

Spring 2007

Medicare Update

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PHYSICIAN QUALITY REPORTING INITIATIVE TO LAUNCH JULY 1

*In April, the AMCNO co-sponsored a Webinar with Palmetto GBA on the topic of the Physician Quality Reporting Initiative (PQRI.) The AMCNO organized this event in partnership with PalmettoGBA in an effort to clarify for our members and their practice staff PQRI's components and requirements. Our featured speaker, Dr. Susan Nedza of the Center for Medicare and Medicaid Services (CMS) Special Program Office, meticulously went through the associated materials to explain the incentive structure and reporting details. Dr. Nedza explained that medical practices will be eligible for a 1.5 percent bonus under the Tax Relief and Health Care Act of 2006, which authorized the creation of the **PQRI**, and that will pay physician practices a capped bonus for reporting validated quality measures during the last half of 2007. It is a voluntary program that will provide a financial incentive not only to physicians but many other eligible professionals who successfully report quality information related to services provided under the Medicare Physician Fee Schedule between July 1 and December 31, 2007. All Medicare-enrolled eligible professionals may participate, regardless of whether they have signed a Medicare participation agreement to accept assignment on all claims.*

There are now 74 reportable quality measures posted at www.cms-hhs.gov/PQRI as a download on the Measures/Codes webpage. Detailed measure specifications and instructions will be posted well in advance of the July 1, 2007 deadline. The form and manner of reporting will be claims-based using CPT Category II codes (or temporary G-codes where CPT Category II Codes are not yet available) for reporting quality data. The CPT II codes are included in Appendix H of the CPT codebook and these codes are also posted on the CMS web site. Inputting modified CPT-II codes, physicians, using either the paper 1500 claim form (for which additional lines are to be added to accommodate this special reporting) or via electronic filing of

claims, will automatically be enrolled in the PQRI beginning July 1. One does *not* need to register to participate, as was required in last year's Physician Voluntary Reporting Program (PVRP). Quality codes are to be reported with a \$0.00 charge (physician participating in the program should check to see if their billing software will accept a zero charge prior to beginning the program, however, CMS will allow a nominal fee to be utilized if a system will not accept the zero charge.) Quality codes must be reported on the same claim as the payment codes. ***What would determine successful reporting?*** Physicians would have to meet reporting thresholds - i.e. if there are no more than 3 measures that apply, each measure must be reported for at least 80% of the cases in which a measure is reportable; and if 4 or more measures apply, at least 3 measures must be reported for at least 80% of the cases in which the measure was reportable. To be included in the PQRI process, the claim must include an accurate use of the National Provider Identifier (NPI.) Participating physicians who successfully report may earn a 1.5% bonus, subject to a cap. The 1.5% bonus calculation is based on the total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule. The 1.5 aggregate bonus payments will come in a lump sum payable to the Tax Identification Number (TIN) of the provider or practice in mid-2008. This is important to note that although individual providers will be reporting through their NPI number, the total bonus will not be delineated by CMS by the same identifier, should more than one in a practice setting submit measures during the six-month reporting period. For more information go to the above referenced web site or call 1-877-567-9232.

Coding Tips for PQRI:

G-Codes - Use only if no CPTII codes are available; report with CPT and/or ICD-9; report alone with no modifier

CPT II Codes - Report with CPT and or ICD-9; Include on same claim form, Report alone (or) with Modifier

Modifiers: 1P - Medical Reasons: Not indicated; Contraindicated

2P - Patient Reasons: Patient Declined; Economic, Social, Religious; Other

3P - System Reason: Resources Not Available; Payor Limitation; Other

Deadline for Use of Revised CMS-1500 Form Extended

Due to mistakes made by the Government Printing Office and other printers, CMS has extended the April 1st deadline for the use of the new CMS-1500 (08-05) form. The current CMS-1500 (12-90) form was revised in July 2006 by the National Uniform Claim Committee, predominantly for the purpose of accommodating the National Provider Identifier (NPI). Since that time, the industry has been preparing for the implementation of the revised form. The original implementation date for the revised form was January 1, 2007 with dual acceptability of both versions until March 31, 2007. Beginning April 1, 2007, the version of CMS-1500 (12-90) that is currently being used was to have been rejected by Medicare payers and the only acceptable version of the form was to have been the revised Form CMS-1500 (08-05). However, CMS recently announced that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office, due to the use of incorrect originals.

