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

SPRING EDITION 2010

In this issue – **AMCNO Medical Records Fact Sheet Revised Due to Ohio Department of Health Calculation Error**

It has come to the attention of the AMCNO that the 2010 Medical Record copying fees posted on the Ohio Department of Health (ODH) web site for 2010 were calculated incorrectly. The ODH has now posted the corrected fees on their web site, which resulted in higher fees per page and slight changes in other related medical record copying fees. Upon notification of this error the AMCNO immediately changed our 2010 Medical Records fact sheet on our web site and we have included a REVISED copy on the last page of this issue of Practice Management Matters. If you have any questions please call the AMCNO at 216-520-1000.

Medicare

Medicare Cuts Delayed Again – COBRA Subsidies Continued

Both the House and Senate have approved a package of short-term "extenders," which includes a freeze on the Medicare payment formula used to reimburse doctors and continues a financial reprieve for the unemployed who rely on COBRA health benefits. The House passed the $18 billion package 289-112. The Senate advanced the bill, 59-38. The votes came on the same day that a scheduled 21.2% pay cut officially went into effect. The legislation extended until June 1 the current higher level of physician payment and also extended federal assistance for COBRA premiums until May 1.

Information concerning the Senate proceedings and the legislative language can be accessed at: http://www.senate.gov/legislative/LIS/roll_call_lists/vote_menu_111_2.htm .

Learn About Physician Consultation Services from the Medicare Learning Network and PalmettoGBA

Questions about Physician Consultation Codes/Policies or Reporting? Check out these publications and links for more information:

SE1010 – Questions and Answers on Reporting Physician Consultation Services
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf

MM6740 – Revisions to Consultation Services Payment Policy
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

Palmetto GBA has prepared an article for physicians and non-physician practitioners (NPPs) who perform initial evaluation and management (E/M) services previously reported by Current Procedural Terminology (CPT) consultation codes for Medicare beneficiaries and submit claims to Medicare Carriers and/or Medicare Administrative Contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physicians, and NPPs who have reassigned their billing rights, and hospices where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice. To view the article go to:
http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/82ZRL45086?opendocument

Medicare Takes Action Against Aetna Insurance

The Centers for Medicare and Medicaid Services (CMS) recently announced that, effective April 21, 2010, Aetna Insurance Company is prevented from marketing to and enrolling new Medicare beneficiaries until further notice. Ohio Department of Insurance Director Mary Jo Hudson has advised Ohio Medicare beneficiaries that this recent action taken against Aetna Insurance Company does not impact subscribers currently enrolled in Aetna Medicare plans.

According to CMS, Aetna was served with the notice because it improperly administered the Medicare drug benefit in the plan's national stand alone Part D prescription drug plan and its 25 Medicare Advantage prescription drug contracts.

Plan members who may have concerns or any difficulties with their current Aetna coverage should call 1-800-MEDICARE (1-800-633-4227). Beneficiaries can also contact the Department's Ohio Senior Health Insurance Information Program (OSHIIP) toll-free hotline at 1-800-686-1578 for Medicare information, which is also available on the Department's web site, www.insurance.ohio.gov

Medicare Enrollment Deadline for PECOS Sign Up Extended

The Centers for Medicare and Medicaid Services (CMS) has pushed back the date on which it will implement PECOS – the new deadline has been extended to January 3, 2011. This new deadline gives physicians more time to make sure they are signed up with PECOS – The Provider, Enrollment, Chain and Ownership System. CMS states that this new enrollment system will speed up application process, reduce paperwork, and help cut down on fraud and abuse. This is the second time CMS has pushed back this deadline.

With few exceptions, physicians need to be enrolled in PECOS if they want to continue seeing or referring Medicare patients after the end of this year. Many who are not in PECOS enrolled in Medicare before the launch in 2003 and have not changed their information since then. CMS offers an online enrollment process. Applicants must:

- Have or obtain a National Plan and Provider Enumeration System user ID and password. This is the same system that physician practices use to sign up for an NPI.
- Complete, review and submit an electronic enrollment application on the PECOS web site https://pecos.cms.hhs.gov/
- Print, sign and date the two-page certification statement; mail it and supporting paper documentation to the Medicare contractor within seven days of electronic submission.

