

# PRACTICE MANAGEMENT MATTERS

## Winter 2007

### NPI: The Time is NOW

*On May 23, 2007, less than 3 months away, the National Provider Identifier (NPI) will change the health care industry. Physicians and other health care professionals must begin using this unique, all numeric, 10-position identifier when requesting reimbursement for health care services. The transition to NPI directly affects claims processing and payments for providers and impacts electronic transactions and paper claim transactions. By acting now, your organization will be able to greet the transition to NPI feeling confident that you have tested their systems and will continue to operate with all the capability you have today.*

#### **Apply for NPIs today.**

*If your office has not already done so, contact the Centers for Medicare & Medicaid Services (CMS) today to apply for the physician's NPI(s) at <http://www.cms.hhs.gov/NationalProvIdentStand> or dial toll free at (800) 465-3203 to get started. Simply log onto the National Plan and Provider Enumeration System (NPPES) at*

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Update

*[www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov) and apply on line.*

*Providers who have not completed this step put themselves at risk of not being able to complete the full NPI transition with their health plans and electronic vendors - prompting disruptions in service and payments.*

#### **Conduct a complete inventory of practice management systems.**

*Health care professionals need to evaluate practice management systems' software in anticipation of the NPI changes. With only a few months until the NPI implementation, providers, health plans and electronic vendors need ample time to successfully incorporate changes.*

#### **Ensure all vendors (such as medical supply companies, third-party billing agencies, laboratory services) who impact providers' practice management systems are also working toward becoming NPI compliant.**

*If you haven't already, have conversations with your electronic vendors to ensure these vendors will be compliant with the NPI requirements by May 23, 2007. It is critical that you coordinate*

any upgrades to your systems with your software vendors. The vendors' noncompliance could seriously impact your operations and hamper your ability to transition to NPI.

**Work with health insurance payers, software vendors, & clearinghouses to conduct NPI testing in a simulated NPI environment to ensure anticipated results are received.**

The process is not complicated. The paper application is six pages long including detailed instructions, the actual application is three pages of information you probably have readily available.

**Important TIP:** When applying for the NPI, CMS urges you to include ALL of your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated state name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

**Get It. Share It. Use It.**

If you are a health care provider who bills for services, you probably need an NPI. If you bill

Medicare for services, you definitely need an NPI! Getting an NPI is easy. Getting an NPI is free. The first step is to get your NPI. Once you obtain your NPI, it is estimated that it will take 120 days to do the remaining work to use it. This includes working on your internal billing systems, coordinating with billing services, vendors, and clearinghouses, testing with payers. As outlined in the Federal Regulation, (The Health Insurance Portability and Accountability Act of 1996 (HIPAA)) you must also share your NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

For many, there are several critical tasks yet to complete before the federally mandated implementation date of May 23, 2007. **Will your office or facility be ready for NPI? The time to act is now. Please do not delay.**

## **The Academy of Medicine of Cleveland & Northern Ohio**

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131 telephone 216-520-1000 fax

### CBO Estimates Physician Payments to Decrease 10% in 2008

● Medicare physician reimbursements will decrease by 10% in 2008 under a tax, trade and health care law signed by President Bush Dec. 20, 2006, according to the Congressional Budget Office. The law includes a provision that will reverse a 5.1% reduction in Medicare physician reimbursements scheduled for 2007. Medicare physician reimbursements for 2007 will remain at the same level as for 2006. However, Medicare physician "payment rates will revert to the prior-law level in 2008," the CBO document states, adding, "Assuming that occurs, CBO estimates that payment rates for physician's services will be reduced by 10% in 2008." The law includes a "Physician Assistance Quality Initiative Fund," which places \$1.35 billion under the authority of the HHS secretary to help offset the cost of the decrease in Medicare physician reimbursements in 2008. The "funds will remain available until spent, but (the legislation) instructs the secretary to obligate those funds for physicians' services furnished during calendar year 2008 to the maximum extent feasible," according to the CBO document. CBO estimates that the HHS secretary will spend 90% of the fund in 2008 and 10% in 2009. The

law also includes a provision that will provide a 1.5% increase in Medicare reimbursements to physicians who agree to report data on certain quality-of-care measures.

