

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

PRACTICE MANAGEMENT MATTERS

Summer 2008 Edition

Medicare Update

In this issue – Don't forget to register for the AMCNO Solving the Third Party Payor Seminar in November – details inside

AMCNO Applauds Congress for overriding presidential veto to stop Medicare physician payment cuts

In July, Congress voted overwhelmingly to override President Bush's veto of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331), allowing the bill to become law. The AMCNO applauds Congress for this action and we sent thank you letters to all of the Representatives from Northern Ohio who voted in favor of the legislation along with both Senators Voinovich and Brown.

Following the president's veto, the U.S. House of Representatives reached a required two-thirds majority to override it with a 383-41 vote, and the Senate followed suit by a 70-26 margin. The bill replaced the 10.6 percent payment cut that went into effect on July 1 with a 0.5 percent update extension through Dec. 31, and it provides an additional 1.1 percent update for 2009. The 18-month reprieve this bill provides allows Congress time to work with physicians on developing a long-term solution to a payment system that all agree is completely inadequate. The legislation specifies that the 0.5 percent payment update for the remainder of 2008 becomes effective July 1, so the 10.6 percent cut that was to be reflected in claims paid this week will be cancelled.

The AMCNO will actively work to assure that Congress reviews the Sustainable Growth Rate (SGR) formula in order to provide for a system that will appropriately reimburse physicians in order to avert this yearly battle at the legislature. The AMCNO is also concerned about the manner in which the Geographic Practice Cost Indices (GPCIs) are applied throughout Ohio creating an unfair reimbursement level for physicians in Northern Ohio. The AMCNO has written to the Center for Medicare and Medicaid Services (CMS) regarding this issue, providing comments on the latest federal rule, and plans to pursue a change in the GPCI formula in Ohio if possible.

The Centers for Medicare & Medicaid Services (CMS) 2007 PQRI Final Feedback Reports Now Available

2007 PQRI final feedback reports are available and can be obtained from a secure website. To obtain the reports, the first step is to register for access through a CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS). **Do not register if you did not report PQRI quality measures in 2007.**

There are two categories of user types in IACS: individual practitioner and organization. The CMS approval process differs depending on the type of user you are; therefore, it is important to register correctly.

Follow these instructions if you are a professional paid by Medicare directly (you have not reassigned Medicare payments to a group practice):

If you do not have employees, the CMS approval process requires you to register as an individual practitioner and access the PQRI 2007 feedback report personally. Some solo professionals have incorrectly registered in IACS as organizations, and have had to reregister as individual practitioners.

If you have employees and therefore are an organization for tax purposes, you may select one of two options:
Option 1: Register in IACS as an organization if you will use one or more employees to access IACS and/or your PQRI feedback reports, **OR**
Option 2: Register in IACS through the Individual Practitioner role if you will access the PQRI report personally.

If you are a professional who has reassigned Medicare payments to a group practice:

Do NOT register in IACS unless you are one of the individuals designated to do so by the group practice. Group practices will register in IACS as organizations. Up to two individuals will be able to access the 2007 PQRI feedback report for each organization that registers in IACS. One 2007 PQRI feedback report will be prepared for each taxpayer identification number (TIN). The group practice will be responsible for sharing National Provider Identifier (NPI) level information with the appropriate professionals within the group practice.

For more Information:

IACS Quick Reference Guides may be found at http://www.cms.hhs.gov/IACS/04_Provider_Community.asp on the CMS website. Summary information about accessing the 2007 PQRI feedback reports for those registering as organizations and individual practitioners will soon be posted on <http://www.cms.hhs.gov/PQRI> on the CMS Web site.

Top Five Reasons for Denials as tracked by PalmettoGBA

PalmettoGBA lists the following five items as their top reasons for a denial:

- “Noncovered services” – these services are never covered, including eye refraction, “well person” exams, and hot/cold packs used in physical therapy.
- Bundling due to “Correct Coding Initiative “ –services denied most often for these reasons include: pulse oximetry; heparin; creatinine (blood); and some supplies.
- Medicare is secondary, but the claim was submitted as primary. The MSP Lookup Tool can help guide you as to whether another insurer may be involved.
- Noncovered services by a chiropractor – the only service Medicare will reimburse, when performed by a chiropractor, is manual manipulation of the spine (CPT codes 98940, 98941, and 98942). Physical therapy and x-rays performed by chiropractors are never covered by Medicare.
- Pre- and post-op visits are included in the global surgery package. Tip: access the CMS Medicare Physician Fee Schedule Database (MPFSDB) to determine the global period for surgical procedures. The Palmetto GBA Modifier Lookup tool provides step-by-step instructions for accessing the MPFSDB as well as guidance on how to submit “exceptions” to the global surgery package.

