and functionality of the system to avoid any disruptions in Medicaid reimbursement down the line.

UnitedHealthCare Discloses Premium Designation Results for 2011

UnitedHealthcare (UHC) recently sent out letters to network physicians in eligible specialties providing the physician's UHC Premium Designation assessment results for 2011. Network physicians can earn up to two stars by qualifying for Premium Designation in quality and efficiency. The stars are then displayed in UHC's physician directory. If you are a UHC network physician, be sure to read the Premium Designation letter completely. AMCNO was advised at a recent UHC Physician Advisory Committee meeting that the Premium Designation program has been changed this year and physicians may find that while they had qualified in both categories last year, they may not this year due to the change in the program.

So if you are a UHC network physician, be sure to read the Premium Designation letter completely. And if you did not qualify for Premium Designation, in either category, you can request consideration after review of your data.

To review your data use the Tax Identification Number (TIN) and a personal identification number (PIN) that was included in your letter from UHC to log into the Premium section of www.UnitedHealthcareOnline.com. Once you are logged-in, you can review your practice data and the scoring methodology that was used for your assessment. If you find discrepancies and you can provide specific reasons why an expected diagnosis or procedure was not included with a particular patient – request reconsideration.

To request reconsideration you can utilize the UHC online reconsideration tool. Additional information regarding the reconsideration process is available on UHC's Premium website. You must be logged into the website to view this information. If you requested reconsideration before Feb. 15, 2011, your reconsidered results will be displayed on UHC's physician directory for 2011. To contact UHC about the program call (866) 270-5599 or contact them through their web site at:
https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=2deff1ab39f24210VgnVCM100000b640dd0a____%20

If you have questions about the UHC Premium Designation program go to:
https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium%20Methodology/UnitedHealth_Premium_Frequently_Asked_Questions.pdf

BWC Welcomes Administrator/CEO Steve Buehrer

Steve Buehrer was sworn in January 10 as BWC Administrator/CEO. During a brief ceremony at BWC's William Green Building in Columbus, he vowed to an audience of staff, business leaders, labor representatives and representatives of

Ohio's workers' compensation system that their input will be expected and important in making workers' compensation a compliment to Ohio's overall business climate.

A native of Delta in northwest Ohio, Administrator Buehrer has been a practicing attorney and most recently represented Ohio's 1st Senate District, a seat he held since 2007. There, he served as chairman of the Insurance, Commerce and Labor Committee, focusing on key issues that impact Ohio's economy, including business regulations, consumer protection and workers' compensation law. Buehrer previously served four terms beginning in 1999 as the state representative for the 82nd Ohio House District. He has extensive experience in state government including work in the offices of the late Congressman Paul Gillmor, and former Ohio House Speaker Jo Ann Davidson. He also served as Director of Legislative Affairs for the Ohio Bureau of Employment Services; Deputy Director with the Ohio Department of Administrative Services; and was BWC's Chief of Human Resources from 1995 to 1998.

Anthem – Facility Owned Clinic Charges

Effective June 1, 2011, when a physician or other professional provider delivers care to a covered individual through Anthem for a service covered by the member's health plan, and the care is given in a clinic owned, operated or controlled by a facility, providers will not be reimbursed for any technical component or overhead connected to the service (e.g., including but not limited to UB-04 revenue codes 510-529 or any successor codes). Instead, the facility should seek reimbursement from the physician or other professional provider who delivered the service. For more information, refer to the Anthem Clinic Charges Facility Reimbursement Policy, available online via their secure provider portal at MyAnthem.com.

How to Access MyAnthem:

Not registered yet? Sign on to www.anthem.com, select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. Complete the registration form and your ID and Password will be mailed to you within two weeks. If you are unable to complete the registration form online because the provider's tax ID is already registered, you will need to send your request to central.eprovider.rep@anthem.com

Ohio Health Information Partnership (OHIP)

Ohio has received funding to provide 6,000 primary care physicians and health care professionals with assistance in implementing or upgrading their health information systems. Plus, doctors can qualify for financial incentives through Medicare and Medicaid. Seven regional extension centers throughout the state are currently signing up primary care providers who would like assistance in implementing electronic health records under the guidance of OHIP. OHIP has already signed up over 3,000 primary care physicians into the program; therefore, physicians interested in utilizing the OHIP services should consider contacting OHIP or the Case REC in the near future.

The AMCNO has physician and staff representation on OHIP committees and we are integrally involved with these discussions at the state level as well as at the regional level. OHIP is a nonprofit, state-designated entity responsible for establishing regional extension centers to assist physicians and hospitals with information technology and for creating the infrastructure for a health information exchange in the state. To find out more about OHIP and regional extension centers, go to: www.ohiponline.org.

