

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

## *PRACTICE MANAGEMENT MATTERS*

**SPRING EDITION 2011**

Medicare

Make plans now to attend the **CIGNA Government Services educational sessions** sponsored by the AMCNO – see details in this issue!

### **AMCNO Participates in Provider Outreach and Education Advisory Group Meeting - PalmettoGBA and CIGNA Government Services Provide Updates**

At a recent POE meeting, the AMCNO was provided with an update on the Jurisdiction 15 transition to CIGNA Government Services (CGS). By way of background, CIGNA Government Services (CGS) is currently a wholly owned subsidiary of CIGNA Corporation with over 40 years' experience as a Medicare contractor. Beginning on May 1, 2011, CGS will be acquired by Blue Cross/Blue Shield of South Carolina. CGS is currently evaluating a name change – with the hope of retaining the “CGS” acronym. BC/BS of SC also works with PalmettoGBA and it is possible that some items may be handled by them going forward, however, it is important to note that CGS will be taking over all aspects of the Medicare Administrative Contractor (MAC) Part B function for Jurisdiction 15.

The transition to CGS from PalmettoGBA will occur on June 18, 2011. The AMCNO has learned that as a result of the sale of CIGNA Government Services (CGS) to Blue Cross Blue Shield of South Carolina, there have been changes to their Jurisdiction 15 (J15) Ohio Part B EDI Strategy. While CGS will assume support for the Ohio Part B EDI submitters, and they have elected to sub-contract with Palmetto GBA to continue to support the Ohio Part B EDI workload on the current EDI Gateway, GPNet. What this means for the Ohio Part B provider community is that there will be no change to your connectivity or transmission of EDI transactions for the J15 A/B MAC. Physicians should continue to send claims and receive remittances to and from the same front-end system they are currently using. CGS will assume responsibility for the EDI Help Desk support at a later date. In the interim, please continue to contact the EDI Technical Support Team for technical assistance at 1-866-308-5438.

In order to prepare for the remainder of the transition J15 providers may wish to reference the CMS MLN Matters article "Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)", available from the following CMS Web page: [www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf](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. Most provider action items will take place within the 90 day window leading up to cutover: EFT Re-enrollment – 90 days prior to cutover; EDI Preparations – 45 - 60 days prior to cutover; and LCD publication – 45 days prior to cutover.

**EFT re-enrollment - Ohio** Part B providers who are currently enrolled with Palmetto GBA to receive their Medicare payments electronically must submit a new CMS-588 EFT Authorization Agreement to CIGNA Government Services immediately upon receipt of notification. Request letters for Ohio Part B providers were mailed the week of March 7, 2011 for CMS-588 - your timely completion of the EFT agreement will ensure continued receipt of electronic Medicare payments following the completed transition of claims processing and payment operations to CIGNA Government Services. Once CGS processes your EFT application, they will send out a confirmation letter and it will remain on file with CIGNA Government Services until they begin processing claims. This will not disrupt your payments processed by your current contractor.

EFT re-enrollment for a group - If you represent a group of physicians who reassign their individual benefits to the group itself, then it is only necessary to complete one EFT re-enrollment at the group level. There is no need to submit additional EFT applications for each member of the group. In these instances, your EFT application should be completed for the “Pay-to” PTAN. You will only receive one confirmation letter from CGS to indicate that the group’s EFT re-enrollment was completed.

CMS-588 EFT Authorization Agreement: [www.cms.gov/cmsforms/downloads/CMS588.pdf](http://www.cms.gov/cmsforms/downloads/CMS588.pdf)

J15 EFT resources in the J15 EFT Homepage: [www.cignagovernmentsservices.com/j15/eft.html](http://www.cignagovernmentsservices.com/j15/eft.html) and an EFT Web-based tutorial: <https://www.cignagovernmentsservices.com/captivate/J15588/CMS588Form.htm>

Electronic data exchange – EDI submitters who have completed an EDI enrollment form with Palmetto GBA do not need to re-enroll or complete a new application with CGS. As part of the transition process, CGS will receive all EDI applications from the Palmetto and you will not need a new Submitter ID.

Payer ID update – However, physicians will need to change their Contractor/ Payer ID for submitting electronic claims to CGS at cutover. The new Contractor/ Payer ID for OH Part B is **15202**. Physicians, either you or your clearinghouse, or vendor should use this Contractor/ Payer ID for submission of electronic claims to CGS after June 18, 2011.

