

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

FALL EDITION 2009

Medicare

In this issue –Solving the Third Party Payor Puzzle Seminar. See inside for details!!

Coverage of H1N1 Vaccine

Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the **administration** of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

G9141—Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

G9142---Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available **at no cost to providers**, Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (H1N1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied. Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Control number for Medicare contractor;
- Patient's health insurance claim number;
- Patient's name;

Patient's address;
Date of birth;
Patient's sex; and
Beneficiary's signature or stamped "signature on file".

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a Form CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself. Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A [H1N1] vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A [H1N1] vaccination, then Medicare will pay for both. However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

If you have any questions, please contact your FI, Medicare carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website or go to <http://www.palmettogba.com/palmetto/Providers.nsf/vMasterDID/7VJJ9W8386?opendocument>

H1N1 Vaccine Update

The AMCNO has participated in several conference calls with the Department of Health and Human Services as well as local health department meetings regarding the H1N1 vaccine. HHS has indicated that the first doses of the vaccine should be available on or about October 15th. The federal government is purchasing the vaccine and making it available to healthcare providers free of charge along with all of the necessary supplies to administer the vaccine. Since the vaccine will be paid for by the federal government physicians can charge an administrative fee only for administering the vaccine to their patients. Currently the Centers for Disease Control (CDC) is recommending the following PRIORITY population to receive the H1N1 vaccination first until the vaccine is available for all recommended groups: pregnant women, people who live or care for children younger than 6 months of age, health care personnel with DIRECT patient contact, children 6 months through 4 years of age, and children 5 through 18 years of age who have chronic medical conditions.

Once the recommended PRIORITY population is vaccinated or additional vaccine supplies are available, the following groups will be targeted: persons between the ages of 5 through 24 years of age, people from ages 25 through 64 years who are at higher risk because of chronic health disorders or compromised immune systems. Any provider who is interested in participating in providing H1N1 vaccine to patients is encouraged to contact the Ohio Department of Health for more information. In addition, the CDC is working on getting information from all 50 states and plans to provide a compilation of the state resources on their web site.

Additional Resources: www.flu.gov – all information is posted there not only on H1N1 but on seasonal flu as well. You can also access toolkits at this website. The Centers for Disease Control (CDC) continues to track the outbreak of human cases of the H1N1 virus and prepare for the upcoming flu season. The CDC has produced a number of documents to help physicians, including an H1N1 flu vaccination planning guide and a list of clinical and public health guidance on the virus. For the entire collection of CDC information on swine flu, go to <http://www.cdc.gov/h1n1flu/> The Ohio Department of Health (ODH) H1N1 (swine flu) information line remains open. Please call 866-800-1404 between 8 a.m. and 5 p.m. Monday through Friday. For more information from the ODH on the virus, go to: http://www.odh.ohio.gov/landing/phs_emergency/guidclin.aspx

CMS issues new ICD-10 fact sheet

The Centers for Medicare and Medicaid Services (CMS) has issued a new fact sheet on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure (ICD-10-CM/PCS) coding system that health care organizations will be required to use by Oct. 1, 2010. The CMS fact sheet says ICD-10-CM/PCS will improve the ability to measure health care services; increase sensitivity when refining grouping and reimbursement methodologies; enhance the ability to conduct public health surveillance; and decrease the need to include supporting documentation with claims.

Learn more view and download the fact sheet at: <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2009.pdf>

October Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)

This article amends payment files that were issued to contractors based upon the 2009 Medicare Physician Fee Schedule (MPFS) Final Rule. The key change is the assignment of H1N1 Vaccine and Administration Level II Healthcare Common Procedure Coding System (HCPCS) Codes. Please ensure that billing staff members are aware of these updates.

<http://www.palmettogba.com/palmetto/Providers.nsf/vMasterDID/7VHL6U4748?opendocument>

Recovery Audit Contractors (RACs) Subject to “Black-Out” Period

The AMCNO has learned that there may be a black-out period for the RAC in Ohio. This is due to the fact that the current contractual protests of the MAC awards are causing a delay in the Medicare Administrative Contractor (MAC) implementation. If the incumbent claims processing contractor is awarded the MAC contract upon resolution of the protests, there will be no black out period for RAC activity.

