

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

Spring 2008 Edition

Medicare Update

In this issue – Discounted Practice Management and Coding Classes Available for AMCNO member staff at Tri-C

The AMCNO urges support of S 2785 – The Save Medicare Act

A bill introduced by U.S. Sen. Debbie Stabenow, D-Mich., would replace 18 months of Medicare payment cuts to physicians with payment updates that better reflect medical practice cost increases. On July 1, 2008, Medicare will cut physician payments by 10.6 percent. The 18-month timeframe in the Save Medicare Act of 2008 (S 2785) will provide stability into the payment system. It will also give Congress time to begin working on a long-term solution to the payment system without having to take action to stop the cuts twice in one year. The Medicare Payment Advisory Commission has made a recommendation to lawmakers to replace physician payment cuts with updates that reflect medical practice cost increases.

The AMCNO and other organizations support the bill sponsored by Sen. Debbie Stabenow (D-Mich.) that would increase physician fees by 1.8% for 18 months and would not include "balloon financing" language that would set up higher pay cuts in the future to compensate for a temporary delay. The AMCNO physician leadership has sent letters to all Northern Ohio Congressional representatives asking for their support of S 2785.

AMCNO members and staff are encouraged to send letters to Congress as well. To send a letter to Congress in support of S 2785 AMCNO members may visit our web site at www.amcnoma.org and click on the "Legislation link/Find you legislator" to send a prepared letter to your representative or senator directly through our web site.

Center for Medicare and Medicaid Services (CMS) Updates Web-based Manual System

The CMS Online Manual System: A Web-based Manual System for Medicare Contractors, Providers and State Agencies brochure has been updated and is now available to order print copies or to download as a PDF file. This brochure explains how to navigate the CMS Online Manual System. To view the PDF file, go to <http://www.cms.hhs.gov/MLNProducts/downloads/on-linebrochure.pdf>. Print copies may be ordered by visiting the MLN Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.

Notice of New Interest Rate for Medicare Overpayments & Underpayments: 3rd Update for FY 2008

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 11.375 percent effective April 18, 2008.

Important NPI Date is Here – May 23, 2008

Physicians and office staff – remember that as of May 23rd old legacy numbers will not be accepted on any electronic claims. Claims will only be accepted with a National Provider Identification (NPI) number. That deadline applies to all payers. Physicians are strongly urged to test sending their claims with just their NPI as soon as possible to avert claims processing and cash flow interruptions that could occur after May 23. Physicians also should ensure that all of their information in the NPI database is up to date. Incorrect information in the NPI database can affect a payer's ability to identify a physician and pay his or her claims. Physicians can change or update their information by visiting <https://nppes.cms.hhs.gov/NPPES/Welcome.do> or calling (800) 465-3203. If AMCNO members experience problems with the implementation of the NPI, please contact our offices.

Carriers must send more detailed denial and revocation letters

CMS has added specific guidelines requiring carriers to provide more details when issuing enrollment denial and revocation letters. CMS has also extended the filing period for submitting enrollment reconsideration letters. Effective on May 12th, physicians will have an additional 5 days to allow for mailing time.

The new guidelines require carrier denial and revocation letters to include the following information:

- a clear explanation of why the application is being denied or why Medicare billing privileges are being revoked;
- the regulatory basis to support each reason or reasons for the denial or revocation;
- an explanation of how the provider does not meet the enrollment criteria or (for a revocation) why the provider no longer meets enrollment criteria;
- how to submit a corrective action plan (CAP);
- in the case of revocation *only*, the effective date of revocation; and
- information on appeal rights, including procedures for requesting reconsideration.