Given the circumstances, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Medicare payers will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At

present, CMS is targeting June 1, 2007 as the new compliance date. In the interim, when practices use the incorrect form, the Medicare payer will return the form to the practice, because CMS believes that this is the best approach to notifying practices of the problem. Practices that have forms returned to them should contact their form supplier for a corrected version. Additional information available at www.palmettogba.com/boh/guide

NPI Contingency Plan Announced

CMS has announced that it is implementing a contingency plan for covered entities (other than small health plans) that will not meet the May 23, 2007 deadline for compliance with the National Provider Identifier (NPI) regulations under HIPAA. The enforcement guidance released by CMS clarifies that covered entities that have been making a "good faith" effort to comply with the NPI provisions, may for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows. CMS made the decision to announce this plan after it became clear that many covered entities would not be able to fully comply with the NPI standard by May 23, 2007. Under this plan, covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, continue to submit claims to Medicare using their Provider Transaction Access Number (i.e., PIN and UPINs) after the May 23, 2007 deadline. Therefore you can continue to report the legacy number alone, the NPI alone or both numbers together on a claim FOR NOW. CMS recommends both numbers be used on claims. However, Medicare officials will assess claims submitted each month beginning in May and when they see a "sufficient" number with NPIs, CMS will begin requiring the NPI for the treating physician on all claims - with one month's notice to the physician. REMEMBER: The Physician Quality Reporting Initiative (PQRI), which starts July 1, requires you to use the NPI on ALL claims. If your office has not already done so, contact the Centers for Medicare & Medicaid Services (CMS) today to apply for the physician's NPI(s) at <http://www.cms.hhs.gov/NationalProvIdentStand> or dial toll free at (800) 465-3203 to get started. Simply log onto the National Plan and Provider Enumeration System (NPPES) at www.nppes.cms.hhs.gov and apply on line. **NPI - Get It. Share It. Use It.**

HCPCS and CPT Modifier Guidance

Palmetto GBA has a new web site feature of interest. Physicians and their staff can now access specific guidance on documentation requirements and submission guidelines for all HCPCS and CPT modifiers. To access guidance specific to each modifier, go to the www.PalmettoGBA.com/boh/articles and select Modifier Lookup.

Palmetto GBA Now Offers Interactive forms

Palmetto GBA is now offering interactive forms for Redetermination Requests (first level of appeal) and Quality Independent Contractor (Reconsideration) Requests (second level of appeal, formerly "hearings"). These forms may be launched directly from the Palmetto GBA web site, completed electronically, and then printed on hard copy to submit with appeal requests. To access these forms go to the Palmetto GBA web site at www.PalmettoGBA.com/boh/appeals and click on "View Attachment."

CMS Launches DOQ-IT University

The Centers for Medicare and Medicaid Services (CMS) now has a free, interactive, Web-based tool designed to provide solo and small-to-medium sized physician practices with the education for successful health information technology adoption, including lessons on vendor selection and operational redesign, along with clinical processes. Known as DOQ-IT University, or DOQ-IT U (pronounced dock it you) the first modules focus on physician office workflow redesign, culture change and communication necessary for EHR adoption, implementation of care management, and the incorporation of patient self-management components to clinical care. A technical advisory panel will provide content - and the panel is made up of experts from various physician-based organizations as well as private payers and HIT organizations. For more information go to <http://elearning.qualitynet.org>

Medicaid

Third Party Liability

By Federal and state law Medicaid is always the health care payer of last resort and therefore, Ohio Medicaid should not pay claims for a period when an individual or family had overlapping private health insurance. This includes the managed care plans. MCPs are to take on some of the responsibility to identify a consumer with third party coverage, and when the MCP does identify a consumer with other coverage, the MCP must verify the type and scope of the individual's benefit. If the Medicaid managed care consumer does not provide information about insurance coverage or denies having it to a health care provider, that provider may submit their health care claims to the MCP for reimbursement. MCPs should pay provider claims submitted that meet "reasonable measures." These include:

- ⇒ The provider has first submitted a claim to the third party payer and received remittance advice citing a valid reason for not paying the claim;
- ⇒ The provider has submitted the claim to the third party payer at least 3 times within a 90 day period and has not received remittance advice or other documentation (the provider must be able to document each claim submission.)
- ⇒ The provider has not submitted a claim, but has obtained written documentation from the third party payer that the service is not eligible for coverage.

Providers who have been unsuccessful with resolving third party payer payment issues with MCPs should contact the Bureau of Managed Health Care at (614) 466-4693.