CGS is subcontracting with Palmetto GBA to provide 5010 EDI translation services for Ohio Part B claims starting at cutover on June 18, 2011 and continuing through September 30, 2011. During this time period, Palmetto GBA will be supporting 5010 testing, translation, and CEM integration to include second level help desk support. CGS expects to start 5010 translation during the month of September. EDI resources J15 EDI Homepage: [www.cignagovernmentsservices.com/j15/edi.html](http://www.cignagovernmentsservices.com/j15/edi.html)

Local coverage determinations (LCDs) - CIGNA Government Services has worked closely with Palmetto GBA to identify and consolidate current LCDs. These “Future Effective Documents” are available from our Website at: [www.cignagovernmentsservices.com/j15/LCDs.html](http://www.cignagovernmentsservices.com/j15/LCDs.html). Remember, the effective date for CGS’ Ohio Part B LCDs is **June 18, 2011**. Until that time, continue to follow the policies and guidelines in place with Palmetto GBA.

LCD Crosswalk - In an effort to assist physicians in understanding the key differences between LCDs currently being followed and those that CGS will use after June 18, 2011, CGS has developed an LCD crosswalk. It is available here: [www.cignagovernmentsservices.com/j15/LCDCrossWalk.xls](http://www.cignagovernmentsservices.com/j15/LCDCrossWalk.xls)

Contacting CIGNA Government Services - As of this printing, mailing addresses for the submission of paper claims, provider enrollment applications, refund checks, appeals, and others were not available and will be updated with the transition. Those details are currently being finalized and will be made available in the near future. Please remember that until notified by CGS, you should continue to direct your requests and inquiries to Palmetto GBA for timely completion.

However, the J15 help desk is now available. The toll-free implementation help desk is for physicians with specific questions related to the transition. Telephone number: **1.877.819.7109**, Hours of Operation: **8:30 am - 4:30 pm CT, Monday – Friday**. J15 inquiries – see email form [www.cignagovernmentsservices.com/J15Questions.html](http://www.cignagovernmentsservices.com/J15Questions.html) **Stay connected - Web site** [www.cignagovernmentsservices.com/J15](http://www.cignagovernmentsservices.com/J15)

J15 list serve – The CGS ListServ is the fastest and easiest way CGS can communicate news and information related to J15 transition activities. New Customers may register at: [www.cignagovernmentsservices.com/medicare\\_dynamic/ls/001.asp](http://www.cignagovernmentsservices.com/medicare_dynamic/ls/001.asp) NOTE: If you are already receiving email updates from your current contractor, your email address has likely been added to the CGS J15 ListServ database. J15 news page - This page will feature news items directly from CMS and CGS regarding the J15 transition: [www.cignagovernmentsservices.com/j15/News.html](http://www.cignagovernmentsservices.com/j15/News.html)

## **Want to Learn Firsthand About the Jurisdiction 15 A/B MAC Implementation? Plan to attend the AMCNO Sponsored Upcoming Educational Sessions in Cleveland**

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to welcome representatives from CIGNA Government Services to Cleveland on May 19<sup>th</sup> and 20<sup>th</sup>. Representatives from CIGNA will be on hand at that time to offer Jurisdiction 15 A/B MAC implementation provider workshops for Ohio Part B providers. These sessions will be hosted by the Jurisdiction 15 Implementation team from CIGNA Government Services and sponsored by the AMCNO. Providers will have a choice of a morning or afternoon session. The same material will be covered in all courses, so choose the class that best fits your schedule.

This is your opportunity to meet the staff at CIGNA Government Services, learn about important news and information that will help you prepare for transition activities, and ask your questions relative to the implementation of Jurisdiction 15. Due to limited space, we ask that you limit your registration to no more than two individuals from your organization. Your cooperation is greatly appreciated, as this will allow us to accommodate as many J15 providers as possible for these events.

### **Morning Sessions:**

Date: **Thursday, May 19, or Friday, May 20, 2011**

Time: 8:30 – 11:30 am ET

Location: The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)  
Park Center One  
Lower Level Meeting Room  
6100 Oak Tree Blvd.  
Independence, Ohio 44131

### **Afternoon Sessions:**

Date: **Thursday, May 19, or Friday, May 20, 2011**

Time: 1:30- 4:30 pm ET

Location: The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)  
Park Center One  
Lower Level Meeting Room  
6100 Oak Tree Blvd.  
Independence, Ohio 44131

You may register at the CIGNA J15 Education page at <http://www.cignagovernmentservices.com/j15/education.html>.

