

SPRING EDITION 2013

Medicare

SAVE THE DATE: BACK AGAIN FOR ITS 27TH YEAR
– SOLVING THE THIRD PARTY PAYOR PUZZLE SEMINAR
– WEDNESDAY, NOVEMBER 13, 2013

What Providers Need to Know about EHR Audits

All eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) attesting to receive an incentive payment for either the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program may be subject to an audit.

Pre- and Post-Payment Audits

CMS and its contractor, Figliozi and Company, perform audits on Medicare and dually eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs. States perform audits on Medicaid providers participating in the Medicaid EHR Incentive Program.

In addition to the post-payment audits that have been conducted since 2012, CMS began pre-payment audits this year, starting with attestations submitted during and after January, 2013.

New Resources to Prepare for Audits

For those providers selected for pre-payment or post-payment audits, CMS and its contractor will request supporting documentation to validate submitted attestation data. To help providers prepare for a potential audit, CMS created the new Supporting Documentation for Audits Fact Sheet. The fact sheet and a sample audit request letter for both EPs and eligible hospitals are also available on the Educational Resources page of the EHR Incentive Programs website.

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website for the latest news and updates.

ICD-10: Assessing Your Vendors

Vendors are key partners who can help you prepare for ICD-10. When considering how your vendor can assist you in your transition to ICD-10, you should first assess your vendor's capabilities:

- Do your current vendor contracts cover your practice's ICD-10-related needs?
- What is the vendor's timeline for the ICD-10 transition?

- Will your vendor install products well before the October 1, 2014, deadline, so you can begin testing them in 2013?
- Has your vendor scheduled with you to test your system with your trading partners?
- Will all your vendor's current products and applications be updated for ICD-10?
- Has your vendor scheduled training for your staff on the ICD-10 system updates?
- Do products give you the ability to search for codes by the ICD-10 alphabetic and tabular indexes? By clinical concept?
- Will the product allow for coding in both ICD-9 and ICD-10 to accommodate transactions with dates of service before October 1, 2014, and transactions with dates of service after October 1, 2014?

Communicating Your Transition

After assessing your vendor's capabilities, continue to communicate with them throughout the ICD-10 transition:

- **Planning.** Include your vendor in planning the transition. Communicate your needs and goals to your vendor and ask for your vendor to provide assurance in writing that products and testing plans will fulfill your requirements. Ask your vendor to share some strategies that other clients have used successfully.
- **Implementation and internal testing.** Work with your vendors to update and test clinical, financial, actuarial, and reporting processes. Vendors should offer technical support and guidance during and after installation of new software.
- **Testing with payers.** Find out how your vendor will provide support as you begin testing ICD-10 transactions with payers and other business trading partners. Allow up to a year in advance of the October 1, 2014, ICD-10 deadline for testing with trading partners.
- **Resolving testing issues.** Determine what role your vendor will play in resolving any testing failures.

For more information on working with vendors and other external business partners, consult the ICD-10 checklists, timelines, and implementation guides available on the CMS website.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the **October 1, 2014**, deadline.

For practical transition tips:

- Read recent ICD-10 email update messages
- Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape

Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – "Sequestration"

The *Budget Control Act of 2011* requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The *American Taxpayer Relief Act of 2012* postponed sequestration for two months. As required by law, President Obama issued a sequestration order on March 1, 2013.

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a two percent reduction in Medicare payment. The claims payment adjustment shall be applied to all

claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.** Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. All fee schedules, pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

Though beneficiary payments for deductibles and coinsurance are not subject to the two percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the two percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare claims administration contractor. **The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has written to Congress urging them to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.** To view the AMCNO letter to Congress [click here](#).

Center for Medicare and Medicaid Services (CMS) Offers More Information on Sequestration and Impact on Medicare claims.