The Ohio Health Information Partnership (OHIP) Announces Low Interest Loan Program

OHIP has announced that three Midwest banks are offering low-cost loans to physicians and other qualified healthcare professionals to cover the initial expense of using electronic health records (EHRs). Huntington Bank and Fifth Third Bank in Ohio, and U.S. Bank in Minnesota, will offer loans to physicians for the upfront money needed to create the technology infrastructure in their practices at an affordable rate. In turn, these physicians will be able to take advantage of federal stimulus money and receive incentives to repay those loans, once they follow federal guidelines in their use of these health records. Eventually, doctors and health care professionals will become part of a statewide, electronic health information exchange.

OHIP representatives have noted that it has been proven over and over again that when physicians and hospitals move from paper records to electronic ones, they improve the quality of diagnosis and care, can better coordinate medication use, and reduce duplicative or unnecessary services. Ohio has received funding to provide 6,000 primary care physicians and health care professionals with assistance in implementing or upgrading their health information systems. Plus, doctors can qualify for financial incentives through Medicare and Medicaid of up to $44,000 over the next several years.

While some physicians and hospitals already have their own EHR systems, they do not have the ability to "talk" to other physicians and hospitals outside that system and may need upgrades that follow new national standards. As the state-designated nonprofit handling both the implementation of EHRs and the creation of a health information exchange, OHIP's goal is to enable the secure, real time sharing of patient information across the state. OHIP established seven regional extension centers throughout the state. About 500 physicians have signed up with these partners and are receiving free services, such as an assessment of technology needs, staff training, selection of a vendor, and implementation of the EHR within the practice or hospital, and how to use health records in a meaningful way, so they can draw down Medicare or Medicaid incentives. Five preferred OHIP vendors offer affordable pricing, including Allscripts, eClinicalWorks, e-MDs, NextGen and Sage. To find out more about OHIP, go to: www.ohiponline.org For loan information, go to http://ohiponline.org/Pages/LoanProgram.aspx

Registration for the EHR Incentive Program Now Available

All eligible professionals, hospitals and critical access hospitals must register to participate in the electronic health record (EHR) incentive program. Registration for the Medicare program began at the beginning of January 2011. The Medicaid EHR incentive programs can also begin in 2011, but the actual start dates vary by state.

In order to register, physicians will need to have enrollment records in the appropriate systems, including:

National Provider Identifier (NPI)

- All EPs must have an NPI in order to participate in the Medicare and Medicaid EHR incentive programs.

National Plan and Provider Enumeration System (NPPES)

- Most providers will need an active user account with the National Plan and Provider Enumeration System (NPPES.)

Provider Enrollment, Chain and Ownership System (PECOS)

- All eligible Medicare professionals must have an enrollment record in PECOS to participate in the EHR incentive programs. Eligible professionals who are only participating in the Medicaid EHR incentive program are not required to be enrolled in PECOS.

To obtain information from the Center for Medicare and Medicaid Services (CMS) on the registration and attestation process go to: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

The AMCNO is also working with the Ohio Health Information Partnership (OHIP) on EHR initiatives. OHIP has additional information available online regarding the registration process. To view this information go to: http://ohiponline.org/Pages/EHRIncentiveProgram.aspx

To begin the registration process go to: https://ehrincentives.cms.gov/hitech/login.action

Pharmacy Board Changes Prescription Copy Rule

On January 1, 2011 an Ohio Board of Pharmacy rule change will go into effect that will limit the transfer of a prescription from one pharmacy to another pharmacy for both a non-controlled substance and a controlled substance to one time. The change involves rule 4729-5-24, Ohio Administrative Code, titled Prescription Copy.

Previous to this rule change, federal and state laws and rules restricted the transfer of only controlled substances to one time. You should be aware that during the education phase patients and pharmacists may be calling you to obtain a new prescription when wanting to transfer a prescription more than one time. If you have any questions, please contact the Ohio Board of Pharmacy at (614) 466-4143.

Ohio Department of Health Revises HIV Testing Process Rule

The Ohio Department of Health recently updated rule 3701-3-11, Ohio Administrative Code (OAC), to address changes in state law regarding the HIV testing process in the State of Ohio. The rule changes went into effect October 31, 2010.

In summary, in Ohio, as of October 2010:

1. State law no longer requires a separate informed consent. Consent for HIV screening can be combined into one general consent form.