If a new contractor is chosen in Ohio (e.g., not the incumbent MAC) and is awarded the MAC contract, a black-out period will go into effect for a period spanning 3-months before and 3-months after the MAC cutover date (the date the claims processing systems actually change from the incumbent to the new contractor). In this 6-month period, the RAC will be prohibited from sending out medical record request letters (for complex reviews) or overpayment demand letters (for automated review) to providers. It is CMS’s contention that this will allow providers to become acclimated to the new MAC and its processes without adding any additional burden (e.g., RAC audits). However, once the black-out period is lifted, a RAC may go back and look at claims processed during that 6-month period. *Information to transition to a new MAC has not yet been posted on the PalmettoGBA site due to the protests, but if Ohio does transition to a new MAC the black-out will go into effect.*

This was addressed in a June 2008 publication released by CMS outlining the black-out period for the implementation of the Permanent RAC program To view the publication go to <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf> under Item 7. Implementation of the Permanent RAC Program.

The Process for Identifying and Recouping Improper Medicare Payments Made to Health Care Providers is Changing in Ohio:

By: Marilena DiSilvio, Esq.
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Are You RAC Ready?

Over one billion Medicare claims are processed each year in the United States. Inadvertent errors in filing these claims amount to approximately \$10 billion in combined overpayments and underpayments to health care providers annually. In an effort to identify and recoup the costs associated with improper payments, the U.S. Congress passed Section 302 of the Tax Relief and Health Care Act of 2006.

This Act requires the implementation of a permanent and nationwide program consisting of Recovery Audit Contractors (RACs), working in each state to perform post-payment audits on health care providers. RACs are private companies hired by the Centers for Medicare and Medicaid Services (CMS) to identify improper payments. The RACs have the authority to perform random computer based audits, as well as unannounced on-site audits of any health care provider receiving Medicare reimbursements.

The start date of the RAC program in Ohio:

CMS initially intended Ohio's RAC program to begin on August 1, 2009. CMS then delayed the program, while CMS and CGI Federal decided to first begin the process of educating health care providers about the RAC program. CMS and CGI Federal are currently hosting forums across the state in which health care providers can attend and ask questions to learn more about the RAC program prior to its implementation. The education outreach program does not have a scheduled ending date, but is expected to be complete at the earliest by October 2009. Although the exact ending date of the education outreach has not yet been determined, it is planned for the RAC audits to begin a short time after the education outreach program is complete. When the RAC program does start, at the earliest during October 2009, the program will begin on a roll-out basis. Non-complex automated reviews are set to start first. The staggered start will then follow with DRG validation reviews, then complex reviews for coding errors, and lastly DME and medical necessity reviews. The start of each roll-out phase will be staggered by several months, with the specific dates for each phase of the roll-out not yet set.

There is one additional factor to consider when attempting predict the exact start date of the RAC program in Ohio, and that is the potential of a "black-out period." CMS recently released a decision that the RAC program will be delayed by three months in any state that makes a transition to a new Medicare Administrative Contactor (MAC). In Ohio, it is still unclear if a new company will be awarded the contract to serve as the MAC for Ohio. If this happens, then the RAC program will not begin until at least three months after the date of that transition. The black-out period would allow the new MAC to focus on claims processing activities before having to get adjusted to working with the RACs.

What can I do to prepare for a RAC audit?

1. Educate yourself. Right now, CGI Federal is conducting various education outreach programs throughout the state. Attend these programs to learn more.
2. Conduct a pre-RAC risk assessment by auditing your own files. You may do this in-house with the help of your current staff, or you may hire an outside audit company to assist. A review of your own files and claims will help you make sure your practice is in compliance with all Medicare guidelines.

3. Designate one administrator in your office as the point of contact who is responsible for an unannounced audit. Educate non-designated staff members of the audit process, so that they learn who has been designated the contact person, and so that they do not speak with auditors.
4. Ensure that no one associated with your practice signs any statement certifying the completeness of medical records that are provided to the auditor without your approval.
5. Be aware that if you choose, you can request to have legal counsel present during any conversation with an auditor.
6. Visit the CGI Federal website once the RAC program begins in Ohio. The website will list areas of “vulnerabilities” for health care providers to study, so that providers may learn from the listed vulnerabilities the types of common mistakes which result in provider billing errors and improper payments.