Question: *How long is the two percent reduction to Medicare fee-for-service claim payments in effect?*

Answer: The law specifies that the two percent reduction to Medicare fee-for-service payments resulting from the sequestration order that the President was required to issue on March 1, 2013, applies to all payments for services furnished in the one-year period after the reductions begin. For Medicare, the reductions begin on the first day of the first month after the order is issued, meaning they began on April 1, 2013. Accordingly, this sequestration order covers all payments for services with dates of service or dates of discharge (or a start date for rental equipment or multi-day supplies) April 1, 2013, through March 31, 2014.

Question: *Are drugs excluded from the two percent reduction?*

Answer: No. All fee-for-service Medicare claim payments are subject to the two percent reduction. There are no exemptions provided in the law for drugs or any other health care item or service provided under the fee-for-service program.

Question: *Will incentive payments earned in the Medicare and Medicaid Electronic Health Records (EHR) Incentive programs be affected by sequestration?*

Answer: Incentive payments made through the Medicare EHR Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for two months. Under these mandatory reductions, Medicare EHR incentive payments made to eligible professionals and eligible hospitals will be reduced by two percent. This percent reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.

Please note: This reduction does not apply to Medicaid EHR incentive payments, which are exempt from the mandatory reductions.

Mandated Sequestration Payment Reductions Beginning for Medicare EHR Incentive Program

Incentive payments made through the Medicare Electronic Health Record (EHR) Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011.

Incentive Payment Reduction

Under the above-mentioned mandatory reductions, Medicare EHR incentive payments made to eligible professionals and eligible hospitals will be reduced by two percent.

Reduction Timing

This two percent reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.

Please Note: This reduction does not apply to Medicaid EHR incentive payments, which are exempt from the mandatory reductions.

Want more information about the EHR Incentive Programs?

Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs.

Here is the direct link to the FAQ: <https://questions.cms.gov/faq.php?faqId=8173>

Ordered and Referred Services (Phase II): Immediate Action Needed to Prevent Claim Rejections

If you order or refer Medicare patients for services, or if you perform services based on these orders, please review the following information closely. There are changes in the way the Medicare claims system will handle claims for ordered and referred services. This includes, but is not limited to, claims for clinical laboratory tests and radiology and imaging services.

Effective for dates of service on or after May 1, 2013: If the referring provider's information (National Provider Identifier (NPI) and name) is missing, incomplete, or invalid, or the ordering/referring provider is not eligible to order or refer services under Medicare, claims for ordered/referred services will be returned as unprocessable. These claims must be corrected and filed as new claims; they cannot be appealed.

Who may order or refer items or services for Medicare beneficiaries?

- Physicians (MD, DO, DDS, DMD, DPM, OD (optometrists may only order and refer DMEPOS products/services and laboratory and x-ray services under Medicare Part B))
- Physician Assistants
- Clinical Nurse Specialists
- Nurse Practitioners
- Clinical Psychologists
- Interns, Residents, and Fellows
- Certified Nurse Midwives
- Clinical Social Workers

Other important notes:

- Chiropractors are **not** eligible to order or refer supplies or services for Medicare beneficiaries.
- Services of Home Health Agencies may **only** be ordered or referred by an MD, DO, or DPM.

What this means to ordering/referring providers:

- Testing entities and other health care providers who perform services based on orders or referrals rely on the information from the ordering/referring provider in order to file Medicare claims.
- Verify that your specialty is permitted to order or refer the services.
- You must be enrolled in in the CMS Provider Enrollment Chain and Ownership System (PECOS). If you are not sure you are enrolled in this system, you may:
 - Download the [Medicare Ordering and Referring File](#) from the CMS website and look for your name and NPI, or
 - Call the CGS Provider Contact Center at 866.276.9558 and ask if you have an enrollment record that contains your NPI, or
 - Access Internet PECOS for your record (no record means you do not have an enrollment record in Medicare)
- Provide your **individual** NPI and the exact spelling of your name, as listed in PECOS, to the provider who is performing services based on your order or referral.