## **Medicare Electronic Health Record (EHR) Incentive Program Attestation Began 4/18/2011!**

This means that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) can attest through the CMS web-based attestation system and be on their way to receiving Medicare EHR incentive payments. Several new CMS resources can help physicians successfully navigate the Medicare EHR Incentive Program:

- A new attestation page is on the CMS EHR website, where participants in the Medicare EHR Incentive Program can find important information on attestation.  
[https://www.cms.gov/EHRIncentivePrograms/32\\_Attestation.asp#TopOfPage](https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage)
- The meaningful use attestation calculator allows EPs and eligible hospitals to check whether they have met meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary. <http://www.cms.gov/apps/ehr/>
- The Eligible Professional User Guide provides step-by-step guidance for EPs on navigating the attestation system. [https://www.cms.gov/EHRIncentivePrograms/Downloads/EP\\_Attestation\\_User\\_Guide.pdf](https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_User_Guide.pdf)

## **If you are not ready to attest, follow these steps to participate in the programs:**

- **Make sure you're eligible for the EHR Incentive Programs.** View eligibility guidelines at our Eligibility page and select the program in which you want to participate.  
[http://www.cms.gov/EHRIncentivePrograms/15\\_Eligibility.asp](http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp)
- **Get registered.** Registration is open for EPs, eligible hospitals, and CAHs. Visit the registration page for more details. [http://www.cms.gov/EHRIncentivePrograms/20\\_RegistrationandAttestation.asp](http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp)
- **Use certified EHR technology.** To receive incentive payments, make sure the EHR technology you're using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology.
- **Be a Meaningful User.** You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent years) to receive EHR incentive payments. Visit the link below to learn about meaningful use objectives and measures.
- **Attest for incentive payments.** To get your EHR incentive payment, you must attest through Medicare's secure website that you've demonstrated meaningful use with certified EHR technology.

### **Want more information about the EHR Incentive Programs?**

Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs. <http://www.cms.gov/EHRIncentivePrograms/>

### **Update to the 2011 Medicare Physician Fee Schedule Database**

Effective April 4, 2011, the Centers for Medicare & Medicaid Services (CMS) has made changes to four codes on the 2011 Medicare Physician Fee Schedule Database (MPFSDB). These changes are effective for services performed on or after January 1, 2011.

<http://www.palmettogba.com/palmetto/providers.nsf/Is/OWV~8FPJPC5748?opendocument>

### **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/Is/OWV~8DVPE58261?opendocument>

### **Critical Care and the Global Surgery Package**

Palmetto GBA has noticed that some providers are submitting CPT modifiers 24 and 25 on all E/M services when it is not applicable (not just the critical care codes). Please note the following guidelines to ensure that your claims are submitted accurately and reimbursed correctly.

<http://www.palmettogba.com/palmetto/providers.nsf/Is/OWV~8DHTBR8657?opendocument>

### **Physicians Must E-prescribe by June 30, 2011 or be Subject to Medicare Penalties**

In November, the Centers for Medicare & Medicaid Services announced that beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program. The payment adjustment in 2012, with regard to all of the eligible professionals' Part B-covered professional services, will result in the eligible professional or group practice receiving 99% of the Physician Fee Schedule (PFS) amount that would otherwise apply to such services.

For purposes of determining which eligible professionals or group practices are subject to the payment adjustment in 2012, CMS will analyze claims data from January 1, 2011- June 30, 2011 to determine if the eligible professional has submitted at least 10 electronic prescriptions during the first six months of calendar year 2011. Group practices

reporting as a GPRO I or GPRO II in 2011 must report all of their required electronic prescribing events in the first six months of 2011 to avoid the payment adjustment in 2012. Even practices that plan to adopt EHR systems between July and December, 2011 will be subject to Medicare payment reductions in 2012 if the eligible professional has not submitted 10 claims coded for e-prescribing between January and June, 2011.

### **Coding for E-prescribing or for exemptions from e-prescribing:**

- **G8553** - At least one prescription created during the encounter was generated and transmitted electronically using a qualified EHR system. Note: If more than one prescription is generated for a patient during the same visit, then this would count as only ONE instance of E-prescribing.
- **G8642** - The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.
- **G8643** - The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.
- **G8644** - The eligible professional does not have prescribing privileges.