What happens if I am audited?

If RACs audit your practice and improper payments are identified, the RACs will issue you an initial demand letter to remit payment. Once you receive this letter, a “discussion period” begins. This allows you the opportunity to speak directly with the RACs regarding their demand. During this time, you may submit evidence to challenge the demand letter if you so desire. Or, you may decide that the demand was legitimate, and issue repayment. It is important to note that this “discussion period” is distinct from the appeal process. The discussion period lasts 40 days, and during this time, you will not accrue interest, nor will CMS attempt to recoup payment. On day 41 of the process, if you have not yet filed a formal appeal, CMS will begin the recoupment/collections process. Importantly, even though recoupment may begin, you still have up to 120 days from the date of receipt of the initial demand letter to start the formal appeals process.

The appeal process is a five step process that begins after the discussion period. In the first step of the appeal process, you will make a formal request for “redetermination.” Next, you have the right to ask for further “reconsideration.” If you are still not satisfied with your results from the first two stages, you may take your issues to be heard before an administrative law judge (ALJ). After the ALJ’s decision, you have the right to ask a Medicare appeals council to hear your concerns. The last step of the appeal process is a judicial review in the U.S. District Court. Each phase of this appeal process has specific time limitations for filing, and specific requirements for submitting evidence in support of your defense. Before beginning this process, you must be aware of these requirements to make sure that you are in compliance.

Interesting statistics:

As of March 27, 2008, only 14% of providers had chosen to appeal RAC determinations made during the three state demonstration program. Perhaps this surprisingly low percentage of appeals is due to a lack of awareness providers have regarding their options to challenge a RAC demand. Getting educated about the RAC process and knowing your rights and options during the audit process is the first step to a successful defense of any demand for recoupment against your practice.

Sources of information:

To answer any questions you might have, we recommend you visit either the CMS website (<http://www.cms.hhs.gov/RAC>), or the CGI Federal website devoted to this RAC program (<http://racb.cgi.com>).

Of note: RAC medical record request limits:

- Solo practitioner – 10 medical records per 45 days
- Partnership of 2-5 individuals; 20 records per 45 days
- Group of 6-15 individuals; 30 records per 45 days
- Large group of 16 or more individuals; 50 records per 45 days

Need More RAC Information? Attend the AMCNO Third Party Payor Seminar in November – CMS and CGI to present (see last page of this publication for sign up information).

The AMCNO has been able to schedule a presentation by the Center for Medicare and Medicaid Services (CMS) and CGI - the recovery audit contractor for Ohio at our upcoming seminar on November 18th – “Solving the Third Party Payor Puzzle.” SIGN UP NOW – this event fills up fast. See the end of this newsletter for full details regarding this event and for sign up information.

News from Other Third Party Payors

UnitedHealthCare (UHC) to Launch Provider Advocate Program in Northern Ohio

As previously noted in the Summer Practice Management Matters issue UHC has adopted a more decentralized approach to customer service, and they are currently implementing local Provider Advocates around the state of Ohio. UHC Provider Advocate staff has been in close contact with the AMCNO regarding the rollout of the program in Northern Ohio. *The following article has been prepared to update AMCNO members and their staff on this project:*

UnitedHealthcare Ramps up Locally Based Provider Services in Northern Ohio

By Mollie Chapman Director, Physician and Hospital Relations, Ohio.

Physicians and hospitals may soon see visitors from UnitedHealthcare in their offices. UnitedHealthcare is introducing a local, personalized provider service to work with UnitedHealthcare network physicians and hospitals in 44 counties in the Northern Ohio region. Physicians and their staffs are central to the delivery of health care and UnitedHealthcare’s Provider Advocates will play a key supporting role to the physician.