To view the transmittal go to: <http://www.cms.hhs.gov/transmittals/downloads/R521Pl.pdf>

New ABN form finalized

CMS has finalized the new Advance Beneficiary Notice (ABN). Physicians have until September 1, 2008 to make the change to the new notice. The new ABN has four key changes:

- It's a consolidated version of the two existing ABN forms, the ABN-G for general services and the ABN-L for lab services, so it replaces both
- It can be used instead of the Notice of Exclusion from Medicare Benefits form (NEMB)
- It contains a mandatory field for cost estimates of the services being performed
- It includes a new option for beneficiaries that allows them to choose a service for which they will pay out-of-pocket, without having a claim submitted to Medicare

For more information on the new ABN go to: <http://www.cms.hhs.gov/bni>

CMS releases HIPAA security checklist for on-site audits

The Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS) has published audit information in a document titled "Information Request for Onsite-Compliance Reviews." This sample checklist was developed to ensure that the industry is aware of key compliance areas should OESS conduct on-site compliance audits related to potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. OESS on-site investigations may be triggered by complaints alleging a violation of the security regulation.

Some examples from the checklist include:

Policies and procedures and other evidence that address:

- Prevention, detection, containment and correction of security violations;

- Employee background checks and confidentiality agreements;
- Establishing user access for new and existing employees;
- List of authentication methods used to identify users authorized to access Electronic Protected Health Information (EPHI);
- List of individuals and contractors with access to EPHI, including copies of pertinent business-associate agreements;
- List of software used to manage and control access to the Internet;
- Detecting, reporting and responding to security incidents (if not in the security plan);
- Physical security:
- Encryption and decryption of EPHI;
- Mechanisms to ensure integrity of data during transmission, including portable media transmission (e.g. laptops, cell phones, personal digital assistants, thumb drives);
- Monitoring systems use – authorized and unauthorized;
- Use of wireless networks;
- Granting, approving and monitoring systems access (e.g. by level, role and job function);
- Sanctions for work-force members in violation of policies and procedures;
- Policies and procedures for emergency access to electronic information systems;
- Password management policies and procedures;
- Secure workstation use (documentation of guidelines for each class of workstation, e.g. on-site, laptop and home system); and
- Disposal of media and devices containing EPHI.

The OESS may request certain documents and other information for investigations/reviews. There are other documents included on the checklist that are of importance to physicians and their office staff. To view the complete checklist, go to

www.cms.hhs.gov/Enforcement/Downloads/InformationRequestforComplianceReviews.pdf.

Medicaid

Ohio Job and Family Services (ODJFS) issues reminder regarding usage of tamper resistant prescription pads

The Ohio Department of Job and Family Services (ODJFS), has officially posted information regarding the April 1st implementation date for the usage of tamper-resistant prescription pads. Physician offices please note: effective as of April 1, 2008, the federal government (CMS) required that all prescriptions provided on behalf of Medicaid patients covered by traditional Medicaid be written on tamper-resistant prescription pads. The prescriptions are required to have, at a minimum, a single tamper-resistant feature. This requirement does not currently apply to Medicaid recipients covered by any Medicaid managed care plan.

Overview of tamper resistant prescription pad law

In order for Medicaid outpatient drugs to be reimbursable by the federal government, all written, non-electronic prescriptions must be executed on tamper-resistant pads. To be considered tamper resistant a prescription pad must contain at least one of the following:

- one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
- one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

As of April 1, 2008, a prescription pad/paper must contain at least one feature in each of the three categories listed above. In addition, as of April 1, computer-generated prescriptions must be printed on paper that meets the above requirements. In addition, at a point one year after the implementation date, in order for prescription pads to be considered tamper resistant, a prescription pad must contain all three of the foregoing characteristics.

Third Party Payors

CIGNA

Online Precertification

CIGNA is now offering online precertification. This service provides a quick response to a precertification request.

- Physicians can complete their precertification request or inquiry online – more convenient than a phone call.
- Get an immediate response to your precertification request – some may receive immediate approval.
- Print request responses for your patient records.
- View the status of any precertification request – even those submitted by phone or fax.
- Search by precertification tracking number or by member.

With online precertification physicians can determine if precertification is required and submit and check the status of precertification requests for covered inpatient services, certain outpatient services (when required by a CIGNA HealthCare plan) and injectable medications (when covered under the medical plan). For more complex services, you may be asked to submit additional clinical information. If your request is denied, you will receive notification, including the reason for denial and how to appeal the decision.