To assist you in protecting, completing and submitting your Medicare enrollment application via Internet-based PECOS, Medicare offers the following enrollment reminders and tips.

Protect Your Privacy: Physicians and non-physician practitioners need to take steps to ensure that their Medicare enrollment information does not get into the hands of people who can use that information to commit fraud. (See the document titled, "Medicare Physicians and Non-Physician Practitioners - Protecting Your Privacy, Protecting Your Medicare Enrollment Record." This document can be found at: http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/MedPhysPrivacy.pdf.)

Organizations Must Be Enrolled Before Individuals: Before a physician or non-physician practitioner can reassign their benefits to a medical group or clinic other than the one they solely own, the medical group or clinic must have an approved enrollment record in PECOS.

Initial Enrollment Application for an Individual: Physicians and non-physician practitioners who have not enrolled or updated their Medicare enrollment since November 2003 will need to complete an initial enrollment application. PECOS does not contain information for physicians and non-physician practitioners enrolled before November 2003 who have not updated their enrollment record since that time.

Using Internet-based PECOS: CMS suggests that you use Internet-based PECOS because it is faster and more efficient than the paper enrollment application process. Before you begin to use Internet-based PECOS, you should:

- Be sure that you have the National Provider Identifier (NPI) that was assigned to you as an individual and, if you solely own an organization provider, the NPI assigned that was assigned to your organization.
- Review the document titled, "Internet-based PECOS -- Getting Started Guide for Physicians and Non-Physician Practitioners." This document can be found at: http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf

Internet-based PECOS Limitations: While Internet-based PECOS supports most Medicare enrollment application actions, there are some limitations. A physician or non-physician practitioner **cannot** use Internet-based PECOS to:

- Change his/her name or Social Security Number,
- Reassign benefits to another supplier if that supplier does not have an approved enrollment record in PECOS,
- Change in non-physician practitioner specialty type, or
- Change an existing business structure. For example:

    - A sole owner of an enrolled Professional Association, Professional Corporation, or LLC cannot change the business structure to a sole proprietorship; or
    - An enrolled sole proprietorship cannot be changed to a solely-owned Professional Association, Professional Corporation, or LLC.

Finalizing Submission and Responding to Development Request: After submitting an enrollment application via Internet-based PECOS, you:

- Must print, sign and date (blue ink recommend) the Certification Statement(s) and mail the Certification Statement(s) and supporting documentation to the appropriate Medicare contractor. The Medicare contractor will not begin to process your enrollment application until it receives a signed and dated Certification Statement.

- May be asked to make corrections or submit additional documents by the Medicare contractor. In order for your application to be processed, you must submit this information.

Reporting Responsibilities: Physicians and non-physician practitioners enrolled in the Medicare program have reporting responsibilities. See the download section found at www.cms.hhs.gov/MedicareProviderSupEnroll for information about your reporting responsibilities.

More Information: For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to www.cms.hhs.gov/MedicareProviderSupEnroll and select the "Internet-based PECOS" tab on the left side of screen.

EUS Help Desk provides assistance physicians and non-physician practitioners if they encounter an application navigation or systems problem with Internet-based PECOS. A navigation problem occurs when a practitioner is unable to determine how to use Internet-based PECOS. Physicians and non-physician practitioners who have problems with their User Ids or password should contact the NPI Enumerator at 1-800-465-3203.

PalmettoGBA Comments on Comprehensive Error Rate Testing (CERT)

In recent months, Palmetto GBA has seen an escalating number of errors assessed by the Comprehensive Error Rate Testing (CERT) Review Contractor due to signature problems with practitioners' medical records, x-ray reports and laboratory/radiology orders. The discovery of CERT errors may lead to increased scrutiny of future services billed to Medicare by the individual provider and/or the specialty practice that incurs the errors. To reduce the signature problems, PalmettoGBA plans to provide quarterly updates containing information on unacceptable documentation/signature issues, what is needed to resolve these issues, and suggestions on ways to share this information and improve claims submission/documentation requirements.