New Services for Northern Ohio Physicians

With approximately 14,000 network providers in the region, UnitedHealthcare is bringing this program to northern Ohio after successful pilots in several other markets including Cincinnati. Physician Advocates will visit physicians and other medical providers in their offices to offer a variety of services including:

- Educating providers and staff on billing and reimbursement practices
- Training office staff to utilize online tools to streamline administrative tasks
- Conducting periodic training programs
- Assisting in resolution of claims issues

Physician advocates will offer a single point of face-to-face and telephone contact for participating physicians, and make it easier for them to navigate, and interact with, UnitedHealthcare. They will be the go-to person for the physician practice, and are supported by a local team. UnitedHealthcare is also enhancing the responsiveness and troubleshooting capabilities of its Market Service Agents, who are available by phone. Additionally, there will be a variety of educational programs for office staff and town hall meetings with physicians.

The process of decentralizing and localizing customer service is continuing across the country and the customer service team has access to dedicated adjusters to move northern Ohio provider claim’s through the system expeditiously. Of particular help will be the enhanced Web-based services for claims navigation (training is available by contacting market service agents or physician advocates).

“We are working to create a new spirit of partnership with physicians and their staffs through the enhancement of our provider services and the introduction of our Provider Advocacy Program,” said Giesele R. Greene, M.D., market medical director for UnitedHealthcare of Northern Ohio. “We believe these physician-driven enhancements will enable us to be more quickly responsive to physicians and other health care professionals. The physician advocates will be a go-to resource for information-sharing and issue resolution.”

How the Program Works

Key elements of the Provider Advocacy Program include:

- Meeting regularly with providers and their staffs (some physicians may be able to meet with their physician advocates as frequently as quarterly, if requested by the physician)
- Facilitating the claims process and troubleshooting claim issues
- Training office staff to utilize UnitedHealthcare’s online tools to streamline administrative tasks
- Educating providers on billing and reimbursement practices
- Answering questions related to UnitedHealthcare’s quality and affordability initiatives
- Providing regular training programs through Webinars and seminars

The enhanced provider services were instituted about a year ago in southwest Ohio and several months ago in the Columbus area. The implementation in northern Ohio is scheduled for 4th quarter 2009. Early indications are that these services are having a significant positive impact.

For example, according to preliminary data from southwest Ohio (which includes Cincinnati and Dayton), turnaround time for claim issue resolution was reduced by more than 50 percent to under 12 days, on average. More than 88 percent of unresolved claim issues are being resolved in less than 20 days, and, ultimately, the program sets a target of 95 percent resolution in less than 20 days.

Over the next year, UnitedHealthcare will continue unveiling similar physician-driven programs across its markets. The Ohio programs were designed in consultation with the state medical association and the Academy of Medicine of Cleveland and Northern Ohio, among other organizations.

Recently, AMCNO physician leadership and staff met with representatives from UnitedHealth Care (UHC) to discuss the imminent rollout of their Provider Advocate Program here in Northeastern Ohio. The AMCNO plans to be involved in the promotion of the program as well as planned participation in town hall and practice management meetings with representatives of the UHC Physician Advocacy staff. ***For information about the Provider Advocacy Program, call 513-603-6744.***

Anthem Provider Access Update

As noted in the last issue of the Anthem Update physician practices that want to check member eligibility, claim status and fee schedules can do so online by registering with Anthem. To access the My Anthem Provider Access Request Form, go to

<https://www33.anthem.com/eproviderreg/Welcome.do;jsessionid=3J2hKQDQgB658MKrKc7STcYLwnPLh mDQ2bpSRTRpdpFTF69Pn0Y2!562609210!315416301>

It is recommended that in order to ensure that your information is protected that you have an authorized staff person from your practice complete the registration form. The individual must be employed by the facility or practice and not an external contractor. Anthem will follow up with the site administrator once the registration is received to confirm the request as well as when the process is complete. Mail confirmation will also be sent to the site administrator.

