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

SUMMER EDITION 2011

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

Medicare

Deadline Set by the Center for Medicare and Medicaid Services (CMS) for Enrollment Revalidation

All providers/suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the *Affordable Care Act* (section 6401a). (Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time).

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers/suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers/suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at https://pecos.CMS.hhs.gov.

Section 6401a of the *Affordable Care Act* requires institutional providers/suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider/supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including Internet based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Information You Need: CMS Fraud Prevention Initiative

If you help people with Medicare, Medicaid and the Children's Health Insurance Program (CHIP), you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

The Affordable Care Act provides additional resources and tools to enable the Centers for Medicare and Medicaid Services (CMS) to expand efforts to prevent and fight fraud, waste and abuse. The CMS **Fraud**

Prevention Initiative aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former "pay and chase" recovery operations to a more proactive "prevention and detection" model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Yet, as important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available in the **CMS Fraud Prevention Toolkit** on the web at https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp#TopOfPage

Providers/suppliers can check online the status of their Medicare applications

This search tool is located at – www.CGSMedicare.com - Ohio Part B - Provider Enrollment- Checking the Status of Your Application - Or by accessing – http://www.cgsmedicare.com/medicare_dynamic/PE/Login.asp

Two identifying items are required to utilize this search tool:

- The application's reference number. This reference number is identified on the acknowledgement letter that is sent to the provider or their designated contact person within 15 days of receipt of the application to our office.

- The application's contact person's 5 digit zip code listed in Section 13 of either the CMS-855I or CMS-855B application, Section 7 of the CMS-855R application or Section 4 of the CMS-855O application.

Recovery Audits – Medicare Transferring Demand Letter Responsibility

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating Recovery Auditor and his/her contact information in the related demand letter. You should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

Additional Information: If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) website. To see the official instruction (CR7436) issued to your Medicare contractor, see **http://www.cms.gov/Transmittals/downloads/R192FM.pdf** on the CMS website.

2010 Medicare Electronic Prescribing (eRx) Incentive Program Payment Update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2010 Medicare Electronic Prescribing (eRx) Incentive Program has begun for eligible professionals who met the criteria for successful reporting. Distribution of 2010 payments Medicare Electronic Prescribing (eRx) Incentive is scheduled to be completed by August 31, 2011.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of **LE** to indicate incentive payments instead of **LS**. **LE** will appear on the electronic remit. In an effort to further clarify the type of incentive payment issued (either PQRI or eRx incentive), CMS created a 4-digit code to indicate the type of incentive and reporting year. For the 2010 eRx incentive payments, the 4-digit code is **RX10**. This code will be displayed on the electronic remittance advice along with the **LE** indicator. For example, eligible professionals will see **LE** to indicate an incentive payment, along with **RX10** to identify that payment as the 2010 eRx incentive payment. Additionally, the paper remittance advice will read, "This is an eRx incentive payment." The year will not be included in the paper remittance.

Who to Contact for Questions?

If you have questions about the status of your eRx incentive payment (during the distribution timeframe), please contact your **Provider Contact Center.** The Contact Center Directory is available at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip, on the CMS website.
The QualityNet Help Desk is available Monday through Friday from 7:00 a.m. – 7:00 p.m. CST at **1-866-288-8912** or via qnetsupport@sdps.org. The help desk can also assist with program and measure-specific questions.

Advancemed - the Program Safeguard Contractor for CGS Alerts Physicians About Identity Theft

A group of unknown individuals are soliciting personal identification information from physicians through various corrupt schemes. Once obtained, the personal information is used to complete fraudulent Medicare provider applications for new practice locations. Once the new provider number is established, these individuals rapidly submit a large volume of claims to the Medicare Carrier for payment.

Protect Your Identity: If you have recently received a phone call or fax from an alleged Contractor employee asking for a "CMS File Update"; please contact the Contractor provider enrollment department immediately for verification. If you have responded to an employment opportunity which, in retrospect seems suspicious, again contact the Contractor provider enrollment department so the information maybe forwarded to the Program Safeguard Contractor (PSC).