2. All individuals consenting to an HIV test must be offered the option of an anonymous test. *(To locate an anonymous testing site in your area, please call your local health department to be linked to a local testing site that offers anonymous testing.)*

3. A minor can consent to be given an HIV test.

4. Pre-test counseling is no longer required in Ohio. Post-test counseling is only required when an individual tests positive for HIV. During the post-test counseling session, the health care provider must include all terms outlined in section D, of the OAC 3701-3-11.

Although the Centers for Disease Control and Prevention (CDC) have issued guidelines for HIV testing in health care settings (http://www.cdc.gov/hiv/topics/testing/index.htm), CDC recommendations do not supersede Ohio law and regulations. If there is any incongruence between CDC's recommendations and Ohio law, State law must be followed.

For additional questions about HIV counseling, testing and referral, please call the Ohio HIV Prevention Program at the Ohio Department of Health at (614) 644-1838 or send an e-mail to HIVSTDPrevent@odh.ohio.gov.

A link to the Department of Health's revised rule is posted on the Medical Board's website: http://med.ohio.gov/pdf/Medical%20Provider%20Memo%20ODH%201210%20Final.pdf

AMCNO Legislative Update

Governor Kasich issued his first executive order by naming Lt. Governor Mary Taylor to spearhead a drive across all agencies to rid the state of regulations that are viewed as stifling job creation. He created a "Common Sense Initiative" (CSI) that Taylor will lead. The CSI will also study privatization of state services and operations and reduce red tape that can be an impediment to the business community in Ohio.

Gov. John Kasich named new directors to lead the Ohio Department of Health and the Office of Health Plans (Medicaid). They are Dr. Theodore (Ted) Wymyslo, who will become the Director of the Ohio Department of Health; and John McCarthy, who will become the Director of the Office of Ohio Health Plans (Medicaid).

In order to address the projected $8 to $10 billion budget shortfall, Governor Kasich created the Office of Health Transformation (OHT), which will devise a plan to restructure health and human service agencies. The new office's charge includes four tasks to be accomplished within its first six months, the biggest of which is to devise a permanent health and human services organizational structure. Mr. Greg Moody has been named to become the Director of the Governor's Office of Health Transformation. Tasks for the OHT include:

- Advocating the administration's modernization and cost-containment priorities for Medicaid in the forthcoming biennial budget
- Initiating and guiding planning for an insurance market exchange
- Engaging the private sector to set clear expectations for overall health system performance

Governor Kasich will also be exploring privatization of state operations and services in order to raise revenue, eliminate waste, and make services cost-efficient. Some potential options are:

- Privatizing some state prisons
- Selling the Ohio Department of Commerce Division of Liquor Control
- Selling or leasing the operations of the Ohio Lottery Commission
- Leasing the Ohio Turnpike

Below is a list of other legislation of note that was introduced recently:

- Prohibit state agencies from implementing or enforcing a provision of the federal Patient Protection and Affordable Care Act without meeting certain conditions (HB 11).
- Direct the Department of Job and Family Services to seek federal approval to create a Medicaid premium assistance component (HB 13).
- Authorize a $2,400 income tax withholding credit for employers that hire a previously unemployed individual (HB 17).

The AMCNO legislative staff is following the budget discussions closely and they are working with the AMCNO physician leadership to set up meetings with the newly appointed legislators and directors.

ICD-10 Straight Talk: Overview
By Angela "Annie" Boynton
BS, RHIT, CPC, CCS, CPC-H, CCS-P, CPC-H, CPC-P, CPC-I

As a result of a final rule published on January 15, 2009 by the Department of Health and Human Services (DHHS) under the Administration Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), all covered entities (including healthcare providers, health plans and healthcare clearinghouses) are required to comply with new code set regulations regarding the International Classification of Diseases, 10th Edition (ICD-10) for all covered electronic transactions for dates of service on and after October 1, 2013.

The new code set regulations address usage for the following:

- Clinical Modifications (ICD-10-CM) Diagnosis Code Set
- Procedure Coding System (ICD-10-PCS) Procedure Coding System.

ICD codes are used to classify diagnoses and inpatient procedures and are one of the fundamental elements of healthcare reimbursement. The conversion to the ICD-10 code sets represents a significant change to the coding structure and will

have impacts in a majority of business processes and systems as well as require significant training and updates to numerous medical policies and contracts. These changes will be felt across all types of health care providers, facilities and payers.

Diagnostic codes are used across inpatient and outpatient service settings to establish medical necessity, to trigger benefit/coverage determinations and to aide in many quality reporting initiatives. It is a gross misconception for outpatient providers and facilities to think that they will not have to deal with ICD-10 codes in the future.