Basically, The Centers for Medicare & Medicaid Services (CMS) has long-standing published requirements that a legible, valid signature (identifier) must be present on all substantiating documentation for claims billed to Medicare. Palmetto GBA examined numerous examples of CERT signature denials and found in almost every instance, the basic documentation was acceptable. However, services that were denied due to one of four "not acceptable" signature reasons included:

- Illegible, unrecognizable handwritten signatures or initials
- Unsigned "typewritten" progress notes with a typed name only
- Unverified or unauthorized electronic signatures
- No indication of the rendering physician/practitioner

PalmettoGBA is sure that this current challenge is fixable and once achieved will prevent the delay in payments caused from claims being denied because documentation is not present to support payment. Important elements to remember:

- Be sure a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval acceptance or obligation.
- Records should clearly indicate they have been "electronically signed by" and include a date/time. We strongly suggest adding verbiage to this effect for clarification and establishing a protocol to ensure valid signatures are affixed to every order, record, or report within a reasonable time frame,

i.e., customarily 48-72 hours after the encounter-but certainly before the claim is submitted to Medicare for payment consideration.

CMS has clarified guidelines regarding signatures in medical records for medical review purposes. While CMS guidelines mandate the presence of signatures specifically for all "medical review" purposes, modifiers, etc., records pertaining to any procedures billed to Medicare are potentially subject to review by not only PalmettoGBA, but other CMS contractors. These guidelines are applicable to every Medicare claim processed by or medical record submitted to PalmettoGBA for Medical Review purposes on or after April 16, 2010. For additional resources and information refer to the following documents:

CMS Medicare Program Integrity Manual (Pub. 100-08):
http://www.cms.gov/manuals/downloads/pim83c03.pdf
CMS Change Request 6698, "Signature Guidelines for Medical Review Purposes":
http://www.cms.gov/transmittals/downloads/R327PI.pdf
MLN Matters article MM6698, "Signature Guidelines for Medical Review Purposes":
http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf
http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/84VQJV2712?opendocument

CMS Meaningful Use Rules Overview

On December 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released proposed rules for what constitutes "meaningful use" of EHRs for hospitals and eligible professionals to qualify for extra Medicare and Medicaid payments. At the same time, the HHS Office of the National Coordinator (ONC) for Health Information Technology (Health IT) issued an interim final rule setting forth the initial set of standards and certification criteria that vendors must meet in order to have their EHR technology certified. Together, these rules set the stage for EHR adoption, use and exchange of health information to meet far-reaching federal health policy goals.

Background

Congress included the Health Information Technology for Economic and Clinical Health (HITECH) provisions in ARRA to establish a framework for HHS to regulate Health IT using objectives for healthcare quality, efficiency and patient safety. The stated goal is the adoption and use of EHR to improve healthcare delivery in a transformative way. ARRA requires CMS to make EHR incentive payments to eligible professionals and hospitals that adopt and begin to meaningfully use EHR technology meeting certification standards adopted by ONC.

Providers must demonstrate they are achieving "Meaningful Use" through three core concepts (1) using a certified EHR technology in a meaningful manner, including e-prescribing for physicians; (2) connecting the certified EHR technology to allow for electronic exchange of health information to improve quality and care coordination; and (3) submitting information, in a form and manner specified by HHS, on clinical quality and other measures selected by HHS.

Incentive payments begin as early as 2011 under Medicare Fee-for-Service, Medicare Advantage (MA) and Medicaid, and those eligible professionals and hospitals who do not establish meaningful use by 2015 face reductions in their Medicare fee schedule. The two new regulations are designed to work together, with the EHR Technology Rule providing a pathway for the technology, closely linked to the Meaningful Use Rule proposing how eligible professionals and hospitals will use it.

Staged Approach

ARRA allows CMS to build up to a more robust definition of Meaningful Use as technology and provider capabilities ramp up over time. CMS has proposed a three-stage approach with the criteria for qualification becoming more stringent as the expectations rise to reduce the gap between today's reality and the desired state of widespread use of EHR. Both rules contemplate that the state of the art of EHR technology and its adoption will evolve to move providers from the initial stages of capturing and using health information in a structured format to tracking clinical conditions and using health IT for order entry, result reporting and improving quality at the point of care to later stages where interoperability of EHR technology is possible and providers manage high priority conditions and improve population health with decision support.