### **The Ohio Board of Pharmacy Approved E-prescribing Modules**

If your practice does not have a full EHR system capable of generating an e-prescription, you may still meet the Medicare e-prescribing requirements by utilizing a stand-alone e-prescribing module. The following is a list of the e-prescribing modular systems that are approvable by the Ohio Board of Pharmacy:

- AllscriptseRx, also known as Allscripts eprescribe (This product used to be free; unclear of the current status)
- NewCrop
- OnCallData
- MicroMD
- Cyber Access (This product used to be free; unclear of the current status)

### **Centers for Medicare and Medicaid Services (CMS) Physician Compare web site – Check Your Data for Accuracy**

In a previous email, the AMCNO informed our members about the CMS Physician Directory tool at [www.Medicare.gov](http://www.Medicare.gov) which includes 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. This 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](http://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 first phase of the site, which offers searchable, online directory for Medicare patients, includes physician contacts and addresses, gender, medical specialty, education, residency or other training and languages spoken in addition to English. Additionally, the site also indicates whether physician practices have submitted data to ACMS on the Physician Quality Reporting System (PQRS). The ACA also requires CMS to post physician performance information on the web site by January 1, 2013.

Demographic data on the Physician Compare web site, such as practice phone numbers and addresses, Medicare participation status and education information is copied from the Provider Enrollment, Chain, and Ownership System (PECOS). Therefore, it is very important that physicians keep their Medicare enrollment information up to date. Physicians should take the time to go to the site and review their data and if the data is not correct be sure to make the necessary changes through CMS. Also, if you find that your data has been posted inaccurately please let us know – we would be interested in learning if the site contains inaccuracies.

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](http://www.Medicare.gov/find-a-doctor) or click on the “Compare” tab at [www.Healthcare.gov](http://www.Healthcare.gov).

News from Other Third Party  
Payors

## **MEDICAID**

### **Ohio Department of Job and Family Services Announces Approval of Medicaid Provider Incentive Program (MPIP)**

Recently, the ODJFS announced that the Ohio Medicaid Provider Incentive Program (MPIP) had received federal approval. Ohio’s MPIP is an incentive program designed to encourage Medicaid providers to adopt electronic health record (EHR) systems. Ohio’s MPIP was established in accordance with the meaningful use final rule. Under Ohio’s MPIP, eligible Medicaid professionals and hospitals who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in the first year of participation, and demonstrate meaningful use of EHRs over six years will be eligible for federal incentive payments. As a result of these incentive payments, ODJFS estimates that as many as 4,000 Medicaid providers will transition to certified EHR systems in the first two years of the program. Ohio MPIP will be open by June 2011, with incentive payments expected to begin in June as well. A help desk number will soon be available. For more information on the MPIP go to <http://jfs.ohio.gov/OHP/HIT%20Program.stm>

### **UnitedHealthCare 2011 Administrative Guide Available**

UnitedHealthCare has released the new UnitedHealthcare Physician, Health Care professional, facility and ancillary provider 2011 Administrative Guide effective April 1, 2011. The new guide is available for viewing and printing at [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com)

### **Anthem Changes in Reimbursement for Not Otherwise Classified (NOC)**

As of June 15, 2011, providers in Ohio submitting on a CMS 1500 claim form will see changes in the reimbursement for Not Otherwise Classified (NOC) codes. As a reminder, NOC or unlisted CPT/HCPS codes are to be used only when no other available codes describe the rendered service. Under the reimbursement agreement with Anthem, providers submitting NOC or unlisted codes must include applicable documentation so that Anthem can determine pricing. The reimbursement is based upon several factors, including but not limited to: a copy of the provider’s invoice, the manufacturer’s list price for the item or similar item(s), review of operative reports, like or comparable codes, and national drug codes.

### **Anthem CPT Coding Compliance Program**

Anthem has launched a CPT coding compliance program to be conducted by Healthcare Recoveries, Inc., a vendor of professional audit services. Healthcare Recoveries will review use of modifiers 24, 25, 57, and 59 and evaluation and management claims. Prior to a review, a notification will be sent, in writing to cover specific review guidelines. After the review, all findings will be provided in writing to physicians and/or

their billing staff. The goals and objectives of the compliance program in part are to identify and correct any underpayments/overpayments that may be identified during the review; to maintain proper communication throughout the review process and after, and to educate providers on billing practices to promote compliance with the CPT/HCPCS Coding guidelines and/or Anthem policies and procedures.