Third Party

this review will become effective May 1, 2007.

MMO asking physicians to register their NPI

In order to assure a smooth transition, MMO is asking physicians to register their NPI. NPI numbers may be submitted by completing the Provider Information Form (PIF). The PIF may be found online in the Provider section of the MMO Web site at www.medmutual.com

MMO ProviderLink to be Discontinued

Providers who currently are registered ProviderLink users will soon be notified that this service is being disconnected. For providers that have used ProviderLink in the past to check claim and benefit and eligibility status that have not yet moved to another vendor, MMO asks you to view the current payers accessible through Emdeon Office. The ProviderLink site presently offers a gateway page to www.office.webmd.com, which will take you to an overview of Emdeon Office.

UnitedHealthcare - How to submit your NPI information

If you wish to register your NPI with UnitedHealthcare go to www.UnitedHealthcareOnline.com and select "National Provider Number" (under "Most Visited") for additional information on NPI and links on how to submit your NPI information to UnitedHealthcare.

UnitedHealthcare 2007-2008 Administrative Guide Effective April 2007

The new UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for 2007-2008 were effective April 1, 2007 for currently contracted providers. For providers contracted on or after January 1, 2007 the guide became effective immediately. The guide contains changes you will want to review, such as new notification requirements to certain services, modifications to the elements of a complete claim, and the new protocol regarding delays in service. The Guide is available for viewing and printing at www.UnitedHealthcare.com

AMCNO board of directors meets with new medical director of United HealthCare for the Northern Region

In April, the AMCNO board of directors had an opportunity to meet and talk with Dr. Giesele Greene, the new medical director of UHC for the Northern Ohio region. Among the topics discussed with Dr. Greene were UHC's practice to require participating providers to refer lab services to a participating lab network. The intent of this program is that after March 1, 2007 continued referrals to non-participating labs may, after appropriate notice, subject the referring physician to one or more of the following actions: 1.) a financial penalty of \$50; 2) a decreased fee schedule; 3) a change in eligibility for the Premium Designation program or 4) termination of network participation. The AMCNO is of the opinion that UHC should remove the economic sanction until such time that any questions that have arisen regarding these new rules have been addressed and reviewed. It is our opinion that our members should not be subject to a change in rating or a penalty by an insurance company if the patient makes a decision to use a non-network lab. In addition, the AMCNO questions whether or not UHC even has the authority to require

such financial penalties. Last, the AMCNO expressed concern as to whether or not the imposed rules to use only in-network labs would in some way impact existing referral contracts with UHC.

Dr. Greene also briefly discussed the UHC radiology notification program. Beginning April 16th, UHC required prior notification for the following defined set of outpatient imaging procedures: CT scans, MRIs, PET scans and nuclear medicine studies, including nuclear cardiology. Dr. Greene noted that UHC is calling this process prior notification and the program contains different requirements than prior authorization or pre-certification. In addition, failure by a practice to notify UHC prior to performing the procedure can result in not getting paid for the service. Physicians and their staff may obtain additional information regarding the Radiology notification program at <http://www.unitedhealthcareonline.com>. If any AMCNO members have specific issues with either of these programs, please email your comments to ebiddlestone@amcnoma.org

NEWS YOU CAN USE

Postage Rates to Go Up May 14, 2007

A major change in how we pay for postal service will go into effect May 14, 2007. Currently, a letter or large envelope costs 39 cents per ounce, regardless of size. Beginning May 14, there will be four basic types of mail, each with their own rate structures. The rate schedules are based upon the dimensions of the item being mailed and are categorized as post cards, letters, flats and packages. The basic letter, which is now 39 cents, will increase to 42 cents an ounce. There are strict dimensions as to what is considered a letter. The flat category, which most patient records, and x-rays are in, will increase from 39 cents to 62 cents an ounce. A package will cost \$1 per ounce. For more information, contact you local post office.

CCHIT Certifies 30 EHR Systems

The Certification Commission for Healthcare IT has certified 30 additional electronic health record systems for ambulatory care under the 2006 criteria, which brings the total number of CCHIT certified products to 81.

The recently certified systems include:

- ⇒ athenahealth;
- ⇒ The Department of Defense/Military Health System's Armed Forces Health Longitudinal Technology Application;
- ⇒ MeridianEMR;
- ⇒ Partners Healthcare System's Longitudinal Medical Record; and
- ⇒ WorldVista EHR, an open-source system that runs in the hospitals and clinics in the Department of Veterans Affairs.