The EHR Technology Rule

ARRA requires providers to use EHR technology certified by HHS and set December 31, 2009 as the statutory deadline for HHS to adopt an initial set of standards, implementation specifications and certification criteria for EHRs. ONC organized quickly and obtained input on what should constitute certified EHRs and how to address Meaningful Use in a way to advance HITECH health policies. HITECH federal advisory committees and stakeholders helped ONC craft a framework, definitions and timetables for the implementation of these core concepts in public forums last summer. The initial deliverables focused on four outcome policy priorities and care goals and for the use of EHR technologies: (1) improving quality, safety, and efficiency and reducing health disparities; (2) engaging patients and families in their care; (3) improving care coordination; and (4) improving population and public health.

ONC met the statutory deadline for the initial set of EHR certification standards by publishing an Interim Final Rule. Those standards provide a roadmap for what vendors must do to have their technology certified, either as a complete EHR or as one or more EHR modules. ONC anticipates that vendors will offer a variety of software programs that alone or together with other certified modules will allow providers to assemble the capabilities required under the rule. The minimum standards for an EHR that qualifies for certification is one that (1) includes demographic and medical information such as a history and problem list, and (2) has the capacity to (a) provide clinical decision support, (b) support physician order entry; (c) capture query information relevant to quality; and (d) exchange and integrate health information with and from other sources. What is most important is that the EHR technology not only meets the certification criteria, but actually be certified. The certification process will be addressed in a forthcoming rule.

The Meaningful Use Rule

Medicare and Medicaid are separate and distinct programs with different eligibility requirements for both hospitals and eligible professionals. Whiles hospitals may simultaneously participate in both the Medicare and Medicaid incentive programs, physicians must choose between the two (although that election can be changed once before 2015). This choice is strategic and will need to take into account the differences in eligibility, the different payment amounts, Medicaid volume criteria, and whether the physician has received any support payments (e.g., hospital EHR donations) under the rule as proposed.

Professionals eligible for the Medicare EHR program are doctors of medicine or osteopathy, dental surgery and medicine, podiatrists, optometrists, and chiropractors participating in Medicare. Under the Medicaid EHR program, physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who practice predominantly in a federally qualified health center or rural health clinic led by PAs are eligible by meeting certain patient volume criteria. The Medicaid EHR program volume requirements are generally 30% of Medicaid patient encounters, although pediatricians with at least 20% of Medicaid patient encounters would qualify at a reduced level, and a special formula allows professionals who practice predominantly in FQHC and RHCs to meet the 30% threshold by considering needy individuals receiving Medicaid, SCHIP, or services at no cost or reduced cost based on payment ability.

Medicare EHR payments for eligible professions are 75% of Medicare allowable charges up to an annual cap for up to five years beginning in calendar year 2010. This means that eligible professionals can receive a total of up to $44,000 over a five-year period, including $18,000 in the first year for early adopters that qualify in calendar year 2011 or 2012. Eligible professionals furnishing more than 50% of Medicare covered services in a health professional shortage area (HPSA) earn an additional 10%.

Medicare carriers would pay out incentive payments in a single lump sum payment once determining that a physician demonstrated meaningful use for that annual period. CMS has proposed that the payments be made to the physician or to a single employer under a valid Medicare reassignment and would not allow physicians to allocate payments among multiple entities. Most hospitals and group practices will want to amend employment and professional contractor agreements to outline that is entitled to receive the payments.

Under the Medicaid EHR incentive program, the amount payable to eligible professionals is set at 85% of "net average allowable costs" capped by statute at $25,000 for the first year and $10,000 for five subsequent years. CMS proposes to set average allowable costs at $54,000 per physician in the first year and $10,000 per physician in annual maintenance costs for subsequent years. That amount for any particular professional would be reduced for any EHR technology or support service payments received from sources other than state or local governments, so if the eligible professional received more than $29,000 in the first year or $10,610 in subsequent years from hospitals or private payors, those subsidies would be backed out. As a result, the maximum Medicaid incentive payment would be $21,250 in the first payment year and $8,500 annually in five subsequent years or $63,750 over a six-year period for most physicians, with pediatricians in the 20-29% Medicaid patient volume corridor receiving one-third less.