Use the Denial Finder to determine whether your denials for these services are correct or whether there are other steps you should take before submitting these claims - look in the “Cool Tools” section on the site below:

Ohio: <http://www.PalmettoGBA.com/boh>

PalmettoGBA Offers Separate Phone Numbers to Reach Interactive Voice Response (IVR) System and Customer Service

Effective June 2008, PalmettoGBA established separate telephone numbers to reach their Interactive Voice Response (IVR) system and Customer Service Representatives (CSR). The change is being implemented in an effort to better serve physicians and their staff. The IVR number remains the same: 877-567-9232. The CSR number will be 866-332-7025. This change will make more IVR lines available for routine inquiries (claim status, eligibility, etc.), and will help ensure that CSRs are available for more complex questions.

Requests for Medical Records from Medicare

On occasion, physicians may receive requests for medical records from Medicare for a variety of reasons. Requests may also come from several different Medicare contractors. Record requests may be related to any of the following:

- Review of a Medicare contractor, through the Comprehensive Error Rate Testing (CERT) program
- More information is required before the Medicare contractor can process the claim
- Review of a new physician or practitioner, to ensure a good understanding of Medicare claim submission and documentation guidelines
- Review of an established physician or practitioner, before or after the claim is paid, based on analysis of data
- Investigation of a complaint alleging possible fraud or abuse of the Medicare program

In all cases, it is imperative that you return the records to the requesting entity within the timeframe specified. **Note: your facility may have designated a single point of contact or coordinator for requests for medical records from Medicare contractors.** Check with your compliance officer or manager before submitting records or transferring the request to another department.

It is also vital that you include all of the requested records. Before responding to the request, double-check to ensure that you have included all relevant information, such as:

- If the request is for a physician or nonphysician practitioner (NPP) visit (Evaluation & Management service, or E/M service) and include documentation for that encounter:
 - ... and the physician/NPP's note refers to an earlier encounter date (such as a prior history or list of prescription medications), include copies for the earlier note as well as information pertinent to the date requested.
 - ... and the physician/NPP's note refers to results of a lab or other diagnostic test, include the test results with the requested information.
 - ... and the physician/NPP's note refers to a form completed by the patient listing his or her symptoms or past history, copy this form along with the physician's notes.
 - ... and if the service is a consultation, copy the request from the referring physician to the consulting physician or your documentation of such, along with the physician's written consultation report.
- If the physician or practitioner's signature is not legible, provide a key and indicate whose signature appears in the records.
- If the physician or practitioner uses abbreviations that are not common, provide a key.
- If the patient signed an Advance Beneficiary Notice (ABN), include a copy with the requested records.
- If the service is the physician's interpretation of a diagnostic test, such as an EKG or x-ray, provide his or her complete interpretation and copies of the test results. Do not send original x-ray films or other original records.

OTHER TIPS:

- Each letter from Medicare requesting medical records will be on CMS letterhead and will include a telephone number. If you are unsure what information is being requested, call the number and ask questions to clarify.
- If the medical records are two-sided, copy both sides before sending copies to the requesting entity.
- You may respond to medical record requests from Medicare contractors without having the patient sign additional HIPAA release forms. The patient's signature on file, or his/her signature on the Medicare claim, authorizes release of the records to a Medicare contractor upon request.
- If the request is from **Palmetto GBA** and you have additional questions, please call the number listed in the letter. If you cannot locate the telephone number in the letter, please call them at 1-866-332-7025.

- If the request is from **AdvanceMed**, call the specific telephone number listed in the letter.
- If the request is from **National Government Services**, the Fiscal Intermediary (Part A) for Ohio, please contact them directly with any questions or concerns at 1-866-419-9457.
- If the request is from **National Government Services**, the Fiscal Intermediary (Part A) for West Virginia, please contact them directly with any questions or concerns at 1-877-908-8474.