### Remittance Advice Remark Code and Claim Adjustment Reason Code Update

● CR 5456 announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes>. CMS has also developed a new tool to help you search for a specific category of code and that tool is at

<http://www.cmsremarkcodes.info>. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

### 2007 Physician Quality Reporting Initiative

● The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Web page is now available. On December 20, 2006 the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative.

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary reporting program. Eligible professionals who report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services. For more information on 2007 PQRI, visit [http://www.cms-hhs.gov/PQRI/01\\_Overview.asp#TopOfPage](http://www.cms-hhs.gov/PQRI/01_Overview.asp#TopOfPage)

### Questions? Concerns?

● The Provider education staff at Palmetto GBA is committed to being a trusted resource for all your Medicare questions and/or concerns. Customer service representatives are available 8:30 a.m. to 4:30 p.m. Monday thru Friday to assist with more complex queries and can be reached by calling the Provider Contact Center at 1-877-567-9232. This differs from what is known as the Telephone Reopening Line, where reps are available 9 a.m. to 3 p.m. handling requests to reopen an initial claim to correct minor errors or omissions. And those looking for a claim/appeal status report can contact the Interactive Voice Response, or IVR, at 1-877-567-9232.

## Medicaid

● The Academy of Medicine of Cleveland & Northern Ohio was recently updated on contact information of staff involved with provider education and assistance from the Bureau of Managed Health Care, Office of Ohio Plans, of the ODJFS. Ms. Christi Pepe is the lead communication and support staff for providers involved in any way with the ABD transition to managed care. Forward your questions or requests for provider presentations to [pepem@odjfs.state.oh.us](mailto:pepem@odjfs.state.oh.us) or by phone at 614-466-4693. A Mr. Dan Hutson will continue to be the primary contact for provider

telephone requests and email inquiries at [bmhc@odjfs.state.oh.us](mailto:bmhc@odjfs.state.oh.us). If further information is needed, contact the MCP's directly at:

Anthem Blue Cross Blue Shield Partnership Plan, Inc.  
Buckeye Community Health Plan, Inc.  
CareSource  
WellCare of Ohio, Inc.

[www.anthem.com/home/html](http://www.anthem.com/home/html)  
[www.bchpohio.com](http://www.bchpohio.com)  
[www.caresource.com](http://www.caresource.com)  
[www.wellcare.com](http://www.wellcare.com)

866.464.9953  
866.246.4356  
800.993.0780  
800.951.7719

### Ohio Receives Federal Funding for Medicaid Project

● The Ohio Department of Job and Family Services Director Helen Jones-Kelley last month announced that Ohio is to receive \$100 million over five years from the federal government to enable about 2,200 seniors and persons with disabilities to be relocated from institutions to home and community-based settings. Ohio is one of 17 states to receive funding (the 3<sup>rd</sup> largest grant of any state) for the "Money Follows the Person" demonstration project enacted by Congress in 2005. The statewide project will indemnify and relocate Medicaid consumers who have lived for at least six months in nursing facilities, intermediate care facilities or hospitals. The federal government will pay a larger than normal share of costs for the first year after the person is relocated, and will also add some services that are not currently funded by Medicaid to help facilitate a successful transition from institution to community.

## Third Dart

### WellPoint Launches E-Prescription Pilot in Ohio

● Indianapolis-based WellPoint recently announced the launch of an electronic-prescription pilot program for physicians in its subsidiary, Anthem Blue Cross and Blue Shield of Ohio. The program will allow participating physicians to submit patient prescription electronically to pharmacies and provide information about the prescription, such as possible drug interactions, drugs with similar names and cheaper generic options. Physicians will be reimbursed \$750 for computer hardware and \$40 per month for the cost of the e-prescribing service. WellPoint said that other such programs have resulted in changes to 2% of prescriptions because of alerts about safety concerns. General Motors also provided funding for the test program.