Medicaid payments will be made through the states and states must prepare a health information technology plan to receive the CMS match for their EHR incentive programs. Unlike hospitals that are deemed to be meaningful users under Medicaid by meeting the Medicare criteria, eligible professionals seeking Medicaid incentive payments must meet the Medicare "floor" and additional state requirements that CMS approves. CMS would restrict states from adding required functionality to the EHR, but allow states to add additional objectives for eligible professionals and hospitals or measure their achievement in a different way.

Another distinctive provision of the Medicaid incentive program allows eligible professionals and hospitals to qualify for payments before achieving meaningful use during the first year only by adopting, implementing or upgrading EHR technologies. CMS would define this to mean that the EHR technology has at least been installed or use of it has begun, or for upgrades, that the available functionality of the certified EHR technology has been expanded at the practice site, including staffing, maintenance, and training.

The Hospital-based Exclusion

Hospital-based physicians were excluded from both programs. While the ARRA language contains this exclusion, CMS would define the term expansively to include not only pathologists, anesthesiologists and emergency physicians, but any other professional furnishing 90% or more of his or her professional services within a hospital inpatient, outpatient or emergency department setting. CMS proposes to use place of service codes on the professional claim form to determine who becomes ineligible under the 90% test.

CMS has said it believes that since Medicare already pays hospitals for hospital outpatient and provider-based overhead, including an integrated medical record system, and physicians using these systems should not benefit under the new program. This despite the fact that throughout the Medicare rule, CMS makes clear the basis for incentive payments is not simply purchasing technology but going beyond EHR adoption to actually using it in a manner to support the HITECH health policy priorities. Medicare payments are not designed to be a reimbursement or pass through for software costs, rather incentive payments for using it as set forth in the statute.

While CMS acknowledges that there is an interest in assuring nearly all primary care physicians qualify for EHR incentive payments, it estimates that 27% of physicians would be considered hospital-based under this definition and ineligible for EHR incentive payments. For areas like northeast Ohio with several academic medical centers and integrated health systems, this proposal would have had a devastating effect on the number of physicians eligible to participate in the program.

Fortunately, CMS seeks public comment on whether it should use a different method and any associated complexities and implementation issues resulting from including integrated health settings. Many comments were received on this portion of the rule and prior to the final rule being released Congress passed legislation to clarify this language. Specifically, the legislation amends the definition of hospital based eligible professional under ARRA. Instead of a hospital based eligible professional pertaining to a professional included in an "in-patient or out-patient" setting, the legislation amends the ARRA definition to include a professional in an "in-patient or emergency room setting". As a result, physicians practicing in an outpatient setting can now be eligible for the Medicare/Medicaid incentive program under ARRA. The AMCNO sent a detailed letter to in response to the meaningful use rule indicating our concerns with this definition. This EHR Clarification language is good news for the physicians in Northern Ohio. **The AMCNO is very pleased that this legislation has passed with this new definition. (See next item on AMCNO comments on meaningful use).**

Achieving Meaningful Use for Physicians

Physicians could be eligible for incentive payments as early as January 1, 2011. For the first payment year only, CMS proposes that physicians may demonstrate meaningful use of certified EHR technology over any continuous 90-day period within a calendar year. This flexibility would mean that a physician may begin using certified EHR technology in a meaningful manner as late as October 1, 2011 and still receive an incentive payment for 2011. However, after the first year, the physician would need to demonstrate meaningful use at all times. This requirement could pose challenges for physicians experiencing problems with a vendor keeping up with the EHR certification standards or desiring to change EHR systems over the three stages of the incentive program. Expect commentators to request that CMS provide for some type of relief for these extraordinary or uncontrollable events. Eligible professionals and hospitals should be working with their vendors to confirm that the vendor can and will pursue certification of the technology under the initial standards and is committed to ramping up over the three stages.

Beginning in Stage 1, eligible professionals must demonstrate that they meet all of the Stage 1 objectives and associated measures. Examples of some of these initial measures for physicians include directly entering orders using CPOE for at least 80% of all orders, maintaining an active problem list in ICD-9 for at least 80% of unique patients, transmitting 75% of all permissible prescriptions electronically, and maintaining at least 80% of all active medications and medication allergies as structured data. Measures for hospitals to demonstrate meaningful use are separate and distinct but achievement obviously impacts or is dependent on physicians. For example, hospitals must demonstrate that 10% of all orders are entered directly by an authorizing provider on the inpatient EHR. In an effort to interface the physician with EHR decision support, CMS proposes that these orders be entered directly by the authorizing practitioner, triggering industry debate over the appropriate use of "scribes" or other members of the clinical team for order entry.