Medicare Adds Two New Categories to Its' Do Not Pay List

Medicare is adding to its do-not-pay list for hospitals two new categories of preventable conditions it won't cover, a much smaller number than it had been contemplating. Last year, the Centers for Medicare and Medicaid Services set new ground by determining it no longer pay would extra costs for treating certain preventable conditions, referred to as "never events." An example of a never event is a transfusion with the wrong blood type. Medicare officials have now announced that it no longer will pay the extra-care costs associated with treating dangerous blood clots in the leg following knee or hip-replacement. The program also will not pay extra for complications stemming from poor control of blood sugar levels. The changes were made as part of a final rule setting payment rates for inpatient hospitals for the next fiscal year, which begins Oct. 1.

Medicaid

Anthem Will Not Renew Contracts for Benefits to ABD Consumers

The Ohio Department of Job and Family Services (ODJFS) has recently learned that Anthem Blue Cross Blue Shield Partnership Plan, Inc. (Anthem) and WellCare Of Ohio, Inc. (WellCare) will not renew their contracts to provide Medicaid managed care benefits to Aged, Blind and Disabled (ABD) consumers. ODJFS has assured the AMCNO that all Ohio ABD consumers will continue to have choices.

ABD managed care members in the Northeast and Northwest regions will be provided an opportunity to select from either the remaining managed care plan (Buckeye Community Health Plan in the Northeast and CareSource in the Northwest) or fee-for-service Medicaid. Those who do not respond to the mailed opportunity to make a selection will be automatically assigned to fee-for-service Medicaid. Additionally, those currently enrolled with Buckeye or CareSource will be allowed to choose between staying with their existing plan or may return to fee-for-service Medicaid.

All enrollment changes will take effect by September 1, 2008. Please note that this change does not affect the Covered Families and Children managed care members. In addition, Anthem and WellCare will be notifying their provider networks of this change. Providers who have outstanding claims for services can bill for dates of service prior to September 1, 2008, according to their existing contracts. If you have any concerns or questions, please contact the Bureau of Managed Health Care at 614-466-4693 or by email at <mailto:bmhc@jfs.ohio.gov>.

Third Party Payors

CIGNA

Never Events Policy

CIGNA plans to implement a Never Events and Avoidable Hospital Conditions reimbursement policy effective October 1, 2008, for both CIGNA and Great-West Healthcare. CIGNA's policy is modeled after the policy of the Center for Medicare and Medicaid Services (CMS), which will be implemented on October 1. Paper and electronic claims must be coded with the Present on Admission (POA) indicator, beginning October 1. The POA indicator will be a required element of a clean claim. Never events are surgical procedures that are performed on the wrong side, wrong site, wrong body part or wrong person. CIGNA will not reimburse for never events because they are not medically necessary. Avoidable hospital condition, is one that a patient does not have when admitted to the hospital, develops during the patient's hospital stay and may have been avoided

if evidence-based guidelines were followed. Conditions CIGNA has identified as potentially non-reimbursable are: Objects left in surgery, air embolism, blood incompatibility; catheter-associated urinary tract infection, pressure ulcers, vascular catheter associated infection, Mediastinitis after Coronary Artery Bypass Graft; and hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes). CIGNA will not reimburse for these conditions when permitted under their hospital contracts. To view the policy go to the CIGNA website at www.cignaforhcp.com

UNITEDHEALTH CARE

CPT Code List for Imaging Accreditation Program Updated

UHC has modified the list of CPT codes subject to the imaging Accreditation Program. Six codes – 76376, 76377, 77013, 77014, 78000 and 78001 – were removed from the program's list of in-scope procedures. To obtain the updated version of codes subject to the program from UHC's physician web site go to [UnitedHealthcareOnline.com/Clinician Resources/Radiology/Imaging Accreditation](http://UnitedHealthcareOnline.com/ClinicianResources/Radiology/ImagingAccreditation).

UHC Plans to Improve Physician Relations in Ohio

UHC has rolled out a physician advocacy program in Southwest Ohio and they are planning to expand it across the state with an eye to rolling this program out in the Cleveland market by late 2008. The concept is to provide simple, reliable service and develop value added, personal relationships with physicians and their staff. UHC's role and what they plan to deliver is a navigational specialist who can represent all products that is externally focused and would maximize a physician's ability to interact with UHC. They plan to build positive relationships and communicate changes to providers in a timely fashion. AMCNO will continue to monitor this program and watch for the rollout in Northern Ohio.