What this means to providers who perform services based on orders or referrals (including laboratory, radiology, and imaging services):

- Since October, 2009 (Phase I), Medicare has included “warning messages” on remittance advices (RAs) for claims that have a missing, incomplete, or invalid ordering provider name or NPI or that include ordering/referring provider information for a provider specialty that is not eligible to order or refer:
 - N264: missing/incomplete/invalid ordering provider name
 - N265: missing/incomplete/invalid ordering provider primary identifier
- Effective for dates of service on or after May 1, 2013, these warning messages will result in claim rejections as “unprocessable.”
- Act now: monitor your RAs to identify claims with remark codes N264 or N265.
 - Contact the ordering/referring provider, as necessary, to obtain valid and complete information.
 - Verify that the ordering/referring provider is listed in PECOS and is of a specialty permitted to order/refer by downloading the [Medicare Ordering and Referring File](#) from the CMS website.
Note: this report is updated weekly, so check often.
 - On your claim, enter the ordering/referring provider’s name **exactly** as it appears in the provider’s record in PECOS. Do not include titles like “Dr.”
- Claims with missing, incomplete, or invalid ordering/referring provider information will be rejected as unprocessable with remark codes MA130, CO-16, and N264 or N265.

For more information:

- Read CMS [MLN Matters article SE1305](#) to learn more about the edits for ordering/referring providers.
- [Internet-based PECOS](#)

The Centers for Medicare and Medicaid Services (CMS) Issues Final Rule on Sunshine Act

CMS has issued the final rule for the Physician Payment Sunshine Act including a new section of the rule that does not require CE program speakers to report indirect payments as long as certain conditions are met. Below is a short summary by the Alliance for Continuing Education in the Health Professions of the new section, 42 CFR §403.904(g):

Section 42 CFR §403.904(g):

The final rule contains a new section, 42 CFR §403.904(g), under which an indirect payment made to a continuing education program speaker is not considered an indirect payment or other transfer of value for the purposes of this rule and, therefore, does not need to be reported. All of the following conditions must be met:

(1) The program meets the accreditation or certification requirements and standards of the Accreditation Council for Continuing Medical Education (ACCME), American Academy of Family Physicians, ADA's Continuing Education Recognition Program, American Medical Association, or American Osteopathic Association;

(2) The applicable manufacturer does not select the covered recipient speaker nor does it provide the third party vendor with a distinct, identifiable set of individuals to be considered as speakers for the accredited or certified continuing education program; and

(3) The applicable manufacturer does not directly pay the covered recipient speaker. Payments or other transfers of value that do not meet all of these requirements must be reported as required by this section.

The Physician Payment Sunshine Act – Answers to the 5 W's

**By David E. Schweighoefer and J. Ryan Williams
Walter/Haverfield, LLP**

Introduction

The Physician Payment Sunshine Act was enacted as part of the sweeping federal health reform legislation Accountable Care Act. The Centers for Medicare and Medicaid Services recently released final rules that implement the Sunshine Act. In general, the Sunshine Act requires two things. First, applicable manufacturers of drugs, medical devices, biologicals or medical supplies must track and report payments made to physicians. Second, applicable manufacturers and group purchasing organizations must disclose for public reporting any ownership or investment interests held by physicians.

Physicians should be aware of the ins and outs of the Sunshine Act to avoid any unintended and/or uncomfortable public reporting and disclosures. Answering the proverbial “5 W” questions regarding the Sunshine Act is an important first step in guarding against any of these unintended risks.

Who is Required to Report?

The Sunshine Act requires public reporting and disclosure from manufacturers of drugs, medical devices, biologicals and medical supplies and group purchasing organizations. A manufacturer is any entity operating in the United States that produces or prepares at least one drug device, biological or medical supply covered under Medicare, Medicaid or the Children's Health Insurance Program. Manufacturers operate in the United States if they have a physical location or conduct activities in the United States. Distributors and wholesalers are also manufacturers for purposes of the Sunshine Act if these entities hold title to the drug, device, biological or supply.

What Must be Reported?

The Sunshine Act requires reporting and disclosure of two items: (1) payments and other transfers of value to physicians and (2) certain ownership or investment interests held by physicians. For any payments or transfers of value, both the “form” and the “nature” of the payments or transfers must be reported. Examples of the “form” include cash or cash equivalents, in-kind items or services, stock, stock options, or any other ownership interest, dividend, profit, or other return. Description such as consulting fees, honoraria, entertainment, food, and travel, royalties, or grants speak to the “nature” of the payments or transfers.