### **Red Flags Rule Finally Clarified**

The AMCNO joins the American Medical Association and many other medical organizations in applauding the recent court decision finally clarifying the application of the red flags rule. A federal appeals court issued a decision that validates the long-standing argument to the Federal Trade Commission (FTC) that physicians who bill after rendering services are not subject to the red flags rule as creditors. To view the federal appeals court decision go to: <http://ama.pr-optout.com/ViewAttachment.aspx?EID=rhvBPIv6TFrQEnOBF28gCsqW26QjUiF4A5BGk5cMYbg%3d>

The United States Court of Appeals for the District of Columbia Circuit found the present regulations of the FTC invalid in light of the Red Flag Program Clarification Act of 2010, passed by Congress last December to shed much needed light on who is considered a creditor under the red flags rule. The court issued the judgment in a lawsuit filed by the American Bar Association challenging the application of the red flags rule to attorneys.

According to the court's opinion, "...the Clarification Act makes it plain that the granting of a right to 'purchase property or services and defer payment therefore' is no longer enough to make a person or firm subject to the FTC's red flags rule – there must now be an explicit advancement of funds. In other words, the FTC's assertion that the term 'creditor,' as used in the red flags rule and the FACT Act, includes 'all entities that regularly permit deferred payments for goods or services,' including professionals 'such as lawyers or health care providers, who bill their clients after services are rendered,' ...is no longer viable."

### **Version 5010 Transaction Standards Deadline Is Approaching. Are You Ready?**

There are less than *10 months* until all *HIPAA*-covered entities need to transition from Version 4010/4010A1 to Version 5010 electronic transaction standards. With the Sun Jan 1, 2012, deadline quickly approaching, have you taken the necessary steps to get ready?

Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes and must be in place before the changeover to ICD-10 on Tue Oct 1, 2013. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code. A key step in preparing your office for this upgrade is testing transactions in the new Version 5010 format. If you have not already done so, you should begin external Version 5010 testing now. Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will also allow you to identify any potential issues and address them in advance of the Sun Jan 1, 2012, compliance date. Keep Up to Date on Version 5010 and ICD-10. CMS has resources to help you prepare. Visit <http://www.CMS.gov/ICD10> and click on "Version 5010."

## **The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Spearheads Legislation to Address Physician Ratings in Ohio**

After several months of working with the AMCNO leadership and lobbyists, Senator Tom Patton (R-24) has introduced SB 121 - legislation meant to address the issue of physician ratings by insurance companies in Ohio.

The purpose of this legislation is to provide patients with accurate information when selecting a physician. This legislation would prevent health insurance companies from ranking physicians based solely on specific criteria to persuade a consumer to choose one physician over another. The legislation would modify the usage of physician rating (also referred to as physician ranking and physician designation) by medical insurance companies and public health plans.

The intention of the legislation is to apply a system of quality standards if and when a medical insurance company or public health plan uses a system of physician rating. The legislation will also notify a physician when they are being rated and allow for a process of appeal if the physician does not agree with the rating. This legislation will provide a system of fairness to the physician community. If passed, Ohio will be on the forefront of implementing important new policy that promotes accurate, safe and effective health care transparency for everyone.

The issue of physician ranking has been hotly debated for several years. In recent years, there has been an increase of physician ranking across the country. Insurers have supported obtaining data in order to tier and quantify cost effective care, and consumers have wanted data to compare quality of doctors. The crux of the debate is balancing the rights of physicians to have accurate and relevant reporting of their practice with the desire of health insurers and consumers to have access to information about their treating physician.

In the past, there has been a lack of scrutiny that has enabled health insurers to unfairly evaluate a physician's individual work by using an insufficient number of patient cases, questionable quality measurements and poor risk adjustment systems.

The AMCNO is of the opinion that doctor rankings can be confusing and could be used to steer patients to the least-expensive health care providers, rather than being based on quality. It is important that the insurance companies are truly reviewing quality issues versus cost and claims data, and the data must be accurate with the ability of physicians to appeal their data.

In the 128<sup>th</sup> General Assembly legislation was introduced by Rep. Barbara Boyd (HB 122) and Senator Patton (SB 98). HB 122 passed out of the House with a 97-1 vote and had two hearings in the Senate Insurance, Commerce and Labor Committee. The AMCNO was very active in this debate and was instrumental in getting this legislation to move through the Ohio House in the last General Assembly. The AMCNO also worked with other interested parties and stakeholders including the state medical association to craft changes to the legislation – changes which are reflected in this latest piece of legislation – SB 121.