MEDICAL MUTUAL OF OHIO (MMO)

Medical Mutual Update Website

MMO has redesigned their web site to offer additional information and resources. Medical policies, credentialing information, forms, manuals and other publications, pharmaceutical formularies, patient safety information, online services and contact information are some of the resources that can now be accessed on the MMO site. To view the site go to www.MedMutual.com

Administration of Immunizations – Update

Effective May 1, 2008, MMO began providing separate reimbursement for immunization administration. The separate line reimbursement replaced the practice of including administration reimbursement within the payment for immunization itself. This is a procedural change only – payment for administration of immunization has always been made when a benefit was available, but not as a separate line item. Codes affected were 90465 through 90474.

ANTHEM

Answers to Medicare Advantage Products Available on Anthem Web Site

Physicians can now go to www.anthem.com/medicare for answers about the Medicare Advantage products offered by Anthem BC/BS. Just go to the above referenced web site address, click on the provider services link and choose from the list of Medicare Advantage products to access the information you need. Available on the site are provider disclosures (plan terms and conditions), payment methodology grids, provider manuals, contact telephone numbers and other information on the products.

BUREAU OF WORKERS' COMPENSATION

The Ohio Bureau of Workers' Compensation is updating their fee schedule. The fee schedule has not been updated since 2004. BWC acknowledges that this is a complete update of the fee schedule, including all CPT (Current Procedure Terminology) and HCPCS (Health Care Procedural Coding System) codes. BWC is also indicating that the proposed revisions take into account industry best practices and inflation since the last update.

Any eventual revisions to the fee schedule must go through the Ohio rule-making process. BWC will submit the fee schedule proposal to the BWC Board of Directors for approval in August. If the board approves the new fee schedule, November 2008 is the earliest the new schedule would take effect. For more information go to www.ohiobwc.com



NEWS YOU CAN USE

State Law Regarding Sales and Distribution of Dangerous Drugs to Change in September 2008

On June 12, 2008 Governor Strickland signed Sub. H.B. 283, which added changes to the Ohio Revised code addressing to whom a registered Wholesale Distributor of Dangerous Drugs may sell or distribute dangerous drugs. Therefore, effective Sept. 12, 2008, state law will change regarding the sale and distribution of Dangerous Drugs by registered Wholesale Distributors of Dangerous Drugs in certain instances.

The new law will allow registered wholesale distributors of dangerous drugs to sell dangerous drugs to a business practice that is a corporation, limited liability company, or professional association if the business practice has a sole shareholder who is a licensed health care professional authorized to prescribe drugs (prescriber) and is authorized to provide the professional services being offered by the practice.

This means that if the business practice has a single prescriber who is a sole shareholder, member or owner of the practice then this business practice is not required to be licensed as a Terminal Distributor of Dangerous Drugs with the Ohio Board of Pharmacy. Previously, this exemption was only for a prescriber who practiced as a Sole Proprietor.

If the practice is a group practice and there are multiple owners, shareholders, or members then the business practice (corporation, professional association, LLC, or partnership) must continue to be licensed as a TDDD with the Board of Pharmacy. A separate license is required for each separate location where dangerous drugs are received, stored, used, or distributed. The other change in the law pertains to dentists.

To obtain a copy of the memo explaining the new law and the forms required, as well as providing information on DEA status questions go to http://pharmacy.ohio.gov/Licensing_Issues_for_Prescribers_07252008.pdf

State Coverage Initiative (SCI) Team Issues Report that Recommends Comprehensive Health Care Coverage Reforms in Ohio

The State Coverage Initiative (SCI) team, appointed by Ohio Governor Ted Strickland, issued a report in July entitled Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland, which recommends health care coverage reform options for the State of Ohio.

Since September 2007, Ohio has been one of 14 states to participate in the Coverage Institute sponsored by Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program. Over the past year, the SCI team worked diligently to uncover the facts about Ohio's uninsured residents, Ohio's health insurance programs and markets, and the gaps in the current system that cause many Ohioans to be uninsured.

The SCI team also worked closely with the Healthcare Coverage Initiative Advisory Committee, a group of over 40 stakeholders appointed by Governor Strickland, to develop a comprehensive set of recommendations to cover Ohio's uninsured residents. These recommendations are based on the best available information and the diverse views of those impacted by Ohio's health care and coverage systems.