Common Sense Tips:

1. Perform rigorous research regarding opportunities presented to you when making application for joint venture opportunities of companies unknown to you.
2. Remove any unnecessary personal identifying information from outgoing correspondence.
3. Do not post your resume on line, especially if it contains any confidential personal identifying information.
4. Remember, no one from Medicare will contact you to verify your Medicare numbers. They already have this information.
5. Do not leave laptops or other gateways into your personal information unattended.
6. Use internal system security measures that limit access to critical personal information to trusted personnel only.
7. Ensure that each employee who has access to your system creates a "strong" password using upper case, lower case and special characters as a means to prevent unauthorized breaches to your system.
8. Cancel computer and system access immediately when an employee leaves your employment.
9. Perform rigorous research regarding the company you intend to work for when applying for employment prior to sharing any personal information.
10. Perform background checks on potential new employee hires, including credit checks.
11. Perform background checks on any entity you subcontract with or use as a vendor that will have access to your personal numeric identifiers.
12. Check with your Carrier to see what practice locations they list for you.

Contact the OIG Hotline if you suspect you are the victim of provider identity theft:
Phone:1-(800)-HHS-TIPS(1-800-447-8477)**Fax:**1-(800)-223-8164**E-Mail:**HHSTips@oig.hhs.gov

5010 Transition

The Version 5010 transition is less than six months away for all HIPAA covered entities. This means that to submit transactions electronically, all covered entities must upgrade from Version 4010/4010A to Version 5010. Version 5010,

unlike Version 4010, accommodates the new ICD-10 code sets, and is a required preliminary step for the use of the new ICD-10 medical code sets. The compliance deadline is January 1, 2012. All internal and external transactions within your organizations and with your billing partners – including payers, vendors, clearinghouses and providers should be tested. External testing should take place now in order to make sure that you are able to send and receive compliant transactions effectively. Testing now will help identify any potential issues that may arise, and allow the necessary time to address them.

Post Card Mailing for the Annual Participation Open Enrollment Period Medicare
Providers will not be receiving the usual Compact Disc (CD) announcing the annual open participation enrollment period from Medicare contractors. CMS has instead directed Medicare contractor to produce a postcard mailing.

Local Coverage Determination Policies (LCD)
LCDs can be found at http://cgsmedicare.com/ohb/coverage/lcd/index.html

News from Other Third Party Payers

BWC

Bureau of Worker's Compensation (BWC) Pharmacy Program Updates and Timeline
The BWC Board of Directors recently approved the Outpatient Medication Rule 4123-6-21 and the Outpatient Medication Formulary Rule 4123-6-21.3. These new rules allow BWC to make several important improvements to the pharmacy program. Charts are available on the BWC website which describe each change, the implementation date and – when applicable – the number of injured workers who will be impacted. The chart also includes some rules, statutes and actions under consideration by the pharmacy program. BWC will post the formulary on www.ohiobwc.com in a searchable format. The pharmacy and therapeutics committee will review the formulary annually. **These new rules override previous approvals of medications for injured workers. The rules do not apply to employees of self-insured companies.**

In addition, BWC is reviewing more than 200 drug classes for possible inclusion on the prior authorization drug list for relatedness. Please be sure to check the prior authorization list on their website.

MEDICAID

AMCNO Co-Sponsors Ohio Medicaid Provider Incentive Program (MPIP) Webinar
The AMCNO was pleased to co-sponsor a webinar for our members illustrating how the MPIP and the Ohio Department of Job and Family services (ODJFS) will begin to accept applications and issue incentive payments to eligible professional and eligible hospitals. Program topics included Medicaid EHR incentive program background, structure and timeline, how to adopt, implement or upgrade (AIU) for Medicaid, the MPIP application process and other key points. If you missed the webinar please go to the AMCNO web site for a link to view the webinar - www.amcno.org

MPIP is Now Live at the ODJFS
The Ohio Department of Job & Family Services is pleased to announce the opening of the Medicaid Provider Incentive Program (MPIP). The Ohio Department of Job and Family Services (ODJFS) is now accepting applications for a new Medicaid Provider Incentive Program (MPIP). MPIP provides financial incentives to qualified Medicaid providers who adopt, implement or upgrade, and meaningfully use certified electronic health record (EHR) technology. MPIP will provide incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) as they adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health records (EHR) technology. Eligible professionals and eligible hospitals can begin the registration process at the CMS website (http://www.cms.gov/EHRIncentivePrograms/) and when they select Medicaid as part of that registration process, they will receive information about how to complete enrollment in MPIP at the MPIP web portal. Under MPIP, eligible professionals can receive up to $63,750 over a

maximum of 6 years of participation in the program. Eligible hospital payments are based on a number of factors and will be distributed over four years. MPIP will continue until 2021, but 2016 is the last year a Medicaid provider may begin participation in the program. Please visit the updated MPIP website - http://jfs.ohio.gov/OHP/HIT%20Program.stm - for more information including a new FAQ reference, tip sheets for EHs and EPs and prerequisites EPs need to enroll in MPIP.