### Anthem Answers Audit Questions

● The AMCNO managed care advocacy committee chairman and several physician leaders of the AMCNO recently met via conference call with the medical director of the Northern Ohio region for Anthem as well as the review company responsible for the audits. Anthem has stated that audits being conducted in our region are based solely on correct coding and supporting documentation and in no way questions the level of care provided by the physician. Anthem indicated this is being done to ensure the level of E/M code billed is supported by appropriate documentation. The Anthem audit process is not conducted directly by Anthem BC/BS; a paid contractor authorized by Anthem to perform the audits conducts the audits.

1. The audits are specific to level 4 and 5 E/M codes only.

2. Claims are obtained from throughout Ohio that contain level 4 and 5 codes and these are “data mined” and once all the codes are in hand then physicians are randomly selected from that pool - no physicians are “targeted.”
  3. Physicians that are audited are asked for 10 records and there is a detailed letter writing process utilized by the contractor when they are attempting to get a response from physicians targeted for an audit - resulting in a total of 75 days response time.
  4. The basis of the process is to determine the correctness of the coding and how well the physicians understand the coding process - it is intended to be an educational audit not a punitive one.
  5. Physicians involved in an audit may speak with personnel at HCS about the claims. Physicians may ask for a peer-to-peer conference and this will be provided if requested.
  6. Physicians and their staff are directed on where to locate educational materials from various sources (other than Anthem BC/BS) about how to code correctly.
  7. The Anthem BC/BS audit process will be expanded to include other physicians.
  8. Once a physician has been randomly audited, he/she will be eligible for an ongoing audit approximately every six (6) months if, and only if, his/her accuracy rate is determined to be less than 80%. Otherwise, a physician can expect to be part of the audit cycle every 18 - 24 months.
  9. Anthem BC/BS does not intend for this process to develop into a “compliance” program and they are not planning to use the data for network paring or a network management tool.
  10. HCS representatives believe that this process is in keeping with the Center for Medicare and Medicaid Services (CMS) audit process.
  11. There are no educational materials, discussion points outlining the audit process, or other background materials on this process available at this time through Anthem BC/BS publications, their web site or other media provided by the insurer
  12. The physician reviewer determines if there was a certain level of risk and during the peer-to-peer conference the physician can discuss this but the physician must prove the reason for the consideration of the risk level through documentation.
- a. **AMCNO Question:** *Why not provide background/criteria used by Anthem to enable physicians and their staff to respond to these audits?*
- Anthem’s Response:** Although Anthem currently provides key information outlining the background and criteria utilized in the audits, as documented in the overpayment notices and request for records notices, Anthem is also taking steps towards further enhancing all correspondence shared with physicians. Ideally, future correspondence will provide more information about the review program as well as a more detailed breakdown of the audit results. This information will be made available via written communication as well as electronically. Anthem also plans to provide on-going information through Rapid Update communications.
- b. **AMCNO Question:** *Why doesn’t Anthem BC/BS provide a series of written articles and web site updates outlining what Anthem perceives would achieve “correct” coding by physicians based upon the criteria you use for the audits and evaluations?*

**Anthem's Response:** As outlined in the current Overpayment Notice that is shared with all providers upon completion of the records review, the CMS 1995 and/or 1997 E & M guidelines, which ever is more favorable to the physician, are used when reviewing the documentation submitted by the physician in determining whether the documentation supports the code that was billed. The results provide a breakdown of each key component of the CMS E/M Guidelines and where documentation was insufficient. Anthem also plans to partner with Parses in providing additional educational resources and materials in the future via a series of free, web based video training modules to any Anthem physician that requests access. Rapid Updates are located on the Anthem web site at [www.anthem.com](http://www.anthem.com). Although Anthem did not include the HCS website in the standard written communications, Anthem and HCS/Parses did direct physicians to the HCS web site, [www.hc-cs.com](http://www.hc-cs.com), via customer service inquiries, face to face audit/appeal meetings and conference calls to further discuss audit results. The HCS web site provides several resources for coding education under their "LINKS" selection, including the link to the CMS 1995 and 1997 E/M Guidelines."