There are two ways to access online precertification

Through the CIGNA for Health Care Professionals website (www.cignaforhcp.com), or through the NaviNet® for CIGNA HealthCare website (<https://navinet.navimedix.com>). If you have any questions, call 1.800.88CIGNA (882.4462).

Laboratory Update

On January 1, 2008, CIGNA expanded the national network of participating laboratory providers. CIGNA currently contracts with Laboratory Corporation of America (LabCorp) and Quest Diagnostics (Quest), as well as other regional laboratories to offer you and your patients quality service at competitive rates. LabCorp has 1,650 patient service centers nationwide, with 36 primary testing facilities. For patient service center information call 1-888-522-2677.

Quest Diagnostics offers more than 2,100 patient service centers. For patient service center information, call 1-800-377-7220. For a complete listing of the participating labs available in this area, access the online provider directory at www.cigna.com and select 'Provider Directory' at the top of the page, then select the 'Facility/Ancillary' category.

UNITEDHEALTH CARE

New and Improved Claim Letters Debuted in April

UnitedHealth Care launched a communication initiative that involves revising the entire inventory of UNET claim transaction letters sent to consumers, physicians and other health care professionals, while launching a new system to produce these letters. Claim letters are typically sent to physicians, facilities and other health care professionals to request additional information needed to process a claim or provide a status on a claim. The focus of this initiative is to improve the quality and readability of these letters and produce them in a consistent, user-friendly format.

Letter recipients have often reported that they are unclear about why they are receiving claim letters and what actions they need to take. Others critiqued the grammar and tone saying that the letters were difficult to understand.

Below is a summary of changes to the claim letters you could receive from UHC:

- Improved content for an easier read
- Professional tone that gets to the point
- An easier-to-read format with call-out boxes and bullets that highlight key information
- Clearer calls to action
- One direct phone number to address questions

UnitedHealth Care began using the improved claim letters in April. Letters will be phased in through June as the letter inventory undergoes its transformation.

Specialty Pharmacy Referral Line Serves as Resource for Prescribing Physicians

UnitedHealth Pharmaceutical Solutions (UHPS) offers a referral line to assist members and physicians who participate in the Specialty Pharmacy Program. The Specialty Referral Line helps direct members, physicians and other health care professionals to the right specialty pharmacy professional for filling a specialty medication. The referral line is also a resource for physicians to call to obtain medications covered under the medical benefit from a contracted Specialty Pharmacy if they choose not to maintain their own inventory and bill the HCPCS code for medications. The Specialty Referral Line is 1-866-429-8177.

MEDICAL MUTUAL OF OHIO (MMO)

Updated Professional Provider Manual (PPM)

Medical Mutual has recently updated the Professional Provider Manual (PPM). CD-ROM versions of the PPM are being distributed to providers and are also available online. The CD version will allow providers to quickly navigate through the important information using bookmarks, thumbnails, links to manual sections and links between and within sections. The *Search* function provides the option to search for a word, phrase or number either in a selected section or throughout the entire PPM. Contact information, claim submission instructions and pre-authorization review guidelines/requirements are only a part of the information available. The 2007 Professional Provider Manual is available online in the Provider section of the MMO web site:

http://provider.medmutual.com/Tools_and_resources/Manuals/Main.aspx

Formularies Available Online

Formularies are also available online at MMO and are continuously updated. Depending on the covered person's benefits, a phone number for additional formulary information may also be found on his/her ID card. Medical Mutual contracts with Medco Health Solutions, Inc. to manage its prescription drug program, and uses Medco's *Preferred Prescription*® (includes more than 900 drugs) and *RX Selections*™ (more than 700 drugs and drug spending reduction feature) formularies. Current pre-authorization information for medications needing prior approval is also available online. To view the formularies online, go to the *Tools & Resources* tab, within the Provider section of Medical Mutual's Web site:

http://provider.medmutual.com/TOOLS_and_RESOURCES/Care_Management/rXBenefits.aspx

ANTHEM

Implementation Change for Changes in Reimbursement of After Hours Services

Recently, Anthem announced that as of May 1, 2008 they would change their policy in Ohio and allow additional reimbursement for 99050 only in the place of service (place of service 11). Codes 99051-99060 would be considered part of the primary service and would not be reimbursed separately in any place of service. Anthem has DELAYED the implementation date for this change – the new implementation date is now set for June 5, 2008. Anthem has noted that they recognize that additional reimbursement is needed when services don't occur during regularly scheduled office hours. However, services that are provided during regular office

hours or in 24-hour facilities are considered a normal course of business and are part of the reimbursement for the actual services provided according to Anthem.