CMS will require substantiation through both data reporting and physician attestations as to the achievement of objectives. Surprisingly, CMS estimates only 9 hours for the physician burden in making these reports. Since many proposed measures require manual tracking and calculation of orders and encounters to compute percentages, one of the early criticisms of the rule has been the administrative burden in collecting and reporting performance.

Another big area of concern for physicians and hospitals is how they are to share health information with patients. Several of the measures address the care goal of patient information sharing and providing patients

with health information, sometimes electronically and sometimes on paper, at least initially. Hospitals and physicians would be required to provide patients an electronic copy of their health information (including diagnostic test results, problem list, medication lists and allergies) on request and within 48 hours at least 80% of the time. In addition, physicians would be required to provide patients with timely electronic access to that same set of health information within 96 hours of it being available to the physician for at least 10% of all unique patients. Hospitals would be required to provide patients with an electronic copy of discharge instructions and procedures at the time of discharge to at least 80% of patients requesting this information. Likewise, physicians would be required to provide clinical summaries for at least 80% of all office visits, although this information could be provided on paper.

There is also concern over the vast scope of the objectives and measures required under the rule. Many provider organizations have expressed concern that an "all or nothing" approach to qualification makes the programs unattractive, especially for those providers who have little or no experience with EHR adoption and are a bit overwhelmed with the breadth and depth of measures involved. Some of the quality measures for physician reporting follow PQRI and are in their infancy in terms of implementation guidance and acceptance by the medical community. Providers are also understandably concerned with making certifications to the government of compliance on technical criteria. Scaling these expectations and providing for the concept of substantial compliance and good faith certifications would help alleviate these concerns.

Comments were due March 15, 2010, and the AMCNO sent various comments on some of these challenging aspects of the rule. CMS does not anticipate publishing a final rule until after the first quarter of 2010, with an effective date 60 days thereafter. Stay tuned for further updates.

This CMS Meaningful Use update was prepared by Ms. Amy Leopard. Ms. Leopard heads the health care practice group at the law firm of Walter & Haverfield LLP. This article presents general information and education on legal developments and does not constitute legal advice.

AMCNO Submits Comments to CMS on Meaningful Use (MU)

On January 13, 2010, the Centers for Medicare and Medicaid Services (CMS) published the *Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs* Notice of Proposed Rule Making (NPRM). Over the past two months, the physician leadership and staff of the AMCNO have been evaluating and reviewing the proposed rule. CMS is charged with ensuring that physicians are a key component of the effort under the American Recovery and Reinvestment Act of 2009 (ARRA) to promote health information technology and its use to transform medical practice and the health care delivery system. Our comments focus on our support for a program that allows as many eligible physicians as possible to participate and that creates trust and buy-in from physicians on the value of that participation and the fairness of the process.

After a detailed review and discussions with physicians and institutions from across the region, the AMCNO has prepared and submitted comments on the rule. Our comments focused on four specific areas of the rule including: The Academy of Medicine of Cleveland & Northern Ohio made four key recommendations to CMS as follows:

- CMS should limit the definition of hospital-based professionals ineligible to participate in the EHR incentive programs to ensure broad physician participation in Meaningful Use. *(Note: In addition to the AMCNO, many organizations commented on the problems with this portion of the rule. The AMCNO and others also notified Congress of the problems that could arise with utilizing this definition as a part of the final rule. Therefore, prior to the release of the final meaningful use rules, Congress passed legislation that included "EHR Clarification" language. Specifically, the legislation amends the definition of hospital based eligible professional under ARRA. Instead of a hospital based eligible*

professional pertaining to a professional included in an "in-patient or out-patient" setting, the legislation amends the ARRA definition to include a professional in an "in-patient or emergency room setting". As a result, physicians practicing in an outpatient setting can now be eligible for the Medicare/Medicaid incentive program under ARRA. This EHR Clarification language is good news for the physicians in Northern Ohio. The AMCNO is very pleased that this legislation has passed with this new definition.)