- c. **AMCNO Question:** *Is Anthem BC/BS performing the same level of audits on hospital and skilled nursing facilities or only targeting physician services - and why does Anthem only target the Level 4 and 5 codes?*

**Anthem's Response:** Anthem has a fiduciary responsibility to its members, employer groups, and the Blue Cross Blue Shield Association (BCBSA) to ensure correct coding and correct reimbursement across all specialty types and services. Anthem does not limit its audit scope to physician services only. Incorrect coding of evaluation and management services continues to be an on-going issue according to the Office of Inspector General (OIG) and CMS's Comprehensive Error Rate Testing (CERT) program. This program not only identifies and corrects services that have been over-coded, but also identifies and addresses services that have been under-coded based on the documentation provided by the physician.

- d. **AMCNO Question:** *Is it correct that, if requested, physicians can speak with a peer in the same specialty as part of the Anthem audit process and has this information been published to physicians in the Anthem network?*

**Anthem's Response:** A peer-to-peer conference is an additional service offered by Anthem, on a case-by-case basis, in an effort to provide a completely fair and objective assessment of the medical documentation provided by the physician. The vendor's medical director, on behalf of Anthem, conducts all peer-to-peer conferences unless otherwise specified. The medical director may or may not be of the same specialty. Before requesting a peer-to-peer conference, the results of the initial review must first be appealed and the normal appeals process followed. If the physician continues to disagree with the results of the appeal, a peer-to-peer conference may be requested. The physician's appeal rights and appeal instructions are outlined in the physician's results letter.

- e. **AMCNO Question:** *If the physician can prove or provide data that clearly shows why a certain risk level should be applied has this ever changed the outcome of an audit?*

**Anthem's Response:** Yes. It would be appropriate to provide this information either during the appeal process or the peer-to-peer conference, if it was not provided with the initial medical records. Anthem is committed to a fair and objective review of all data and documentation on a case-by-case basis and therefore does not solely rely on the premise of "if it isn't documented, it didn't happen".

f. **AMCNO Question:** Has Anthem considered providing data on the results of the process and the findings as a result of the audit process?

**Anthem's Response:** The result of each physician's audit is communicated to him/her upon completion of the initial review of medical records. A complete audit trail, which fully discloses the exact finding of the coding specialist, for each claim reviewed is also included with the results letter. Additionally, Anthem plans to communicate common findings amongst providers via the Rapid Update process on a regular basis in an effort to provide further education where appropriate.

The AMCNO requested Anthem BC/BS publish what they consider correct coding criteria and procedures as well as providing links to web sites and other materials and publications so that physicians and their office staff would have the tools and information needed to comply with Anthem programs.

#### BWC Unveils Updated E-Business Services Online for Medical Providers

Practice managers and physician office staffers may now access vital billing data and request worker's compensation information, forms, services with a click of the mouse—access the agencies' updated Web site at [www.ohiobwc.com](http://www.ohiobwc.com). From checking claim status and ordering publications to contact information for all parties to a claim, online users create a simple e-account with user ID to access all such information. You can also speak with a customer service representative in real-time through LiveSupport. Click on the link on the bottom left of every page on the site, between 7:30 a.m. and 5:30 p.m. M-F.

#### REVISED CMS-1500 CLAIM FORM

The CMS-1500 claim form has been revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the previous claim form.

- The form CMS-1500 (08-05) version was effective Jan. 1, 2007 but will not be mandated for use until April 2, 2007. During this time frame there will be a dual acceptability period of the prior and revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior CMS-1500 (12-90) is the split provider identifier fields.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
  - 17B (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - 24J (replacing item 24K, Form CMS-1500 (12-90));
  - 32a (replacing item 32, Form CMS-1500 (12-90));
  - 33a (replacing item 33, Form CMS-1500 (12-90));

Please note that ONLY providers that qualify for a "waiver" may submit paper claims to Palmetto GBA. The most common reason providers qualify for waivers is that they are considered small providers (10 or fewer full time equivalents (FTE)). All other providers must submit claims electronically to Medicare. This includes claims for which Medicare is the secondary payor.