Transitioning from the Medicaid Management Information System to the Medicaid Information Technology System

Rule 5101:3-1-19.4 of the Ohio Administrative Code (OAC) was adopted to support a transition from the Medicaid Management Information System (MMIS) to the Medicaid Information Technology System (MITS) being implemented by the Ohio Department of Job and Family Services (ODJFS). With MITS, Ohio Medicaid retired it's nearly 30-year old MMIS and created a more multi-functional, secure, and provider-accessible system. Starting July 1, 2011, ODJFS began returning certain types of paper-based transactions because:

1. Several claim formats are being discontinued or replaced. These outdated paper claim forms cannot be processed in MITS.

2. Time must be allowed for current paper transactions to be processed in MMIS and included in the data base before MITS is implemented.

The first reason is critical to the successful implementation of MITS because ODJFS will no longer have the technical ability to process outdated institutional, dental, and professional claim forms. ODJFS will need to return paper claims that have not been processed by MMIS to providers for submission through the MITS web portal or through electronic data interchange (EDI).The second reason is equally important because ODJFS needs to implement MITS with the most accurate and up-to-date information possible. This requires ODJFS start with a data base that includes processed paper transactions submitted to MMIS by providers and trading partners. Provider enrollment/reenrollment, demographic changes and certain types of paper claims that were not processed by MMIS prior to the MITS "Go Live" date will need to be returned to providers for submission through MITS.

For complete information on this issue go to:

http://emanuals.odjfs.state.oh.us/emanuals/GetDocument.do?doc=Document%28storage%3DREPOSITORY%2CdocID%3D%23Ref_MHTL3334_11_04%29&locSource=input&docLoc=%24REP_ROOT%24%23Ref_MHTL3334_11_04&username=guest&password=guest&publicationName=emanuals

MITS Update

The new Medicaid Information Technology System (MITS) went live on August 2, 2011. Since then, MITS has processed almost 3.8 million claims and disbursed more than $438 million to providers. As with any new system, however, especially a system this large and complex, technical issues inevitably arise. While the system continues to process claims, some claims that providers submitted are suspending or denying due to a system problem. This is causing some consumers who are eligible to appear to be ineligible. Hewlett Packard (HP), the vendor contracted to implement MITS, is working to correct this issue. Although it is affecting a relatively small number of Ohio's 90,000 Medicaid providers, Medicaid regrets any problems this may have caused and they will adjust future payments as needed to account for any over or underpayment. As soon as a solution is implemented, providers will be notified of any actions they should take. For up-to-date information about MITS, go to http://jfs.ohio.gov/mits/index.stm.

Anthem

Anthem 5010 Web Page

Anthem has launched a webpage for details about their 5010 activities. Providers can sign up for email updates and 5010 notification alerts. Access this information at www.anthem/edi and select Ohio, Communications > 5010 – direct link http://www.anthem.com/forms/east/notificationsignup.html

Anthem Availity Partnership

Availity offers a multi-payer portal solution that gives users secure, single sign-on access to multiple payers' information. Providers can access Anthem Eligibility and Benefits, claims status, clinical messaging and Availity CareProfile on Availity for free. If you have not yet registered for Availity you can go to www.availity.com – if you need further assistance contact client services at 1-800-282-4548. (Note: the AMCNO has worked with Availity since they launched in Ohio and we encourage our members to look into their multi-payer portal solution).

UnitedHealth Care

UnitedHealth Care Premium Designation Program Public Display

On June 1, UHC posted updated physician designations on their consumer website at www.myuhc.com
In January, UHC sent notifications to physicians that included their new UnitedHealth Premium designation and the process for submitting a reconsideration request. UHC does not display the designations until June in order to allow time for physicians to submit reconsiderations before public display. Physicians may submit a reconsideration request at any time during the review cycle. UHC will review all requests. Designation results and the full suite of assessment reports are now available online – UHC requests that physicians register for the new Premium section of UnitedHealthcareOnline.com as follows: www.unitedhealthcareonline.com
>Clinician Resources > UnitedHealth Premium. Phone – 1-866-270-5588.