The Sunshine Act does exclude certain payments. For example, payments of less than \$100 in the aggregate during any given year, providing educational materials that directly benefit patients and intended for patient use, discounts and rebates, and product samples are not subject to reporting under the Sunshine Act.

The Sunshine Act defines ownership or investment interests in a fairly straightforward manner. An ownership or investment interest can be direct, indirect, and through debt, equity, or other means. This includes stock, stock options, partnership shares, limited liability company membership units, as well as loans, bonds, or other financial instruments that are secured with an entity's property or revenue or a portion of that property or revenue. That said, ownership or investment interests in a publicly traded security or mutual fund are excluded under the Sunshine Act.

When Are Reports Due?

There are various key dates to keep in mind with respect to the Sunshine Act. Beginning August 1, 2013, and continuing through December 31, 2013, manufacturers subject to the Sunshine Act must begin to collect and track payment, transfer, ownership, and investment information. Beginning January 1, 2014, the collection and tracking of this information will be on a calendar year basis. All reports for the partial year 2013 are due by March 31, 2014. Physicians will receive consolidated reports by August 2014. All reports will then be disclosed on a public website by September 30, 2014.

Where and How to Report?

The Sunshine Act requires the federal government to implement and maintain a web-based reporting system. The reporting entities will submit web-based reports that will include the physician's full name, business address, specialty, NPI, dates of any payments or transfers, and certain contextual information associated with the drug, device, biological or supply in question or the nature of the ownership or investment interest. Physicians may challenge these reports via an online portal for a period of 45 days after physicians receive the consolidated reports. This challenge must first involve informal resolution activities between the physician and the applicable reporting party. If a resolution cannot be reached, the report will still be made public but will be flagged accordingly. Physicians may continue to seek corrective action with respect to a report for two years after it is publicly reported.

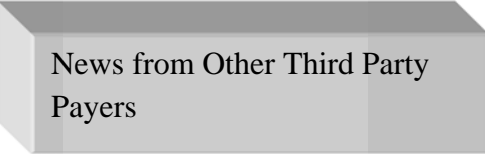
Why is the Sunshine Act Important?

The Sunshine Act is designed to promote transparency. Many healthcare professionals and, more importantly, patients and the public, have a view that monetary or other financial influence from manufacturers of drugs and devices tend to cause biased views about the benefits and risks of treatments and other alternatives. While the Sunshine Act is not designed to hamper innovation and discovery, it is the federal government's attempt to promote transparency and to allow everyone, including patients and physicians, to draw their own conclusions about the significance of any influence that drug or device manufacturers have over physicians.

Conclusion

Physicians should be prepared to address reports and disclosures under the Sunshine Act. After gaining a decent understanding of the requirements of the Sunshine Act, physicians should closely examine any arrangements in which they receive financial payments from manufacturers or otherwise maintain an ownership or investment interests in any of these entities. Physicians should then be proactive in contacting these entities and preemptively discussing each entity's intentions in making reports and disclosures. If possible, these discussions should include a candid conversation about the contents of any reports affecting the physician. Lastly, physicians should keep an eye on the federal government's activities associated with developing the reporting website. Once this website is developed, physicians should be given an opportunity to request and receive portal login information.

The Sunshine Act could have various repercussions to a physician's practice and keeping abreast of a physician's financial relationships with reporting entities and proactively managing these relationships is even more critical now.



News from Other Third Party
Payers

CIGNA

Clinical, Reimbursement, and Administrative Policy Updates

In an effort to support access to quality, cost-effective care for your patients with a Cigna-insured or administered medical plan, Cigna routinely reviews clinical, reimbursement, and administrative policies, as well as coverage positions and their precertification requirements. As a reminder, reimbursement and modifier policies apply to all claims, including those for patients with GWH-Cigna ID cards. However, please continue to follow separate claim submission procedures for these patients.