- CMS should scale back the measures, make the thresholds for the objectives and quality metrics more realistic, and allow achievement of meaningful use on something less than an "all or nothing" basis.
- CMS should allow eligible professionals to demonstrate meaningful use through substantial compliance with the measures and objectives in Stage 1.
- CMS should streamline that administrative burden on physicians so that physicians can easily create the compliance documentation needed.

A complete copy of the letter may be viewed on our web site at www.amcnoma.org and open the headline entitled AMCNO Submits Comments on Meaningful Use. An overview of the AMCNO comments was also highlighted in the May/June issue of the Northern Ohio Physician magazine.

News from Other Third Party Payors

MEDICAID

Ohio Department of Job and Family Services (ODJFS) Changes Web Address for Complaints

A new web address has been created for the managed care provider complaint form. Although the original web address https://www.odjfs.state.oh.us/ohp/bmhc/provider_complaint/complaint.asp will still be functional, the new mcp.ohio.gov web address is much more user friendly, and will automatically redirect the provider to the original web address where the provider complaint form is housed.

The provider frequently asked questions (FAQs) document located on our website will be updated to reflect this as well. To view the new managed care provider complaint form go to mcp.ohio.gov

UnitedHealthCare Convenes Administrative Advocacy Committee

The AMCNO is already a participant in the UHC Physician Advisory Committee, which meets on a quarterly basis to discuss issues of importance to physicians and their practice. Now the AMCNO has been invited to participate as a member of the UHC Administrative Advisory Committee. This committee is comprised of practice administrators and UHC Provider Advocates. The committee will review issues of importance to practice administrators that are currently working with the UHC provider advocates in the region. This committee will meet on a quarterly basis.

UHC has developed a more decentralized approach to customer service, and in order to assist with this concept they have implemented local Provider Advocates. In addition to troubleshooting problem claims, Provider Advocates are charged with providing education and training on plan processes. They are to assist physicians and their staff in understanding new plan programs, garner a better understanding of billing and claims procedures as well as to provide information on new provider service advancements that may be in development by UHC. According to UHC, Provider Advocates across the nation have reduced reworks older than 20 days to 80%; have reduced rework turn-around time from 35 days to 8 days, and they have reduced appeals by 11% in some markets. Provider Advocates are currently working across the state of Ohio with two working in the Cleveland market.

The administrative advisory committee will provide ongoing medical practice staff input to UnitedHealthcare and its affiliated companies in order to provide beneficial enhancements in the company's administrative interactions with physicians. The Committee will specifically focus on priority issues such as:

1. Opportunities to advance simplicity and coordination in the following administrative areas:
    a. Eligibility determination
    b. Claims submission
    c. Claims payment
    d. Reimbursement policy
    e. Contracting
    f. Credentialing
    g. Communication
    h. Issues resolution processes

2. Opportunities and strategies that will advance the application of electronic and other technologies to realize simpler, mutually beneficial and cost effective data-based interactions.

The AMCNO advocates on your behalf not only with UHC but other third party payers operating in the state of Ohio. If you or your office staff have an issue involving a problem claim please contact the AMCNO offices at 216-520-1000, ext. 102. In addition, members of the AMCNO are welcome to submit issues to the AMCNO staff for discussion at the UHC advisory committees.

NEWS YOU CAN USE

CWRU School of Medicine Chosen as an Ohio Health Information Partnership Regional Extension Center (REC) Partner – AMCNO to work as a Stakeholder on the Project

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) president and executive staff were on hand at a media event hosted by the Cleveland Clinic when Governor Ted Strickland announced that seven regional sites across Ohio will receive a total of $26.8 million in American Recovery and Reinvestment Act (ARRA) resources to assist in the implementation of the state's health information technology initiative.

These resources are a portion of Ohio's total $43 million ARRA award for the Ohio Health Information Partnership (OHIP), the non-profit entity designated by Strickland to lead the implementation of health information technology in Ohio. OHIP will work with the selected regional partners to help more than 6,000 primary care providers install electronic health record (EHR) systems and connect to a statewide, secure health information exchange. OHIP regional partners will then work with providers to get their systems connected to the secure statewide health information exchange. Through this exchange, physicians will be able to share information, if the patient has given permission to do so, with other providers such as hospitals, specialists, and laboratories. This will result in better coordination of care, reduced duplicative testing and safer prescribing.