Recommendations include:

- Requiring employers to establish §125 Plans
- Reinsurance for individuals and small businesses

- Extending group coverage to dependents up to age 29
- Premium assistance for low income workers
- Enrolling more Ohioans in Medicaid and expanding Ohio's Medicaid to high income levels
- Allowing non-Medicaid eligible adults to enroll in Medicaid managed care plans
- Reforms to the individual health insurance market

The recommendations were organized to reflect the potential for sequential or partial implementation. Some recommendations may be more readily agreed upon and achieved in the context of limited resources. Other recommendations may be more challenging in terms of the cost and impact. Therefore, reforms should be implemented in light of available resources, Ohio's budget situation and the need to mitigate the potential for market disruptions. The Strickland Administration will review the recommendations in order to work with leaders from the Ohio General Assembly and key stakeholders to identify and discuss legislation to implement appropriate recommendations. To view the full report go to www.healthcarereform.ohio.gov

AMA Unveils New Health Insurer Report Card

To help reduce the substantial administrative burden of ensuring accurate insurance payments for physician services, the American Medical Association (AMA) has launched the Cure for Claims campaign to help heal the ailing system of processing medical claims with health insurers, and unveiled the first AMA National Health Insurer Report Card on claims processing.

The inefficient and unpredictable system of processing medical claims adds unnecessary cost to the health care system, estimated as much as \$210 billion annually, without creating value. Physicians divert substantial resources, as much as 14 percent of their total revenue, to ensure accurate insurance payments for their services.

The AMA's new National Health Insurer Report Card provides physicians and the public with an objective and reliable source of information on the timeliness, transparency and accuracy of claims processing by health insurance companies. Based on a random-sample pulled from more than 5 million electronically billed services, the report card provides an in-depth look at the claims processing performance of Medicare and seven national commercial health insurers: Aetna, Anthem Blue Cross Blue Shield, CIGNA, Coventry Health Care, Health Net, Humana and United Healthcare.

Key findings include:

Denials. There is wide variation in how often health insurers pay nothing in response to a physician claim (from less than 3 percent to nearly 7 percent), and in how they explain the reason for the denial. There was no consistency in the application of codes used to explain the denials, making it extremely expensive for physician practices to determine how to respond.

Contracted payment rate adherence. Health insurers reported to physicians the correct contracted payment rate only 62 to 87 percent of the time. Additional analysis will be necessary to determine how often these errors were tied to inaccurate payment. When health insurers report an amount that does not adhere to the contracted rate, it adds additional, unnecessary costs to the physician practice to evaluate the inconsistency.

Transparency of fees and payment policies. More than half of the health insurers do not provide physicians with the transparency necessary for an efficient claims processing system.

Compliance with generally accepted pricing rules. There is extremely wide variation among payers as to how often they apply computer generated edits to reduce payments (from a low of less than .5 percent to a high of over 9 percent). Payers also varied on how often they use proprietary rather than public edits to reduce payments (ranging from zero to as high as nearly 72 percent). The use of undisclosed proprietary edits inhibits the flow of transparent information to physicians, adding additional administrative costs to reconcile claims.

Payment timeliness. Prompt pay laws appear to have been effective in ensuring a relatively quick response to physician's electronic claim. Further analysis will be necessary to determine the extent to which this response is accompanied by accurate payment if the claim.

The report card is available on the AMA Web site at: www.ama-assn.org/go/cureforclaims.

Using A Lockbox In Your Practice

Over ten years ago, the AMCNO adopted a payment processing mechanism to help the organization better track and protect incoming finances – the bank lockbox. Physician practices that are currently receiving a lot of payments through the mail may wish to look into adopting a similar practice.

What is a bank lockbox?

A bank lockbox is a special post office box that receives payments and remittance information. When mail is sent to the lockbox, the bank's employees retrieve the documents, and scan them. This process allows for funds that are available in a shorter timeframe than a normal bank deposit. The scanned documents are available to the practice either by U.S. mail or by the practice's access to a secure Web site.

Bank lockbox processing is always on a same-day cycle. Typically, the practice will receive a lockbox envelope each day of the week – creating a process whereby cash flow is accelerated by a minimum of two days on a consistent basis. A bank lockbox expedites cash flow, and it may also reduce personnel expenses. And most importantly, it can minimize the potential for theft.

When is a bank lockbox helpful to a physician practice?

When a practice receives checks from many third parties, including patients.

When a practice operates with a small staff.

When the bank is experienced in bank lockbox processing.

What are the disadvantages of a bank lockbox?

Loss of direct control over the deposit function.

Possibility of bank fraud if the practice doesn't monitor the lockbox processing relationship.

There has to be sufficient volume to justify the expense of the lockbox, netted against the cost savings in the practice.

What are the advantages of a bank lockbox?

Faster cash flow - money is deposited to your bank account on the same day of receipt.