Information about these changes, including an outline of the specific updates, is available on the Cigna for Health Care Professionals website (CignaforHCP.com >Resources > Clinical Reimbursement Policies > Coverage Policy Updates) at least 30 days prior to the effective date of the updated policy. On this page, you may also view new and updated policies in their entirety. If you are not registered for CignaforHCP.com, please register so you may log in and access these policies. Go to CignaforHCP.com and click "Register Now," located near the center of the screen.

ANTHEM

Anthem's Peer-to-Peer Process

Anthem Blue Cross and Blue Shield (Anthem) uses a medical peer-to-peer review process by which our internal staff physicians re-examine cases when an adverse clinical determination is made regarding health care services for members. This process allows attending, treating or ordering physicians to request a peer-to-peer review to offer additional information and further discuss their cases with our peer clinical reviewers who made the initial adverse determination.

It is important to note that a peer-to-peer review is **NOT** an appeal nor does it take the place of an appeal. In addition, a peer-to-peer review is not required prior to requesting an appeal. The adverse clinical determination letter may indicate a time frame for you to initiate a peer-to-peer request to encourage early resolution of your concerns. We will accept your request to initiate a peer-to-peer review until such time as the appeal process has been exhausted.

As a reminder, the following guidelines address peer-to-peer reviews through Anthem. The guidelines apply to all of our lines of business (PAR, PPO and HMO), including the Blue Cross Blue Shield Service Benefit Plan (also known as the Federal Employee Program or FEP), our Medicaid plans and Medicare Advantage.

Peer-to-Peer Guidelines

Initiating a peer-to-peer request

You can initiate a peer-to-peer request **IF** you are the attending, treating or ordering physician who provides the care for which any adverse clinical determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, you or your designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

Availability of clinical peer reviewers

Our peer clinical reviewers are available for pre-service or continued stay/services reviews and for post-service clinical claim reviews. If the clinical reviewer who made the initial adverse determination is unavailable, another peer clinical reviewer is assigned to the case.

Our commitment to contacting physicians

Peer clinical reviewers make a minimum of two best effort attempts to contact the attending, treating or ordering physician in response to a peer-to-peer request. We will work to accommodate the attending/treating/ordering physician's schedule within normal business hours for that physician's time zone.

BWC

BWC Board Requires That Providers Join Drug Monitoring System

The Bureau of Workers' Compensation Board of Directors has adopted rules designed to help the agency better monitor its providers' and claimants' drug prescriptions. The rules will permit the BWC to stop reimbursement for controlled substance prescriptions written by providers who are not in compliance with the Ohio State Medical Board's requirement that certain prescribers enroll in the Ohio Automated Rx Reporting System. The rules come in response to legislation passed last session to crack down on the prescription drug epidemic in Ohio (HB93, 129th General Assembly). The measure allowed the bureau access to drug information about workers' compensation claimants through OARRS, according to a Legislative Service Commission summary. It also required the agency to implement a coordinated services program for claimants found to have obtained prescription drugs at a frequency or in an amount that is not medically necessary. BWC implemented the coordinated services "lock-in" program about a year ago to limit the dangers that can arise when medications are prescribed by multiple physicians and are processed in different pharmacies.

MEDICAID

2013 Healthcare Common Procedure Coding System (HCPCS) Regular File

The following rules were amended and emergency filed to implement the new HCPCS codes that are effective for dates of service on and after January 1, 2013. The permanent versions of these rules will be effective on March 28, 2013. They will replace the emergency filed version of these rules that were effective January 1, 2013.

The HCPCS, which includes Current Procedural Terminology (CPT) codes, is a medical procedure coding system that is the national standard for reporting medical services for billing and claims payment purposes. It is

also used by Medicare, private health insurance plans, and managed care plans, as well as state workers' compensation programs and state Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association and other professional groups, updates the HCPCS on an annual basis. OMA must implement the HCPCS updates for the Medicaid program to comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which requires the use of a nationally standardized coding system (45 CFR 162.1000 and 45 CFR 162.1002). The updates to these codes require OMA to make changes in the Ohio Administrative Code (OAC) because HCPCS codes are included in OAC rules or their appendices that guide the Medicaid program.