Medicaid Transmittal Letters Are Now Electronic Access Only

Transmittal letters notify Medicaid providers, county agencies and other stakeholders about rule and policy changes and clarifications. A new rule - Ohio Administrative Code (OAC) 5101:3-1-17.1, "Notification of rule and program changes" - allows ODJFS to communicate rule changes electronically to those who might be affected by them. Therefore, after Aug. 1, Medicaid providers will no longer receive paper copies of Medicaid transmittal letters. Instead of the paper copies you may sign up to receive communications electronically by submitting your names and e-mail addresses through the following link <http://www.odjfs.state.oh.us/subscribe/> ODJFS will also be posting changes at the following link <http://emanuals.odjfs.state.oh.us/emanuals/GetTocDescendants.do?maxChildrenInLevel=10&level=2&group=ODJFS&username=public&password=public&publicationName=emanuals.Title.Presentation>

Medicaid Managed Care Enrollment Update

Over the next few weeks, Medicaid managed care patients will receive notices about statewide open enrollment month. Up to this point, there have been different open enrollment months for ABD and CFC programs within the same region and varying months between the eight regions. To simplify this process, the Bureau of Managed Care has designated November as a statewide open enrollment month for both the ABD and CFC programs. The current open enrollment schedule for CFC consumers will continue as scheduled to accommodate federal requirements. Individuals in the Northeast Ohio region will get open enrollment in October and again in November. If you have any questions, contact the Bureau of Managed Care at 614-466-4693 or by e-mail at bmhc@jfs.ohio.gov

For an ABD region map go to <http://www.jfs.ohio.gov/OHP/bmhc/documents/pdf/ABDRegMap.pdf> For a CFC region map go to

http://www.jfs.ohio.gov/OHP/bmhc/documents/pdf/CFC_RegionalMap_Color_0408.pdf



The Ohio Department of Insurance (ODI) Places The Physicians Assurance Corporation Into Liquidation

The Franklin County Court of Common Pleas has granted the ODI's request to an agreed to order to place The Physicians Assurance Corporation (TPAC) into liquidation. The liquidation order, which was filed on August 18, 2009, allows the Department to take possession of the insurer's assets and administer them under the general supervision of the court. TPAC insurance contracts are currently still in-force, provided premiums are paid. Pursuant to the court order, contracted providers must continue to provide authorized or covered services for the contract period. TPAC was licensed by the Department to write health insurance on February 1, 2008. TPAC covers approximately 300 groups, which include approximately 8,000 members in central Ohio. Individuals and businesses that are currently insured through TPAC are encouraged to call their broker or agent to find new coverage. Consumers who have questions about the order or whose providers are refusing services are asked to call the Department at 1-800-686-1526 or the Office of the Ohio Insurance Liquidator at 614-487-9200. More information on TPAC's rehabilitation can be found on the Department's web site www.insurance.ohio.gov, and the Office of the Ohio Insurance Liquidator's website www.ohliq.com. General information on the Ohio Life & Health Insurance Guaranty Association (OLHIGA) can be found at their website www.olhiga.org.

FTC to delay 'red flags' enforcement until Nov. 1

The Federal Trade Commission has decided to once again postpone the implementation of the “red flags” enforcement rule. The rule will now take effect on November 1st. This rule will require physicians and hospitals to adopt written plans for tracking and responding to indicators of identity theft in their billing operations.

This is the third time the FTC has changed the date, and the agency is again promising additional resources and guidance to help businesses understand if the rules apply to them and how to comply. In the FTC's view, hospitals and physicians are creditors for the purposes of the rule because they accept deferred payment for their services. The AMCNO has sent out detailed information to our members regarding compliance with the “red flags” rule in previous publications. The FTC has also created a web site dedicated to informing businesses about their obligations under the rule. To view the site go to

<http://www.ftc.gov/bcp/edu/microsites/redflagsrule/faqs.shtm>

The AMCNO sent out detailed information regarding compliance with the Red Flags Rule that was to become effective on May 1, 2009 in the Spring 2009 Practice Management Matters newsletter. Physician offices are urged to retain this information or, to obtain a copy go to the AMCNO website: www.amcnoma.org and access “information on red flag rules” within the Practice Management link.

Additional information is also available on the FTC web site at www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm, and at another link on the FTC site at www.ftc.gov/redflagsrule. The FTC is currently working on a compliance template and the AMCNO will inform our members as soon as that information becomes available on their site.

CDC Guidance on Shortage of Erythromycin (0.5%) Ophthalmic Ointment - September 2009

The AMCNO has learned that there is an impending shortage of erythromycin ointment and that the CDC has issued an alert on this issue. The statement from the Center for Disease Control (CDC) was drafted by the CDC with input from the Food and Drug Administration (FDA), the American Academy of Pediatrics, the American Academy of Family Practice, the American College of Obstetrics/Gynecology and the American Academy of Ophthalmology.