The AMCNO plans to work diligently to achieve the passage of SB 121 in this General Assembly and we will keep our members apprised of when the bill will be up for testimony and discussion in the coming months.

## **AMCNO Provides Comments to the Ohio Health Information Partnership (OHIP) Patient Consent Policies for OHIP's Health Information Exchange**

Recently, the Ohio Health Information Partnership (OHIP) requested public comments on their Research and Recommendations for Patient Consent Policies for OHIP's health information exchange. After detailed



discussions and a thorough legal review of OHIP’s consent policy by various parties, a detailed comment letter was sent to OHIP on behalf of the AMCNO, Aultman Health Foundation, Care Alliance Health Center, Cleveland Clinic, EMH Health Care System, Sisters of Charity Health System/St. Vincent Charity Medical Center and Mercy Medical Center, Southwest General Health Center, Summa Health System, and University Hospitals. The parties decided to write and submit a combined letter, as opposed to each organization writing and submitting separate letters, to streamline the comment process. We found that many of the organizations shared similar comments and viewpoints. We all recognized that these issues are complex, and that it is difficult to craft a solution that can be consistently applied on a statewide basis which provides a reasonable level of protection to both patients whose information is exchanged through the HIE, and to provider participants in the HIE. In addition, Ohio law regarding the consent issues raised in the recommendations is not perfectly clear.

The OHIP Consent Model is based largely on an interpretation of Ohio law concerning patient consent. According to the Consent Model, patients must specifically consent to and authorize the transfer of their medical information from provider to provider for treatment purposes. Based upon this interpretation, the Consent Model proposes an “opt-in” framework for patient consent to include health information in Ohio’s HIE. Under the opt-in framework, each patient would need to specifically consent to allowing a provider to access the patient’s medical information through the HIE. The alternative to this framework would be an “opt-out” framework, in which patients could affirmatively choose to restrict the accessibility of their medical information through the HIE (i.e., to “opt-out”), but otherwise would not be required to consent to such access. Our response is based on concerns that the opt-in framework may raise public policy questions and create operational and administrative barriers for healthcare providers to participate in the HIE. In addition, Ohio law regarding patient consent for treatment purposes is silent and the interpretation of Ohio law supporting the opt-in framework is subject to meritorious and valid counter-arguments. Therefore, because of these issues, certain healthcare providers may decide not to participate in the HIE.

The letter to OHIP included an overview of Ohio case law and comments relative to public policy issues. The AMCNO and others from our region believe that the most appropriate approach to this issue is a change in Ohio law confirming that a patient’s consent is not required to allow a provider treating that patient to access the patient’s medical information (to the extent necessary to support the treatment). We believe that this is a commonsense approach to the issue that balances the patient’s interest in the confidentiality of medical information, the patient’s interest in having his or her health care providers conversant with his or her medical history, and the health care provider’s interest in reducing the cost of health care by reducing unnecessary administrative steps in caring for patients. The AMCNO would be supportive of pursuing such a change in Ohio law through legislation. Alternatively, the Consent Model and other OHIP forms, agreements and publications should indicate in relevant areas that because Ohio law is silent on the issue of what patient consent is needed for provider-to-provider transfers of information, each OHIP participant may make its own determination as to whether such consent is necessary. However, the Participant Agreement between OHIP and each provider should very clearly prohibit the provider from accessing medical information through the HIE for any purpose other than to support the treatment being provided to patients. OHIP received comments from around the state on this issue and they will be posting a response to comments no later than April 30<sup>th</sup>. The AMCNO will continue to provide our physicians with updates on this important issue.

### **ICD-10 Straight Talk: Overview**

By Angela “Annie” Boynton

BS, RHIT, CPC, CCS, CPC-H, CCS-P, CPC-H, CPC-P, CPC-I

The need to move to ICD-10 is a well-known and ongoing saga. The current standards: ICD-9-CM Volumes I, II and III are over thirty years old and are becoming increasingly outdated. Several factors including old terminology, obsolete technology, limited upgradability, and a lack of accurate international data exchange, have all furthered the need for an overhaul of the clinical classification system.