**The practice benefits from submitting electronically! Electronic claims may be paid as soon as 13 days after the claims is submitted, while paper claims are not paid until at least 29 days after Palmetto GBA receives the claim.**

CLEVELAND & NORTHERN OHIO

## Medical Records Fact Sheet Update Effective January 2007

## 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 18<sup>th</sup> 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 2007, 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:** \$2.67 per page for the first ten pages; \$0.55 per page for pages 11 through 50; \$0.22 per page for pages 51 and higher  
**For data recorded other than on paper:** \$1.82 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 \$16.38 records search fee is allowed;
  - b) **For data recorded on paper:** \$1.08 per page for the first ten pages; \$0.55 per page for pages 11 through 50; \$0.22 per page for pages 51 and higher  
**For data recorded other than on paper:** \$1.82 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 first adjustment to be not later than January 31, 2007, 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 103.

## News You Can

### OSMB Unveils First Online License Application Form in U.S.

● *The State Medical Board of Ohio is the first Board in the country to employ the new on-line application process for medical and osteopathic physicians called the 'Common License Application*



Form' or 'CLAF.' The CLAF will benefit physicians by reducing redundancy in filling out multiple application forms when applying for licensure in multiple states. For an introduction, complete instructions and detail of the new application process, visit

<http://www.med.ohio.gov/pdf/Applications/mddoapp.pdf>.

**AMCNO to partner with CMS on PQRI Learning Opportunity**

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) in partnership with the Center for Medicare and Medicaid Services (CMS) is pleased to bring to you the opportunity to learn more about the CMS Physician Quality Reporting Initiative (PQRI.)

**When:** Wednesday, April 11, 2007, 12 noon  
**Topic:** Implementing the CMS Physician Quality Reporting Initiative: Capturing Clinical Quality to Gain Financial Reward.

**Presenter:** Dr. Susan Nedza, Office of Value Based Purchasing – Center for Medicare and Medicaid Services (CMS)

**Who should attend?** Physicians, office managers, hospital staff and insurance billers.

CMS will provide a call in number and materials that will be posted on the AMCNO web site. We will provide a call in number and materials that you can post on your website or push out through email. Watch your mail and physician member emails for more details – or call the AMCNO to sign up to receive more information at 216-520-1000, ext. 103.

**CUYAHOGA COMMUNITY COLLEGE’S CENTER FOR HEALTH INDUSTRY SOLUTIONS**

The AMCNO is proud to partner with Cuyahoga Community College in their practice management seminar and class offerings, with **significant discounts made available to AMCNO members and their staffs.** Below is a class list for Winter 2006.

Interested staff will need an exclusive AMCNO course number to register and obtain the discount. For course numbers, call Linda Hale of at 216-520-1000, ext. 101, or e-mail [lhale@amcnoma.org](mailto:lhale@amcnoma.org). For course information visit [www.corporatecollege.com](http://www.corporatecollege.com) Classes are offered at Corporate College East or West (CCE) (CCW) and the Unified Technology Center (UTC).

**Medical Terminology/Anatomy & Physiology**

CEU: 3 HRS: 30 CCE – TBD T Th  
 May 1 - Jun 7 6:00p - 8:30p \$216

CEU: 0.4 HRS: 4  
 CCE - TBD Tues  
 April 17 8:30a - 12:30p

**AAPC Professional Medical Coding Curriculum**

CEU: 8.1 HRS: 81  
 CCE - TBD T Th  
 Mar 20 - Jun 19 6:00p - 9:00p \$1650

**Compliance and Advanced Chart Auditing**

CEU: 0.4 HRS: 4  
 CCE - TBD Th  
 Apr 12 8:30a - 12:30p

**Certified Medical Coder (CMC) by PMI**

CEU: 2.8 HRS: 28  
 CCE - TBD W  
 Apr 11 - May 9 8:30a - 4:30p

**Urology Coding for the Physician's Practice**

CEU: 0.3 HRS: 3  
 CCE - TBD Tues  
 April 17 1:30p - 4:30p

**Practice Management  
 MATTERS**

*The Academy of Medicine of Cleveland & Northern Ohio can provide you information on topics from balance billing to managed care to terminating the physician/patient relationship. Whatever your question or concern, the Practice Management Department is available to address or investigate any issue left unresolved.*

*Call us at 216-520-1000 or email [concerns@amcnoma.org](mailto:concerns@amcnoma.org)*

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