NEWS YOU CAN USE

Save Money on Your Workers' Compensation Coverage

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to offer a Workers' Compensation group rating plan to our members that can help you save money on the premiums you pay to the Ohio Bureau of Workers' Compensation. This plan is made possible through our longstanding partnership with CompManagement, Inc., (CMI) a Sedgwick CMS Company. CMI has begun the review process for 2012 group participation, which means you can find out how much you can save! AMCNO practices already enrolled in the AMCNO Group Rating Program will receive a letter regarding review for renewal with the program as well as contact information for CompManagement.

A free, no obligation quote can be obtained for the 2012 policy year through CompManagement or AMCNO one of three ways:

FAX: Click here http://www.amcnoma.org/webpages/AMCNO_AC3.pdf to obtain a copy of the application form from the AMCNO web site. Complete the form and fax it back to CompManagement at (866) 567-9380.

ONLINE: Go to http://resources.compmgt.com/AC3/GroupRating.aspx?Organization=AMCNO to access and complete the application online.

PHONE: Complete the application over the telephone by contacting the CompManagement Customer Support Unit at (800) 825-6755, option 3.

CompManagement will review the application and determine your potential savings and contact you with a cost analysis. If you decide you want to participate, all you need to do is sign and send in the enrollment paperwork included in your cost analysis. This is a no-cost, no obligation review. If you are currently a member of another medical association in the state and participating in a group rating plan other than through the AMCNO you are probably paying higher member dues to remain in that plan. Upon review, you may find that the AMCNO dues are substantially less per member and we provide group discounts which cost effectively enables our physician members to take advantage of the worker's comp

group rating program along with other AMCNO benefits and services at reduced cost. If you have questions regarding the program contact Ms. Linda Hale at the AMCNO offices at 216-520-1000, ext. 101.

AMCNO Lawyer Referral Brochure Now Available to AMCNO Members and Staff

If you are in need of legal counsel in a specific area of expertise this brochure could be of assistance to you. When legal questions or issues arise, the AMCNO believes it is important for its members to obtain sound advice from legal counsel who are knowledgeable in relevant areas of the law and who have a commitment to the effective representation of physicians and their practice groups. This brochure is the product of our effort to identify such attorneys. We encourage our members to make use of these lawyers (or other practitioners similarly qualified) whenever they encounter significant legal issues. If you would like a FREE copy of the AMCNO Lawyer Referral Brochure please contact the AMCNO staff at 216-520-1000, ext. 101.

News from the Ohio Health Information Partnership

Brochure Available on CliniSync Offerings

The Ohio Health Information Partnership has recently announced that CliniSync has produced new resources for physicians on their new statewide health information exchange (HIE), One brochure covers what a master patient index (MPI) is and how it helps link patients to the HIE with a longitudinal record. Another fact sheet describes what direct messaging is and how it works. Direct messaging will allow a physician to talk with other physicians and send information to them through a secure email message if you're not yet ready with your EHR system. The fact sheet contains pricing and services of CliniSync. The brochures can be obtained online at www.CliniSync.org

The Office of the National Coordinator States that Meaningful Use Stage 2 Likely to be Pushed Back

At a recent ONC regional meeting in Minneapolis, Dr. Farzad Mostashari, MD, director of the ONC, said there's every indication that the meaningful use stage 2 implementation date will be pushed back to 2014.

Some physicians and hospitals are putting off attesting to meaningful use stage 1 this year since they would have to meet stage 2 by 2013, whereas if they waited until next year they'd have until 2014. This is a problem especially for the hospitals, since their meaningful use reporting period coincides with the federal fiscal year. Therefore, a 2013 meaningful use implementation date for the hospitals would mean they would need to meet Stage 2 meaningful use reporting requirements starting in October 2012, the beginning of the 2013 federal fiscal year. Since the new Stage 2 meaningful use regulations would not be finalized until mid-2012, there would be little time to restructure workflow to meet any additional reporting requirements introduced in Stage 2.

A decision by the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare and Medicaid Services (CMS) is expected by the end of the year or early 2012 after receiving public input, with the rule being finalized next summer. In June, CMS reported that 2,400 physicians and hospitals have received Medicaid incentive checks in the 17 states open for registration, and 560 physicians and hospitals have received Medicare incentive checks. A total of $273 million have been paid to physicians by CMS.