CCHIT in 2005 began working under a three-year, \$7.5 million HHS contract to provide certification testing for health IT products. CCHIT was represented at the recent Academy of Medicine of Cleveland & Northern Ohio (AMCNO) seminar in March 2007 – for related stories see our most recent issue of the Northern Ohio Physician magazine.

LAWYER REFERRAL BROCHURE - A membership service of the AMCNO

If an AMCNO member needs to retain legal counsel or representation, the "Lawyer Referral Brochure" may be of assistance. In response to frequent calls received from members asking for the names of attorneys with specific areas of expertise, the AMCNO has created our Lawyer Referral Brochure. The law firms listed in the brochure have indicated that they would be willing to work with physicians on specific issues. The referral brochure contains information from several health care related law firms in the Northern Ohio area. The rates of participating attorneys will vary, with some indicated that they would provide a discounted fee to AMCNO members. This brochure was mailed out to all AMCNO members this month - watch your mail.

Directories Arriving in Your Office Soon

The AMCNO is currently working on our 2007-2008 Membership Directory. All members receive one complimentary copy of the AMCNO membership directory. The directory provides contact information on all AMCNO members as well as information on community resources and legislative contacts. The directory should be ready for mailing by June 2007.

AMCNO to offer "Solving the Third Party Payor Puzzle" Seminar in November 2007

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) will once again offer our yearly seminar entitled "Solving the Third Party Payor Puzzle" on Wednesday, November 14th. This informative session, the first of its kind in the state and now in its twenty-second year offers presenters from PalmettoGBA, Ohio Job and Family Services, and other third party payors including UnitedHealthcare, Medical Mutual of Ohio and Anthem BC/BS. Watch your mail and physician member emails for more details - or call the AMCNO to sign up to receive more information at 216-520-1000, ext. 103.

AMCNO Legislative Initiatives of Interest

The AMCNO employs three lobbyists that work on behalf of our members and staff at the Statehouse on issues relative to doctors in our region. The following is a snapshot of the some of the key issues under review by the AMCNO.

SB 59 directs the head of the Ohio Department of Insurance in collaboration with the Ohio Supreme Court, to establish a pilot program mandating arbitration of all medical liability claims prior to filing a claim in court in specified counties – including Cuyahoga and the surrounding area. The goal of the legislation is to utilize Alternative Dispute Resolution (“ADR”) to obtain a more efficient and fair resolution of medical liability claims. Key provisions of the bill include: review of claims by an arbitration panel made up of a one medical expert for the plaintiff and one for the defendant and a chairperson versed in arbitration proceedings; a bifurcated arbitration process where the panel shall only rule on liability not damages; and the bill contains a modified loser pay provision if the panel rules the claim was unwarranted and either party takes the claim to court. The AMCNO spearheaded the introduction of this legislation and we strongly support it. For additional information on this bill go to our website at www.amcnoma.org and click on SB 59.

House Bill 125/Senate Bill 127 are identical bills that would establish uniform contract provisions between health care providers and third-party payers, to establish standardized credentialing, and to require third-party payers to provide follow specified parameters when dealing with physicians such as: prohibiting a health care contract from including provisions such as a “most favored nation clause”; outlining that disputes with insurance carriers are subject to arbitration; requiring a third-party payer, upon presentation of a proposed health care contract, to make available to the physician all compensation and payment terms; and requiring a third-party payer to provide information on enrollees in an electronic format. The AMCNO has a long history of working diligently on behalf of our members on insurance related matters and we support this legislation.

Senate Bill 104 – Benefit agreements – this bill would require insurers and other third-party payers to accept and honor assignment-of-benefit agreements entered into between plan beneficiaries and treating physicians. The AMCNO is supporting this legislation and will write to the sponsor voicing our strong support. Hospitals already have laws on the books regarding this issue but not physicians; therefore, the AMCNO is supporting this legislation and will write to the sponsor voicing our strong support.

If any of our members or office staff would like to contribute items to the AMCNO that we could utilize in testimony on the above referenced bills, please contact our offices at (216) 520-1000, ext. 100.

Did You Know?

The AMCNO offers all manner of practice management assistance to our members from third party payor claims review to discounted Tri-C classes on billing/coding standards. Call the Physician Advocacy Committee and Practice Management staff at 216.520.1000 ext. 103. See detailed information on our discounted classes at Tri-C on the last two pages of this update!!