The CWRU School of Medicine is one of seven RECs in Ohio established by OHIP and made possible by funding from the American Recovery and Reinvestment Act (ARRA). An eighth REC was awarded directly by the federal government to HealthBridge, a not-for-profit health information exchange serving Greater Cincinnati and surrounding areas.

Case Western Reserve University (CWRU) School of Medicine received $7,942,500 in federal stimulus funds from OHIP. The funding will position CWRU School of Medicine as a regional extension center (REC) which allows it to help 1,765 health care providers in Lorain, Cuyahoga, Lake, Geauga and Ashtabula counties advance the use of health information technology (HIT) in their practices.

The REC endeavor, as directed by the federal government, is specifically targeted towards primary care providers, specifically, physicians—MDs or DOs who are family physicians, general internal, pediatric or OB/GYN (does not need to be board certified in these areas), and other primary care providers such as nurse practitioners, nurse midwives, or physician assistants with prescriptive privileges.

The CWRU School of Medicine will provide administration and management to multiple contractors whose roles will vary by expertise but overall will help providers select products and provide training on how to use the technology to its fullest potential in order to improve patient care. This includes providing workforce support, implementation and project management, practice and workflow design, vendor selection, privacy and security best practices, progress towards meaningful use, functional interoperability and health information exchange. The CWRU REC has a number of stakeholders, including the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF). The AMCNO Immediate Past President, Dr. Anthony Bacevice has been appointed to the CWRU Regional Extension Center (REC) Governance Committee. The AMCNO will continue to be integrally involved in this project as it moves forward in our region.

Discounted Classes at Tri-C for AMCNO members

Cuyahoga Community College
AMCNO Discounted Medical Practice Management Seminars

<u>CODING SEMINARS</u>: Professional CEUS: AAPC and PMI-1 CEU per hour
For your AMCNO member discount promo code: Contact Linda Hale AMCNO at 216-520-1000.

Date	Course/Seminar	
June 2 (CCW) 8:30 am – 11:30 am	Cardiology Technology & Coding Techniques	$159
July 21 (CCW) 9am - noon	Modifier Clinic: reduce audit risks & ensure accurate reimbursement	$159
July 26 – Oct 27 (CCE)	AAPC Professional Medical Coding Curriculum (81 hrs) Tues & Thurs evenings	$1650
Aug 19 (CCE) 8:30 am-noon	Evaluation & management coding Getting it Complete, Keeping it Simple	$159
Sept 18 – Nov 14 (CCE)	Accelerated AAPC Professional Medical coding Curriculum (36 hrs) Saturday mornings	$850

<u>Medical Front Office Specialist for the Certified Medical Administrative Assistant (CMAA)</u>
Day and evening classes available. Take the complete program and National Certification Exam for $1922

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

(CCE) Corporate College East, 4400 Richmond Rd., Warrensville Heights
(CCW) Corporate College West, 25425 Center Ridge Rd., Westlake

Medical Records Fact Sheet Update Effective January 2010
(REVISED April 2010**)**

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics. Current Opinion **7.05.** Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of tine of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.74** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2010, the maximum fees that may be charged, are as set forth below.

(1) The following maximum fee applies when the request comes from a patient or the patient's representative.

a) No records search fee is allowed;
b) ***For data recorded on paper:*** $2.83 per page for the first ten pages; $0.59 per page for pages 11 through 50; $0.24 per page for pages 51 and higher
For data recorded other than on paper: $1.93 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 $17.42 records search fee is allowed;
b) ***For data recorded on paper*****:** $1.15 per page for the first ten pages; $0.59 per page for pages 11 through 50: $0.24 per page for pages 51 and higher
For data recorded other than on paper**:** $1.93 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. ****Due to incorrect calculations and information posted on the ODH web site in January 2010 the fees sent out to physicians in January were incorrect. Please use this updated fact sheet when copying your medical records.** If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext 102.

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.amcnoma.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.amcnoma.org

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