Only 1,000 Free Slots Left for Electronic Record Adoption Assistance

The latest numbers from the Ohio Health Information Partnership show that 4,994 physicians and providers have signed up for free Regional Extension Center services. Since the Office of the National Coordinator for Health IT allotted 6,000 slots for free services to those qualified healthcare professionals who want to adopt or upgrade electronic health record systems, only 1,000 or so slots remain. For more information on the RECs go to www.ohiponline.org

Medicity selected as vendor for Ohio's health information exchange

Ohio will soon have a health information exchange where physicians and hospitals can securely share patient information with one another across the state. The Ohio Health Information Partnership has selected Medicity as the vendor to create the technological infrastructure for CliniSync, which is the name of the state's new health information exchange. Instead of relying on the transmission of paper records about a patient's condition – including lab results, past medical history, medications and other test results – Ohio's healthcare providers can use CliniSync to electronically access that information, with a patient's consent, over this secure, protected network.

While hospital and healthcare providers may have been able to exchange this information within their own walls or even regionally, they now will "talk" to one another electronically from city to city, from rural practices to regional hospitals through CliniSync. While this will take time over the next two years to fully implement, the first phase of securing at least 10 hospital systems will begin this summer.

Under a federal grant program from the Office of the National Coordinator for HIT, Ohio already has 4,994 physicians signed up for electronic health record systems out of 6,000 slots available from the federal government. Doctors are now receiving free services at regional extension centers across Ohio to prepare for and adopt electronic health records. CliniSync will now allow them to share those records with one another.

Specifically, Medicity's HIE solutions will:

- Establish a longitudinal health record for each patient so that authorized providers can see a patient's complete medical history
- Enable physicians to communicate about patient care multi-directionally across organizational boundaries
- Support hospitals and physicians as they demonstrate meaningful use of their electronic health records so they qualify for federal incentive funds
- Empower Ohio to connect to any other state or regional health information exchange network
- Facilitate coordinated exchange within Ohio's state departments to report on public health issues at both state and federal levels
- Assist Ohio in providing physicians with a direct, protected and secure email system under the federal Direct Project initiative

For more information, go to www.ohiponline.org or to Medicity at www.medicity.com.

Quality Improvement Organization Program 2011-2014

Ronald A. Savrin, MD, MBA

The Centers for Medicare & Medicaid Services Quality Improvement Organization Program is implemented locally through Quality Improvement Organizations in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. As we begin the newly defined three-year program (2011-2014), Ohio KePRO is pleased to continue its role as the Quality Improvement Organization for the State of Ohio.
The Centers for Medicare & Medicaid Services has established three broad aims as the foundation of the program: (1) Better health care, (2) Better health for people and communities, and (3) Affordable care through lowering cost by improvement. The new three-year program includes many new initiatives and opportunities for improvement. Although supporting each of the broad objectives, the Quality Improvement Organizations will focus on the following specific

Aims:

1) Beneficiary and Family-Centered Care
    a. Case review
    b. Patient and family engagement
2) Improving Individual Patient Care
    a. Reducing healthcare-associated infections and healthcare-acquired conditions
    b. Reducing adverse drug events
    c. Quality improvement through quality reporting and Value Based Purchasing
3) Integrating Care for Populations and Communities
    a. Improving Transitions of Care
    b. Reducing Hospital Readmissions
    c. Using data to drive dramatic Improvement
4) Improving Health for Populations and Communities

a. Promoting the adoption and meaningful use of health information technology
b. Preventive care, including screenings and immunizations
c. Preventing cardiovascular disease

In support of these aims, Quality Improvement Organizations will employ (1) Learning and Action Networks (2) Focused technical assistance and (3) Care Reinvention through Innovation Spread.

Unique to this new three-year program is the use of Learning and Action Networks to drive change. Ohio KePRO will convene and facilitate a number of collaborative networks in Ohio composed of stakeholders with common goals and interests. One such collaborative, an Electronic Health Record (EHR) Learning and Action Network", would welcome physician organizations such as the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the Ohio Health Information Partnership and the regional sub-recipient partners, physicians and physician practices, EHR vendors, hospital and long-term care associations, beneficiary organizations and other interested parties. The agendas and the priorities of these networks, in support of both the broad and strategic aims, will be set by the participating stakeholders. Subject matter experts will be identified and made available to participants, toolkits for success will be developed and distributed, successes will be shared among all, failures will be discreetly subject to root cause analysis to seek out effective remedies, and technical assistance will be offered to providers at no charge. The endorsement and promotion of such a collaborative approach by the Centers for Medicare & Medicaid Services is new and refreshing, and validates a methodology Ohio KePRO and the AMCNO have long espoused.