Preparing for the single largest healthcare change the United States has ever seen is no small task. The longer ICD-10 implementation planning is put off, the harder it will be to comply by the mandate. It has been said over and over again by industry experts, but it is a message that bears repeating: those who wait until the last minute to prepare for ICD-10 are risking their revenue in 2013 and beyond. The risks are tangible, in the form of payment delays and rejected claims; the only way to mitigate these risks is to be fully compliant with ICD-10 by the October 1, 2013 mandate. It is an industry accepted fact that revenue will be impacted to some extent. It will take significant resources, time, and planning in order to adequately achieve compliance, and mitigate any revenue impacts.

There is much work to do in order to prepare for ICD-10: communications, budgeting, training, staffing, IT systems, vendor discussions, business associate issues, trading partner testing, and 5010 implementation are just a few of the areas of concern. Let's discuss a few things practices can do to get the ball rolling toward ICD-10 compliance.

Plan for the ICD-10 Transition:

Organize those responsible for ICD-10 implementation in your practice or facility; form an implementation leadership team. Clearly establish who is going to lead the overall implementation effort. Having a clear "chain of command" will help the implementation process.

There is great benefit in conducting an impact assessment, for a smaller organization it may be as simple as asking "how are ICD-9 codes used today?" Once these areas are identified, it will be easier to see where remediation efforts need to be focused. Having a plan and timeline on paper for the ICD-10 implementation team will help make the process move more smoothly.

Recognize the Documentation Impacts:

In many practices the biggest hurdle in the ICD-10 implementation process will be how to handle the vast new documentation requirements needed for accurate ICD-10 code selection and reimbursement. It is strongly recommended that documentation efforts begin as early as possible. This can be done by performing simple documentation audits comparing ICD-9 coding and documentation with its ICD-10 counterpart and taking note of the gaps.

In its entirety, the ICD-10 code set has just over 155,000 codes. That is significantly more than the 18,000+ codes we use in ICD-9. Much of the reasons for this great expansion are due to the fact that ICD-10 codes are incredibly specific and much more granular than anything we use today.

For example, compare the codes representing "complications of foreign body accidentally left in body following a procedure."

ICD-9 has <u>one code</u>:
998.4, Foreign body accidentally left during procedure, not elsewhere classified.

ICD-10-CM has <u>50 codes</u>, here are a few examples:
T81.530, <u>Perforation</u> due to foreign body accidentally left in body <u>following surgical operation</u>

T81.524, <u>Obstruction</u> due to foreign body accidentally left in body <u>following endoscopic examination</u>

T81.516, Adhesions due to foreign body accidentally left in body following aspiration, puncture or other catheterization

Note the specificity in the code descriptions as identified by the underlined terms. When comparing the codes in this manner, it is important to consider what the documentation will need to reflect in order for a coder to accurately select a code.

ICD-10 Training:

Training can easily be the largest part of any ICD-10 implementation budget. It is important that as early as possible a training plan is developed. A critical point of concern in accepting the fact that there is a significant difference between implementation training and code set training, and when to provide each type of training.

Implementation training is more commonly seen in larger group practices and organizations that have teams of people responsible for the ICD-10 transition and it is given early-on. Implementation training is offered by several industry organizations, like the AAPC (American Academy of Professional Coders), though implementation training is a good introduction to anyone interested in learning about the complexities involved with ICD-10 implementation.

Code set training provides detailed knowledge of the code sets. This is the training that coders will need in order to stay current with the ICD-10 transition. Since ICD-10 is formally divided into two separate and distinct code sets, identification of which code set (ICD-10-CM or ICD-10-PCS, or both) and the timing of the training will be critical in any implementation plan.

Training coders too soon could be a costly risk. In order for coders to be proficient, they must use a code set regularly in order to keep their skills. It is unwise to train coders too far out, less they forget, and ultimately require retraining. CMS recommends training coders 6-9 months ahead of the ICD-10 implementation date, and ensuring that coders have continual practice throughout 2013. This timeline will obviously vary given the specialty, setting, size of the organization, and the number of coders that require training. Planning and budgeting for a strategic training plan will help to mitigate productivity losses as a result of training. Furthermore, ICD-10 training is intensive. Do not underestimate the amount of time coders will likely need to become fully proficient in ICD-10, plan for 20 hours for outpatient coders learning the diagnostic set (ICD-10-CM) and 50 hours for inpatient coders learning both the diagnostic and procedure sets (ICD-10-CM/PCS).