The following types of HCPCS code changes will be effective for dates of service on and after January 1, 2013: new codes added, obsolete codes deleted, revised codes implemented, changes in definition, and associated reimbursement changes. New HCPCS codes correspond to services without existing codes or services with existing codes that have been simultaneously rendered obsolete. New HCPCS codes that correspond to services without prior existing codes require coverage and payment decisions that are reflected in the rules and/or their appendices. Revised HCPCS codes correspond to services that have a revised definition.

Rules being amended to comply with HCPCS updates are as follows:

Rule 5101:3-1-60, entitled "Medicaid Reimbursement," sets forth the Medicaid reimbursement policies for all professional providers. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete HCPCS codes, revise definitions, and update reimbursement amounts associated with the codes. A new payment status indicator has also been developed. This new status indicator (B) will be used to signify bundled procedures. No separate payment will be made for bundled procedures as these services are incidental to the primary procedure. Some of the coding changes require amendments to existing policy on coverage. No changes are being made to the rule body itself.

Rule 5101:3-4-06, entitled "Physician Visits," sets forth coverage and reimbursement policies for physician visits provided in a variety of settings. Changes include the addition of codes for transitional care management services as distinct, covered services for which eligible providers of physician services may obtain reimbursement. The changes are driven only by HCPCS code updates. Changes also include updates to rule references.

Rule 5101:3-4-12, entitled "Immunizations," sets forth coverage and reimbursement policies for immunization services. Changes to Appendix A of the rule, which contains vaccines covered under the federal vaccines for children program, include the addition of a new influenza virus vaccine code and the deletion of codes for the tetanus and diphtheria vaccine. Changes to Appendix B of the rule, which sets forth vaccines that are covered for adults, include the addition of a code for Hepatitis B vaccine and the deletion of codes for tetanus and diphtheria vaccine. Medicaid coverage is not changing as a result of these code changes, as tetanus and diphtheria vaccines will continue to be covered for children and adults using different HCPCS codes. No changes are being made to the rule body itself.

Rule 5101:3-4-19, entitled "Allergy Services," sets forth coverage and reimbursement policies for allergy sensitivity tests performed by eligible providers of physician services, and immunotherapy. Changes include the addition of new HCPCS codes and deletion of obsolete HCPCS codes related to ingestion challenge testing.

Rule 5101:3-4-22, entitled "Surgical Services," sets forth coverage and billing practices for surgical services delivered by physician providers of Medicaid services. The appendix of the rule is being updated based on current values contained in the Relative Value Unit file that the Centers for Medicare and Medicaid releases annually for surgical procedures subject to multiple, bilateral, or assistant at surgery procedure pricing. No changes are being made to the rule body itself.

Rule 5101:3-4-29, entitled "Services Provided for the Diagnosis & Treatment of Mental and Emotional Disorders," sets forth coverage and reimbursement policy for services that are provided by physician providers for the diagnosis and treatment of mental and emotional disorders. The changes to this rule update rule references that have become obsolete because outdated procedure codes in OAC 5101:3-8-05 have been replaced.

Rule 5101:3-21-02.3, entitled "Limited Family Planning Benefit," sets forth coverage and reimbursement policies for procedures and services that are covered under this benefit. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete codes, and update the fee schedule. Anesthesia provided during tubal ligations, vasectomies, and hysterectomies have been added to the appendix to this rule. No changes are being made to the rule body itself.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

Medicaid Expansion Discussion Continues at the Statehouse

House lawmakers provided an opportunity to continue the debate on Medicaid expansion as members voted unanimously in favor of an amendment that would give the chamber more time to study its options. The floor amendment offered in the Ohio House by Rep. Barbara Sears amended the budget bill to require that legislation be introduced in the General Assembly which would:

- Include strategies to lower Medicaid caseloads
- Lower Medicaid costs.
- Reduce Medicaid enrollees – over time.
- Require the administration to inform the General Assembly of the terms of the federal negotiations (not before 09/15/13).
- Require the administration “cease any activity regarding this reform” if the General Assembly does not act before 12/31/13.