As a result of the Final Rule on January 15, 2009 the United States is implementing the diagnostic subset: ICD-10-CM (International Classification of Disease 10<sup>th</sup> Revision with Clinical Modification) concurrently with the procedural subset: ICD-10-PCS (International Classification of Disease Procedure Code System). The federal implementation compliance deadline for covered entities is October 1, 2013.

It is a well-established fact that the United States is one of the last economically developed nations to undergo the transition to ICD-10. Furthermore, the United States will be implementing the most comprehensive version of ICD-10 with a little over 155,000 codes in ICD-10-CM and ICD-10-PCS. Many countries (Germany, Canada, Australia, and New Zealand) implemented customized versions of ICD-10 tailored to their single payer health systems. By the time the October 1, 2013 implementation mandate arrives, almost 20 years will have passed since the first of our international neighbors underwent their ICD-10 transition process.

The single greatest challenge many physicians will have falls within improving documentation, which will require physicians to spend additional time to document better. The increased documentation needs alone are enough to anger many physicians. However, it is important to remember that the rules for documentation are not changing with ICD-10. Ask any physician/coder team who have been audited, and they will tell you that the documentation guidelines in ICD-9 are very specific, but the codes do not keep up with the documentation requirements. This is because the ICD-9 codes have not been specific enough. With ICD-10, for the first time we will have a clinical classification system that is sophisticated enough, and granular enough to keep up with the regulations.

The revenue and productivity impacts surrounding the transition are real and could be very significant if practices do not start building their implementation plan early-on. It is an industry accepted fact that revenue will be impacted in 2013. The severity of the impacts and to what extent is unknown, but the industry agrees that physicians, facilities and payers should plan for at least 6 months of revenue and productivity impacts. This is why early planning is so important for the ICD-10 transition.

As part of your ICD-10 implementation planning all medical practices should ask themselves the following:

- Does your practice have enough savings to sustain itself through 6 months of troubled financial times?
- How will you provide training to your coders to ensure productivity and revenue impacts are mitigated as much as possible?
- Will your payers be ready? Who have you spoken with within your payer organizations to confirm this?
- Will your practice management system be ready for the transition, and will your vendor take care of the update for free?

The banking industry has become more involved with the national transition to ICD-10. Many banks and financial leaders have informed healthcare organizations and industry stakeholder groups like, The Workgroup for Electronic Data Interchange (WEDI), and The Health Information Management Systems Society (HIMSS) that practices worried about their post-ICD-10 implementation revenue should consider financial options available to them now, and not wait until 2013. This is sound advice, which also requires additional planning. Hoping that ICD-10 will go away or ignoring the transition is a guaranteed means to failure.

The key to tackling ICD-10 is to analyze business processes, people and technology within your practice that currently use ICD-9 codes. Having thorough understanding of how, where and why the codes are used will better enable physicians to understand the extent to which work will need to be done to transition to ICD-10 successfully. Early planning is the key to success.

### **Coding Spotlight ICD-10-CM:**

The ICD-10-CM, the diagnostic subset, does have some additions, and changes, the most startling is the look of the code, up to seven alphanumeric characters which is quite different for the current 5 character system we use today. Physicians should expect the learning curve for ICD-10-CM to be much smoother than the procedural counterpart. The rules, conventions and guidelines in ICD-10-CM are very similar to what is currently in ICD-9-CM with only a few changes.

Let's use Chronic Kidney Disease (CKD) as an example: currently coders are required to make their code selection based on severity, this does not change in ICD-10. Classification of CKD in ICD-10 continues to be based on severity represented by stages I-V and is assigned from the N18 section. End Stage Renal Disease (ESRD) is still only assigned when it is actually documented and is also assigned from the N18 section. For cases where patients have CKD in conjunctions with other diseases like diabetes mellitus or hypertension, the ICD-10 book still directs the coder in the proper sequencing of the codes. Furthermore there are still codes to represent the complications of transplants, but in this area there is greater specificity available to adequately represent complications. A newer concept in ICD-10-CM is the multitude of combination codes available. In ICD-9-CM what took us two or three codes may now only take one combination code in ICD-10-CM. Take a look at this example:

- A patient diagnosed with malignant hypertension and stage 5 chronic renal disease is admitted to the critical care unit. The patient is now in acute renal failure with acute cortical necrosis.
  - o First listed diagnosis: I12.0 Hypertensive chronic kidney disease with stage V chronic kidney disease or end stage renal disease
  - o Second listed diagnosis: N18.5 Chronic kidney disease, stage V