The specific aims of the three-year program seek to address areas we can all agree represent opportunities for quality improvement. We would all like to eliminate healthcare-associated infections and through a Learning and Action Network, we will work to reduce central line-associated bloodstream infections, surgical site infections, catheter-associated urinary tract infections and *Clostridium difficile* infections. Collaborative efforts will be directed toward reducing healthcare-acquired conditions such as the development of pressure ulcers, the inappropriate use of restraints, and patient falls. Preventing adverse drug events, particularly among patients with diabetes, patients on anticoagulation and other high-risk populations will improve the quality of care and may reduce both Emergency Room visits and hospitalizations. By providing technical assistance to providers and facilities, at no charge, we will facilitate quality reporting and improve provider reimbursements under the new Value-Based Purchasing program.

Improving health for populations and communities is supported by all stakeholders in the healthcare sphere. Through Learning and Action Networks and focused individual and group technical assistance, Quality Improvement Organizations will facilitate the adoption and meaningful use of electronic health records and promote electronic reporting in the Physician Quality Reporting System, increasing physician reimbursement. Recognizing that cardiovascular disease is a major determinant of population health, specific efforts will be undertaken to promote smoking cessation, control hypertension, and reduce LDL-cholesterol.

As the Ohio's Medicare Quality Improvement Organization, Ohio KePRO will, at no charge, support providers in their efforts to improve the quality of care delivered. Within each Learning and Action Network we will cultivate and convene providers, organizations, health departments, administrators, boards of directors, patients and other stakeholders. We will plan, coordinate and support network meetings and conferences. As part of the national Quality Improvement Organization network and in conjunction with the Centers for Medicare & Medicaid Services, the Office of the National Coordinator for Health Information Technology, and others, we will share aggregate (de-identified) data, results of interventions, patient feedback and other actionable data. We will seek to identify and promulgate best practices and work closely with physicians and others to promote the highest quality of care. The newly defined three-year program establishes a new model for change. Although the Centers for Medicare & Medicaid Services through the Quality Improvement Organization Program will facilitate and sustain the program, the drivers for change will be a decentralized consortium of all stakeholders organized into Learning and Action Networks. As Ohio's Quality Improvement Organization, Ohio KePRO will offer focused technical assistance including on-site visits, intensive consultation and distribution of resources, all at no charge to providers.

If you wish to learn more about the Quality Improvement Organization Program, or wish to participate in one or more Learning and Action Networks please contact Ronald A. Savrin, MD, MBA, Medical Director, Ohio KePRO, Rock Run Center, Suite 100, 5700 Lombardo Center Drive, Seven Hills, Ohio 44131, rsavrin@ohqio.sdps.org.

The analyses upon which this publication is based were performed under Contract Number HHSM-500-2008-OH9THC , entitled "Utilization and Quality Control Peer Review Organization for the State of Ohio," sponsored by the Centers for Medicare & Medicaid Services, Department of Health & Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health & Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.
The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by the Centers for Medicare & Medicaid Services, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this contractor. Feedback to the author concerning the issues presented is welcomed.

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.

Date	Description	AMCNO discount cost	CEU	location
Sept 14th 8-11:30 am	Compliance 101 for Coders $155	$135	CEU 3	CCE
Sept 14th 12:30–5 pm	ICD-10 Overview ((87879) $120	$105	CEU 4.5	CCE
Sept 27th – Nov 8th 6 – 9 pm (Tues)	Hospital/Facility Billing & Reimbursement $249	$229	CEU tbd	CCE
Oct 12th 9 am – 3:30 pm	ICD 9-CM Fundamentals and More ($199)	$179	CEU 6	CCE
Oct 26th 9 am -3:30 pm	CPT Coding Fundamentals ($199)	$179	CEU 6	CCE
Dec 7th 8:30 am–12 noon	ICD9-CM & CPT updates for 2012 $159	$139	CEU 3.5	CCE

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

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
For a "Third Party Payor Review Form".

Call us at 216.520.1000 or email concerns@amcnoma.org

The AMCNO Practice Management Matters newsletter includes links that provide direct access to Internet sites other than our own. The AMCNO takes no responsibility for the content or the information obtained on other Web sites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our Web site at www.amcno.org

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