CDC continues to work with the U.S. Food and Drug Administration (FDA) and other experts to provide updates regarding the shortage of Erythromycin Ophthalmic Ointment (0.5%). This page provides guidance on securing supplies and recommendations for preventing increases in the occurrence of ophthalmia neonatorum during the shortage. To view the CDC statement regarding this shortage go to:

<http://www.cdc.gov/std/treatment/2006/erythromycinOintmentShortage.htm>

Physician Ranking Legislation Gains Momentum - Sponsor and Proponent Testimony Presented to Ohio House

In June, Representative Barbara Boyd provided sponsor testimony to the Ohio House Health Committee on legislation spearheaded by the AMCNO on the issue of physician ranking/designations. At a later committee hearing, Dr. John Bastulli, Vice President of Legislative Affairs of the AMCNO, provided testimony on behalf of the AMCNO to the House Health Committee on HB 122. HB 122 is sponsored by Rep. Barbara Boyd, and Senator Tom Patton has introduced a companion bill in the Ohio Senate. Both bills were spearheaded through the efforts of the AMCNO and we strongly support the legislation.

The legislation is meant to establish standards for physician designations by health care insurers. Rep. Boyd said the bill creates requirements that health insurers establish a rating system for physicians that are based

on cost efficiency, quality of care or clinical performance. The insurers would be required to disclose those designations to any individual, with the inclusion of language declaring that the ratings shouldn't be the sole factor in selecting a doctor. Rep. Boyd noted that insurers would be required to notify doctors of their designations before they are published, and gives doctors and others the opportunity to review the method and data used to make the determination and physicians would also have the ability to appeal their designations.

The AMCNO proponent testimony keyed in on several important points noting that insurers have supported obtaining data in order to tier and quantify cost effective care, and consumers have wanted data to compare quality of doctors. The crux of the debate is balancing the rights of physicians to have accurate and relevant reporting of their practice with the desire of health insurers and consumers to have access to information about their treating physician. Our testimony stressed that many insurers “profile” or “rank” their physicians to analyze and monitor cost of care. The way that insurers do this is calculated through insurer claim databases and analytic software. These systems analyze the actual cost of care incurred by physicians in caring for patients and compare it to the expected and average cost of care. In effect, the insurance company determines its own definitions of “efficiency” based on the difference between expected cost of care and actual cost of care. However, the manner in which insurers define “efficiency” is contentious and requires a better definition. Rather than focusing on the cost of clinical resources for a set of services, there should be greater focus on the overall benefits of care provided, including clinical outcomes.

This legislation stresses that health plans must use risk-adjusted data, and base grades and ratings at least in part on nationally recognized quality of care measures and not on cost alone. The legislation also provides physicians with the right to review and appeal their ratings prior to the ratings being released to the public. The AMCNO noted that we also believe that an independent ratings examiner, with expertise in efficiency measurement should be considered to oversee compliance ranking systems. The AMCNO continues to meet with Rep. Boyd, House and Senate leadership and other interested parties with regard to this important legislation. For more information on HB 122 go to

http://www.legislature.state.oh.us/analysis.cfm?ID=128_HB_122&ACT=As%20Introduced&hf=analyses128/h0122-i-128.htm

AMCNO provides input to Northern Ohio Congressional Leaders regarding H.R. 3200

The AMCNO executive committee discussed H.R. 3200 at their July meeting and as a result, Anthony E. Bacevice Jr., M.D., AMCNO president, prepared and sent a letter to members of the Northern Ohio Congressional Delegation. In his letter, Dr. Bacevice identified several provisions in H.R. 3200 that would benefit physicians and their practice. He also identified several problems in the draft that the AMCNO would like to see addressed during the discussions taking place in Congress. The AMCNO will monitor the debate on health care reform as the debate continues in Congress.

To view a copy of the AMCNO letter to Congress go to the AMCNO web site at www.amcnoma.org and click on “Health Care Reform.”