Improved internal controls.

Possible reduction in staffing.

A practice may wish to determine what the costs are for having a staff member open, endorse and copy checks, prepare deposits, and distribute checks every day. This could take several hours per day and if a lockbox were used it is possible that this person could be doing something else in the practice. The use of a lockbox is important to enhance internal control. A lockbox is one way to guard against embezzlement of funds.

How do I get a lockbox set up?

In order to have a lockbox at a particular bank, the practice would have to have a depository account with the bank. Fees for lockbox services are negotiable, depending on the services the practice purchases from the bank along with the assets held by the bank from the practice and the physician. You will want to contact your current bank for additional information. The practice may also want to contact other banks in the area to compare costs and services.

AMCNO Discounted Practice Management Classes at Tri-C

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to partner with Cuyahoga Community College's (Tri-C) Center for Health Industry Solutions to offer Certification Courses and Continuing Education Unit Seminars at discount prices for AMCNO members and staff. Participants in the classes also earn Certification and CEUS through Cuyahoga Community College's Medical Practice Management Seminars.

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

The following courses are now open for registration at the AMCNO discounted rate:

CPT Coding Fundamentals and more!

New! – 6 CEUs – evening or day class

A companion class to the ICD-9-CM Fundamentals program - Take advantage of this CPT coding seminar to strengthen your procedural coding skills and reduce your claims denials. In a hands-on, interactive session, you will work on multiple coding exercises with a focus on accuracy and compliance. Explore the construction of the CPT-4 Code book so that you truly understand how to use this reference guide. Coding scenarios will increase in complexity as the day progresses.

Note: Bring current CPT Coding Manual. \$179

#87924 October 15, 2008 9:00 am – 3:30 pm, Wed. Corporate College West

Teri Kleinschmidt, CPC, CPC-H, CMC

ICD-9-CM Fundamentals and More!

New! – 5.5 CEUs

Take advantage of this seminar to strengthen your ICD-9-CM diagnostic coding skills and reduce your claims denials. In a hands-on, interactive session, you will work on multiple coding exercises and have your coding questions answered. Explore the construction of the ICD-9-CM Code book so that you truly understand how to use this reference guide when coding for compliance. Coding scenarios will increase in complexity as the day progresses.

Note: Bring current ICD-9-CM Coding Manual.

\$179

#87922 September 17, 2008 9:00 am – 3:30 pm, Wed. Corporate College East

Teri Kleinschmidt, CPC, CPC-H, CMC

Locations:

Corporate College East, 4400 Richmond Rd., Warrensville Hts., OH 44128

Corporate College West, 25425 Center Ridge Rd., Westlake OH 44145

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.

6100 Oak Tree Blvd. Suite 440 Independence, Ohio
44131
www.amcnoma.org

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



The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Presents

“Solving the Third Party Payor Puzzle”

WHEN:

Thursday, November 13, 2008

Registration: 7:30 a.m. - 8:00 a.m.

Seminar: 8:00 a.m. - 4:30 p.m.

*** Boxed lunches will be provided ***

WHERE:

AMCNO Executive Offices

Park Center Plaza I

6100 Oak Tree Blvd Independence, Ohio 44131

Lower-Level Meeting Room

COST:

AMCNO Members and their staff - \$50 per participant

Non-Members - \$100.00 per participant

PURPOSE:

To educate/update physicians and office staffs about the current happenings with third party payor claims and managed care issues.

FEATURED SPEAKERS:

- Aetna
- Anthem Blue Cross and Blue Shield
 - CIGNA Healthcare of Ohio
 - Medical Mutual of Ohio
- Ohio Department of Job and Family Services (Medicaid)
 - Palmetto GBA Medicare Part B
 - United Health Care

Note: Speakers will be allotted time to answer general questions.

Registration deadline: November 6, 2008

Questions? Contact Debbie Blonski (216) 520-1000, Ext. 102; E-mail: dblonski@amcnoma.org.

Please complete & return along with your check payable to AMCNO:

AMCNO, PO Box 901724, Cleveland, Ohio 44101-9932

Or, fax this form with credit card information to: AMCNO at (216) 520-0999

ALL REGISTRANTS: Payment Amount \$ _____ for _____ Attendees.

Name(s) of Attendee(s): _____

Physician(s) Name(s): _____

Office Address _____ City, State, ZIP: _____

CREDIT CARD NUMBER: _____, EXPIRATION DATE: _____