### **Coding Spotlight ICD-10-PCS:**

The procedural subset: ICD-10-PCS, is unlike anything we have seen before. It vastly differs from what we currently use as it is a seven character, alphanumeric code that is table based. The ICD-10-PCS subset will be used highly in the inpatient facility coding arena, but knowledge of the codes at the practices level would be necessary for revenue analysis. The key to building an ICD-10-PCS procedure code is finding the correct table. This will require coders to have a higher level of anatomical and path physiological education, a medical terminology class is no longer enough. Coders will need a college level anatomy and physiology that can help them maneuver ICD-10-PCS. Take a look at this example:

- An in-patient diagnosed with gallstones opts for an elective laparoscopic cholecystectomy.
  - o Procedure: 0FT44ZZ Laparoscopic Cholecystectomy

Coders will need to understand body systems, root operations, body parts, approach, and devices. Root operations could pose serious issues for coders who do not have thorough understanding of anatomy, and how procedures are performed. For example coders will be required to differentiate between the following excision vs. resection, inspection, occlusions vs. restrictions, release vs. division, transplantation vs. administration, etc. Practices can be on the look out for reputable anatomy classes specific for ICD-10; many organizations are conducting or will begin conducting these classes soon. Furthermore, specialty physicians should look to their specialty societies for guidance. Many specialty societies are developing materials to help smaller practices navigate ICD-10 implementation. Bottom-line is that physicians should be engaging any available resource to them, whether it is from a specialty society or even from a payer. Most payers are further down the implementation pathway and have valuable knowledge and resources to share.

Simply put, if practices are not compliant by the October 1, 2013 deadline they are risking their business. This is not an over-dramatization, it is reality, and 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. There are absolutely no signs coming out of Washington D.C. that point toward ICD-10 being delayed. On the contrary, documentation coming out of the Centers for Medicare and Medicaid Services (CMS) states that October 1, 2013 is the final deadline. Therefore, the only sure way that physicians can protect themselves is to begin ICD-10 implementation before it is too late.

*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.*

Discounted Classes at Tri-C for  
AMCNO members

**Cuyahoga Community College  
AMCNO Discounted Medical Practice Management Seminars**

**The AMCNO is pleased to partner with Cuyahoga Community College (Tri-C) Center for Health Industry Solutions to offer certification courses and continuing education unit seminars at discount prices for AMCNO members and staff.**

For AMCNO member discount information contact: Linda Hale at 216-520-1000

- May 11<sup>th</sup>**                    **Compliance Update & Chart Auditing Workshop**  
8:30 am – 12:30 pm, \$169 (\$149 AMCNO), CEUs 4, CCE
- June dates TBA  
(contact AMCNO)**        **Surgical Coding--Optimize your reimbursement.**  
Location/time/date to be announced \$169 (\$149 AMCNO), CEUs 3.5, CCE
- Tuesday Evenings**        **Hospital/Facility Billing & Reimbursement**  
6 – 9 pm, \$249 (call AMCNO for discount price) CCE
- Saturday Mornings**      **Hospital/Facility Billing & Reimbursement**  
9 am – noon, \$249 (call AMCNO for discount price) CCE
- Coming soon:**            **ICD-10 Overview:**  
**Review of ICD-10 Structure plus Anatomy, Physiology & Terminology Review**  
Location/time/date to be announced; \$120 (call AMCNO for discount price), 4.5 CEUs
- Coming soon:**            **Anatomy and Physiology Program –**  
60 hours in-depth preparation to better understand and perform ICD-10-CM coding.  
Location/time/date to be determined; \$550 + \$200 book (call AMCNO for discount price).

**Locations**

CCE Corporate College East  
4400 Richmond Rd.  
Warrensville Hts 44128

CCW Corporate College West  
25425 Center Ridge Rd.  
Westlake 44145

IFHC Independence Family Health Center  
5001 Rockside Rd., Conf. Rm. B  
Independence 44131

UTF Unified Technologies Center  
2415 Woodland Ave.  
Cleveland 44115

***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](http://www.amcno.org)  
For a “Third Party Payor Review Form”.

Call us at 216.520.1000 or email [concerns@amcnoma.org](mailto: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](http://www.amcno.org)*

6100 Oak Tree Blvd· Suite 440 Independence, Ohio 44131

[www.amcno.org](http://www.amcno.org)

**216-520-1000 Executive Offices      216-520-0999 Facsimile**