Links to additional information regarding health care reform legislation: The Kaiser Family Foundation (KFF) has also compiled an interactive tool to compare the leading health reform proposals. To view the information provided by KFF go to: <http://www.kff.org/healthreform/sidebyside.cfm>
To view H.R. 3200 go to: <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3200>:
To view the Congressional Budget Office report on H.R. 3200 go to:
<http://www.cbo.gov/cedirect.cfm?bill=hr3200&cong=111>

Insurance Department Changes Web Site Address

The Ohio Department of Insurance has announced that the Department web site address will now be

<http://www.insurance.ohio.gov>. The old address, <http://www.ohioinsurance.gov>, will remain active for a several months but will eventually be shut down in place of the new address. A new feature of the Department's web site will be the addition of a powerful new search engine. This robust feature will allow visitors to the site to search all pages and documents using key words, which will allow the visitor to find more information on their topic of choice.

AMCNO Member Service – Assisting with Third Party Payor Issues

For over 25 years the AMCNO has offered an invaluable service to our members and their staff. On occasion, we know that our members experience problems with third party payors on a particularly difficult claim issue or regulation question. If you have an issue that you cannot resolve with a third party payor we encourage you to utilize this service. To begin the process you must complete the AMCNO Third Party Payor Review Form and return it to the AMCNO office with the pertinent information attached for our assistance. While we cannot guarantee resolution of every matter, the AMCNO has been successful in the past in resolving difficult issues. One of our members provided the following testimonial regarding our service:

“The Academy of Medicine of Cleveland & Northern Ohio above all others supported me and advocated for me during the ordeal of a Medicare audit. The AMCNO is the one professional society to which all Northeast Ohio doctors should belong. With more Ohio Medicare audits on the way this year, the AMCNO is the one place we can count on for help.”

Note: See the last page of this newsletter for a copy of the AMCNO Third Party Payor Review Form

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.

The AMCNO Practice Management Department is available to address or investigate any claim issue as well. 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

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

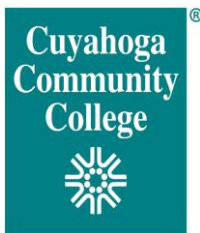
www.amcnoma.org

216.520.1000 Executive Offices 216.520.0999 Facsimile

Discounted Classes at Tri-C for
AMCNO members

Are You Prepared for ICD-10? Get the answers you need at ICD-10 classes offered to AMCNO members at a discounted rate

The Center for Medicare and Medicaid Services (CMS) announced earlier this year that it would replace the ICD-9 system with ICD-10 and that adoption of ICD-10 will be mandatory by Oct. 1, 2013. Along with the necessary steps to accommodate the conversion to ICD-10, a new 5010 security standard is set to begin Jan. 1, 2012. Although the timeframe is still three years out, it is time for physicians and their staff to start thinking about transitioning to these new codes. ICD-10 will include hundreds of new code sets so physician practices will be required to learn a new system. The AMCNO offers discounted classes at Tri-C on coding and practice management issues. We have been working with Tri-C to begin offering classes to help prepare physician practices for the upcoming ICD-10 changes. In October, two classes on ICD-10 are available to AMCNO members at discounted rates.



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

Professional CEUS: AAPC and PMI

For member discount information: Contact Linda Hale at the AMCNO at 216/520-1000.

For class information: Contact Barbara Neilsen at 216/987-3187 or barbara.neilsen@tri-c.edu

Date	Course/Seminar
Oct 21, 2009 Cost \$120 8:00-12:30 pm	ICD-10 Preparation: Part 1 Fundamentals of ICD 10 Structure Anatomy, Physiology & Terminology Review
1:30-4:30 pm Cost \$105	ICD-10 Preparation: Part 2 Get Started Preparing the Practice Timelines, Checklist and Staff Training Tracking Your Progress

Location: Corporate College East, 4400 Richmond Road, Warrensville Hts, OH 44128

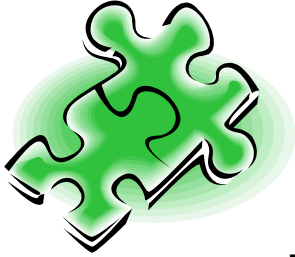
Medical Terminology: Cost \$253 and **Medical Billing Reimbursement: Cost \$282** are also offered at various times and at various Tri-C campus locations. Please call the AMCNO, Linda Hale 216-520-1000 to obtain course details, location, times, cost and discount promo code.