Changes regarding Modifiers 50, 52, and 53

On December 1, 2007, Anthem implemented modifier changes for modifiers 50, 52 and 53 as noted below. Since the implementation, Anthem has received inquiries as to whether the 12/1/07 date applies to date of service (DOS), the date when the service was rendered or to the date the claim was processed. This change date applies to DOS. Anthem has noted that for services performed on or after 12/1/07 the following new processes apply:

- Modifier 50 (Bilateral procedure) – Modifier 50 should be submitted on a single line, and bilateral and multiple surgery logic applied, consistent with current Medicare guidelines.
- Modifier 52 (Reduced services) and/or Modifier 53 (Discontinued Services): Reimbursement for services submitted with modifier 52 and/or modifier 53 will be reduced by 50% of the allowable amount. Anthem has stated that this reimbursement is to more accurately reflect the actual services performed. If a physician feels a higher percentage should be allowed due to the work completed, a review of the records may be requested.

NEWS YOU CAN USE

AMCNO Meets with Ohio Department of Insurance regarding prompt pay and external review issues

The Ohio Department of Insurance (ODI) convened a meeting of physician/provider groups to discuss how ODI handles prompt pay and external review issues. In brief, the ODI staff noted that they receive about 2,000 complaints a year from providers, however, over one-half of the complaints involve ERISA plans, Medicaid/Medicare or Federal Employee Benefit Plans and under the law these are all outside the jurisdiction of ODI, so only about 1,000 prompt pay complaints are evaluated by ODI each year.

Fifty percent of those reviewed and submitted to ODI are not prompt pay issues and involve denials or other insurance issues and therefore, are not reviewed. Of the complaints that were valid and filed in 2007 – 27% of these were reversed or payments were made to the providers. ODI staff noted that it is important that physicians/providers understand that they have to go through the insurance company internal appeals process first before filing a complaint with ODI. Currently, no reports on prompt pay complaints are issued by ODI. AMCNO and other groups in attendance voiced concern that this information was not readily available and asked that ODI consider preparation of such reports for dissemination. It would be helpful to know what type of complaints are processed, how many involve hospitals, physicians or other provider types and what percentage are reversed each year. In addition, a breakdown by category of complaint and insurance company involved would be helpful. ODI plans to review this request and respond back to the AMCNO.

The next topic discussed was the Ohio Patient Protection Act. With regard to the external review process, ODI staff stated that an external review by an independent review organization (IRO) can only be done after the consumer has completed the health plan internal review process. After a consumer has been told that they have been denied by the insurance company there must be, by law, included on the explanation of benefits form or denial letter that is sent to the patient a notation from the insurance company stating that they are entitled to an external review process. This review could occur if it involves a medical necessity issue over \$500.00 and if the member can show that the provider states that the service is needed; or it involves an experimental investigational therapy for a terminal illness with a probable cause of death within two years. The health insurance company would file the request for review and the IROs are randomly selected. When the IRO makes their decision the decision is binding on the health plan but not on the member – they can seek legal counsel.

The AMCNO raised the question regarding the issue of medical necessity and what was the definition of “medical necessity” utilized in the review process and did the IROs use a specific definition of medical necessity when making their decision. The ODI staff provided a brief overview of the Ohio statutes but then

indicated that they need to research this further and respond back to both the AMCNO and the group on the medical necessity issue.