Avoiding ICD-10 will not make it go away. It will make the process more costly, more difficult, more resource intensive, and more stressful. The only sure way to lessen the costs associated with ICD-10 implementation is to understand the impact that implementation will have on your organization. Even as I write this, I know there will be organizations that will go out of business because they waited too long to implement ICD-10. There will be revenue impacts across all settings, provider, facility, vendor and payer alike. Physicians, practices, and facilities that do not adequately prepare for ICD-10 risk not getting paid for the services they render. The best advice is to start implementation planning now, the longer it is put off the harder and more costly it will be.

Annie Boynton is a multi-credentialed coder and the Director 5010/ICD-10 Communication, Adoption and Training for UnitedHealth Group. She is an adjunct faculty member at Massachusetts Bay Community College and is a developing member of the AAPC's ICD-10 Training team. Annie frequently speaks and writes about coding matters, including ICD-10 and 5010 implementation.

The AMCNO has partnered with Tri-C to offer discounted practice management and coding classes to our members. For more information on these classes please see below.

Discounted Classes at Tri-C for AMCNO members

2011 Cuyahoga Community College Center for Health Industry Solutions

Take advantage of discounted classes for AMCNO Members and their staff.
Contact Linda Hale at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price**.**

Date/Time	Title	Fee		Location
Mar 1 – Mar 24 9 am – noon T & Th	**Fundamentals of Billing Reimbursement**	$283 ..call AMCNO for discount price	24 hrs	UTC
March 9th 8:30-12 noon	**Confident Communication with Providers about Coding Issues**	$159 ($139 AMCNO)	CEUs: 3.5	CCE
March 23rd 9 am-3:30 pm	**ICD 9-CM Fundamentals and More** **Strengthen your ICD-9 diagnostic coding skills**	$199 ($179 AMCNO)	CEUs: 6	CCE
April 6th 8 am-12:30 pm	**ICD-10 Preparation: Review of ICD-10 Structure + Anatomy, Physiology & Medical Terminology**	$135 ($120 AMCNO)	CEUs: 4.5	CCE
April 13th 9 am-3:30 pm	**CPT Coding Fundamentals and More**	$199 ($179 AMCNO)	CEUs: 6	CCE
May 4th 8:30 am – 12:30 pm	**Surgical Coding** **Optimize your reimbursement**	$169 ($149 AMCNO)	CEUs 3.5	CCE
May 11th 8:30 am – 12:30 pm	**Compliance Update & Chart Auditing Workshop**	$169 ($149 AMCNO)	CEUs 4	CCE

Course Locations: Corporate College East 4400 Richmond Rd, Warrensville Hts, OH 44128
Corporate College West 25425 Center Ridge, Westlake, OH 44145
Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 44115

Medical Records Fact Sheet Update Effective January 2011

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 §**3701.742** 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 2011, 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****:* $2.88 per page for the first ten pages; $0.60 per page for pages 11 through 50; $0.24 per page for pages 51 and higher
For data recorded other than on paper: $1.97 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 $17.70 records search fee is allowed;
b) ***For data recorded on paper*****:** $1.17 per page for the first ten pages; $0.60 per page for pages 11 through 50: $0.24 per page for pages 51 and higher
For data recorded other than on paper**:** $1.97 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.

The Academy of Medicine of Cleveland And Northern Ohio (AMCNO) Invites you to attend our 2011 Annual Meeting

Friday, May 6, 2011
Ritz-Carlton Cleveland, 1515 West Third Street
6 p.m. Reception • 7 p.m. Dinner
Black Tie Optional

Presentation of 50 Year Awardees

And

Academy of Medicine Education Foundation (AMEF)
Scholarships to medical students from
Case Western Reserve University School of Medicine
Cleveland Clinic Lerner College of Medicine
Northeastern Ohio University College of Medicine
Ohio University College of Osteopathic Medicine

AMCNO 2011 Honorees

C. Martin Harris, MD
John. H. Budd Distinguished Membership Award

Michael L. Nochomovitz, MD
Charles L. Hudson MD Distinguished Service Award

Marvin D. Shie, III, MD
Clinician of the Year Award

Mary Jo Hudson, Esq.
Special Recognition Award

Timothy F. Hagan
Honorary Membership Award

Amy S. Leopard, Esq.
AMCNO Presidential Citation Award

Call 216.520.1000 for reservation information.

Practice Management Matters

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
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.
Visit ***Practice Management*** at www.amcno.org
For a "Third Party Payor Review Form".

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.amcno.org

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