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

is pleased to present:

Solving the Third Party Payor Puzzle 2009

Wednesday, November 18, 2009



Registration: 8:00 a.m. – 8:30 a.m.

Seminar: 8:30 a.m. – 4:00 p.m.

WHERE: AMCNO Executive Offices

Park Center Plaza I

6100 Oak Tree Blvd – Lower Level Meeting Room
Independence, Ohio 44131

PURPOSE: To educate physicians and office staffs on the many third party payor claims and managed care issues.

COST: AMCNO Members and their staff ~ \$50 per participant
Non-members ~ \$100 per participant

◆ Lunch provided ◆

Featured Speakers:

Anthem Blue Cross and Blue Shield Ohio Department of Job and Family Services *
CIGNA Healthcare of Ohio Palmetto GBA Medicare Part B
Medical Mutual of Ohio UnitedHealthcare
Centers for Medicare and Medicaid Services (CMS) & CGI - Topic: Recovery Audit Contractor (RAC) Issues

*

* Speakers via teleconference supported with PowerPoint presentations.

Questions? Contact Debbie Blonski at:

(216) 520-1000, Ext. 102 or E-mail: dblonski@amcnoma.org

TO REGISTER, PLEASE COMPLETE & RETURN WITH PAYMENT. DEADLINE: NOVEMBER 13, 2009.

of Attendees _____ Amount due \$ _____

Name(s) of Attendee(s): _____

Physician(s) Name(s): _____

Office Address: _____ City, State, ZIP: _____

* Phone: _____ * Email: _____

Make check payable and mail to: AMCNO P.O. Box 901724, Cleveland, Ohio 44101-9932

Or by credit card: fax to (216) 520-0999

AMEX MASTERCARD VISA

Account # _____ Exp. date: _____

SEATING IS LIMITED; LIMIT two people per office. CUTOFF: 75 People

REGISTRATION REQUIRED PRIOR TO DAY OF SEMINAR.

Note: Payment also accepted day of seminar at registration



THIRD PARTY PAYOR REVIEW FORM

The Practice Management Department of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been in existence for more than 20 years. When AMCNO members or their office staff has specific practice management issues, questions or concerns with the numerous insurance carriers, the practice management department is always available to address or investigate these and other issues. This third party payor review form is a tool physician offices may utilize when specific issues/problems with an insurance carrier arise.

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Date Submitted: _____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____

CPT code in question: _____ Expected amount of reimbursement: _____

Patient First Name Only: _____ ***Insurance ID#: _____
 (Please do not include the patient's last name)

Date of Service _____

Issue or Concern: (mark all that apply)

Types of Denials

Preauthorization
 Referral
 Claim

Payment Issues

Delay in payment
 Late payment pattern
 Pre/Post payment review

Claim Patterns

Down coding
 Recording of claims
 Lost claims
 Data entry errors by insurer
 Supporting documents missing
 Pertinent claim information missing

Documentation Requests

Copy of medical record
 Operative report

Telephone Access

Continuous busy signal
 Excessive hold time
 Numerous calls for a single claim
 Other (specify) _____

Attach a letter describing the problem and detailing the sequence of events between your office and the insurance company. Also please attach copies of pertinent documentation including the claim, explanation of benefits, and any correspondence.

IMPORTANT: Please do not send confidential patient information without the proper patient consent. Remove all identifying information, such as patient's last name, from documentation prior to submitting to AMCNO. ***All claims must have a numeric identifier as a form of identification. If the patient does not have an insurance identification number, use the primary policyholder's social security number or the patient's social security number. Please be advised that the AMCNO may share this information with the insurance carrier, relevant state agencies, or other parties to expedite resolution of your problem. The submission of this form and any attached information is consent to release this form and information, as appropriate, by the AMCNO. Please mail or fax this completed form to the **AMCNO, Practice Management Department, 6100 Oak Tree Blvd., #440, Cleveland, Ohio 44131 or fax (216) 520-0999.** If you have any questions regarding this form and its use or additional issues or concerns, please contact the practice management department at (216) 520-1000 or e-mail concerns@amcnoma.org