AMCNO Discounted
Classes Now Available at
TriC

Coding and Compliance Seminar
Revenue Cycle Management Strategies
Wednesday, June 20th
8:00am-12:30pm
Corporate College East*

AMCNO Member Discount!

Speaker: Kenyokee Crowell, MBA, CPC, CCS brings 13 years of experience in physician billing, coding, provider enrollment and management consulting.

Can you identify your top ten CPT Codes and how your coding affects the revenue in your practice? Do you fully understand all of the elements of your practice’s revenue cycle? Attend to explore how

professional coding practice relates to the financial viability and critical compliance of your practice. Dissecting and assessing the many elements of your revenue cycle is essential for diagnosing problems that can negatively affect the revenue stream of your practice. This session will offer management strategies to effectively and compliantly manage all the critical steps of the revenue cycle from first contact with the patient to a successfully paid claim.

Topics Covered

- Volume, trends and changes
 - The integral relationship between coding and finance
 - Revenue Cycle assessment scorecard
 - Key indicator reports
- How to query potential employees for their coding and compliance knowledge

Are you able to answer these questions for your practice?

“How does my coding accuracy affect my area’s reimbursement?”

“Am I coding for compliance?”

“Do we follow-up denials to resolution in the most efficient way?”

\$159-AMCNO Discount applies – Course Number CRN 54573.

Members and/or their staff will need an exclusive AMCNO course number to register and obtain the discount. For discount course number, call Linda Hale of AMCNO at 216-520-1000, ext. 101, or e-mail lhale@amcnoma.org
After receiving your AMCNO Discount number, call TRI-C to register at 216-987-3075.

For Program questions, call Alison Arkin at 216-987-3071. For other course information visit www.corporatecollege.com

*Corporate College East – near the intersections of I480 & I271

4400 Richmond Road

Warrensville Heights, OH 44128

Phone: 216.987.2800

For directions, visit www.corporatecollege.com

Center for Health Industry Solutions

Presents An AMCNO Discount Program for:

**The American Academy of Professional Coders’ (AAPC)
Professional Medical Coding Curriculum**



**August 7-November 6, 2007
Tuesday and Thursday nights
6:00-9:00pm**

**Corporate College - East
4400 Richmond Road
Warrensville Hts., Ohio 44128**

AMCNO Discount

Would you like to enter the growing field of professional medical coders?

*Do you have professional coding experience but
Need certification?*

\$1650.00

The AMCNO is proud to partner with Cuyahoga Community College in their practice management seminar and class offerings, with **significant discounts made available to AMCNO members and their staffs**. In addition to the other classes noted in this publication Tri-C and the AMCNO are offering additional discounted courses (see below.) Interested staff will need an exclusive AMCNO course number to register and obtain the discount. For course numbers, call Linda Hale of at 216-520-1000, ext. 101, or e-mail lhale@amcnoma.org. For course information visit www.corporatecollege.com Classes are offered at Corporate College East or West (CCE) (CCW) and the Unified Technology Center (UTC).

❖ **CASE SCENARIO CODING II-CODING FOR PHYSICIAN SERVICES**

June 20 - Wednesday, 1:00pm-5:00pm \$159.00
Scenarios will be extracted from actual medical record documentation from medical and surgical cases and procedures and increase your accuracy in the reporting and coding of surgeries. Take your skills to the next level and expand your expertise through hands-on practice from a range of specialty areas. CEUS: AAPC-4; PMI-4
Note: Bring current CPT and ICD-9-CM Coding Manuals

❖ **MEDICAL BILLING REIMBURSEMENT (24 hours)**

July 18-Sept. 12 Wed. eves. 6:00-9:00pm
\$282.00

Take this course to enhance your billing skills. Explore insurance verification, eligibility and billing for Medicare, Medicaid and commercial insurance covered medical services. Practice completing claims for compliance in our computer lab. Texts required.

❖ **MEDICAL TERMINOLOGY/ANATOMY & PHYSIOLOGY (30 hours)**

June 5-July 12 Tues/Thurs eves. 6:00p-8:30pm
\$216.00

Prepare for ICD-10! This course teaches medical terminology, human anatomy, and methods for retaining the material. Participants will review the structure and composition of the human body and organ functions while learning helpful methods for breaking down medical terms and word meaning. Text required.

Practice Management MATTERS

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

Call us at 216-520-1000 or email concerns@amcnoma.org

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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