There was concern expressed by both the AMCNO and the group that the ODI appeal/external review process did not provide better consumer and physician/provider notice of the appeal process and outcome. At this time, the physician/provider is not aware of the appeal and do not receive information on the outcome. A discussion ensued of the value of a one-page document that outlined the rights and process of physicians and patients along with the requisite notice. ODI plans to prepare an explanatory document on the rights of consumers to an external review and provide this information to the AMCNO and the group for dissemination to association members.

Physician members and their staff are asked to provide the AMCNO with any experiences they may have had with the ODI with regard to prompt payment reviews or external reviews conducted on behalf of their patients. Please contact the AMCNO office at 216-520-1000.

State Medical Board of Ohio Requires Criminal Background Check for Licensure

On Monday, March 24, 2008 the State Medical Board began requiring a criminal background check for **initial licensure** and **restoration of licensure**. To view information from the State Board regarding this requirement go to <http://www.med.ohio.gov/pdf/Criminal%20Background/Criminal-Background-homepage.pdf>

Electronic Communications with Patients

Physicians have many ways to communicate with patients, including e-mail and through the Internet. The American Medical Association (AMA) Council on Ethical and Judicial Affairs recommends that physicians consider these guidelines prior to communicating with patients electronically:

- E-mail correspondence should not be used to establish a patient-physician relationship. E-mail should supplement other, more personal, encounters.
- When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance on the appropriateness of offering specialty care or advice through e-mail communication.
- Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
- Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's written authorization.

House Bill 125 – the Healthcare Simplification Act

Ohio recently enacted legislation that requires health plans to be much clearer and open about contract terms with physicians, including disclosing what insurers will pay for services and regulating the use of so-called silent preferred provider organizations (PPOs). The Healthcare Simplification Act, signed in late March by Ohio Gov. Ted Strickland, was the culmination of a 1½-year legislative fight between physician organizations

that demanded health plans to be more transparent about contract terms, and insurers and corporate interests who viewed the law as cumbersome and not cost effective. The bill will become law on June 25, 2008.

The AMCNO supported HB 125 and the AMCNO lobbyists attended the interested party hearings on this legislation. House Bill 125, sponsored by Representative Matt Huffman does the following:

- establishes uniform contract provisions between health care providers and contracting entities;
- establishes rules for standardized credentialing, requiring insurers to credential physicians within 90 days, and establishes a \$500 per day penalty or requires retroactive reimbursement if an insurer does not meet the deadline;
- ensures that physicians get a copy of their full fee schedule from HMOs, third party administrators and other insurers;
- requires insurers to provide physicians with a summary disclosure form of the contract that outlines contract terms such as compensation, coverage categories, contract duration, the entity responsible for processing claims, and also a dispute resolution process. The bill also requires that physicians receive notice of any addenda to the contract;
- modifies the fees that may be charged for electronic copies of certain medical records (i.e. BWC, ODJFS, and others) and allow an authorized person to obtain one copy of a person's medical record without charge (this does not alter the current law for other physician record fees);
- restricts the selling or renting of a physician's contract to another company under certain conditions;
- requires insurers to notify physicians 90 days in advance of changes to the contract that would decrease payment, increase expenses or add a new product;
- restricts the usage of "all products" clauses but only under certain conditions;
- requires the Ohio Department of Job and Family Services to allow managed care plans to use providers to render care;
- creates an Advisory Committee on Eligibility and Real Time Claim Adjudication; and
- provides for a moratorium on the usage of most favored nation clauses (MFNs).

The MFN issue elicited a lot of debate during discussion of the legislation and became a key issue. During the moratorium on the usage of MFNs, the Bill forms a joint legislative committee to review this topic. The 15-member Joint Legislative Study Commission on Most Favored Nation (MFN) clauses in health care contracts is to be chaired by the Superintendent of Insurance and is charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly. There is also a Moratorium on MFN clauses of two years during the deliberations of the Committee. There is also an outright ban on the MFN clauses that begins in three years. The MFN ban and moratorium does not apply to hospitals. The AMCNO has prepared a detailed synopsis of HB 125 – for a copy of the AMCNO synopsis, please contact our offices at 216-520-1000.

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

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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