If Medicaid expansion had not been included in the House proposal, it appeared unlikely the Senate would take up the issue. The amendment requires that overhaul plans be reviewed by lawmakers and challenged against their goals and priorities, which include lowering Medicaid caseloads by promoting employment services, reducing net program costs at the state and federal level, and shrinking enrollment over time.

The amendment does not take the option of expansion through an 1115 Medicaid waiver off the table but it allows lawmakers to examine other alternatives such as a state-based expansion. The amendment gives lawmakers time to study the Medicaid issue and allow the state to pursue other options. The Kasich administration has been negotiating with federal officials for months over the details of possibly providing private health coverage to some people who would be eligible for Medicaid under the expansion. The amendment directs administration officials to assist lawmakers in developing Medicaid reforms and to submit a Medicaid plan to the Legislature by this fall. It says state lawmakers would have to sign off on any Medicaid proposal that has federal approval before it gets implemented. Debate on this issue now heads to the Ohio Senate where Senate leadership has stated that they do not plan to include Medicaid expansion in the budget but rather would prefer to review other options such as legislation. The AMCNO supports Medicaid expansion and

we will continue to work on this issue as the budget bill debate continues in the Senate and we will continue to work with other members of the healthcare community and organizations to educate lawmakers on this important issue.

UNITED HEALTHCARE

2013 UnitedHealthcare Provider Administrative Guide

The *2013 UnitedHealthcare Provider Administrative Guide* became effective April 1, 2013, for all participating physicians, health care professionals, facilities and ancillary providers. For those newly participating on or after January 1, 2013, the *Guide* was effective immediately.

Important Updates in the 2013 Guide include:

- **Commercial pharmacy benefits manager transition** – UHC pharmacy benefit programs are now managed by OptumRx. All services were transitioned in 2013 from Medco to OptumRx.
- **Preventive services guidelines** - UHC Preventive Care Services Coverage Determination Guideline (CDG) was updated to help physicians identify and correctly code preventive services delivered to United Healthcare members as part of the ongoing implementation of the health care reform law.

Notification and Prior Authorization Requirements revised

- The advance notification list includes changes adopted April 1, 2013.
- A new protocol for the *Cardiology Prior Authorization Program* was added for Medicare Advantage plans.
- A new protocol was added for *Specialty Drug Prior Authorization for Commercial Benefit Plans*. It does not include chemotherapy injectables.

In addition, the *Referrals and Authorizations* section of the *UnitedHealthcare Mid-Atlantic Supplement* has been amended.

HealthManagement and Wellness Programs - Additional information has been added regarding case and disease management programs to support physicians' treatment plans and assist members in managing their conditions. Depending on the structure of the benefit plan, additional multiple care coordination programs may be available.

OneNet PPO - A summary of key OneNet policies and practices are now included.

Fraud,Waste and Abuse - Changes have been made to the Medicare compliance expectations for education, training, and screening requirements.

UnitedHealthcare Navigate® includes new sections - Services that do not require a referral and requirements for submitting a referral to include EDI connections.

Guide Improvements - Continuing improvements were made to increase consistency in terminology and the list of benefit plans on pages two through six were updated with added plans. Please contact your Network

Management representative, Physician Advocate or Hospital and Facility Advocate if you would like a hard copy of the Administrative Guide. You can also sign up to receive the *Network Bulletin* electronically at UHC-NetworkBulletin.com.



CliniSync Releases Policy Advice on Exchange of Sensitive Health Information

Both the Board of Directors and the CliniSync Advisory Council have approved a policy related to the exchange of health information, making it clear what can and can't be exchanged through CliniSync. This will become particularly important when The Partnership turns on the ability for providers to search for and find information about a particular patient who has been treated in the past by other physicians and clinicians. Patient consent will be necessary to search for that patient's information.

CliniSync is providing this information in light of a new Ohio law passed last summer that eases restrictions on mental health and HIV information exchange. Federal law still asks for express consent from patients for certain drug and alcohol information, for certain information about minors over the age of 14 and for those who pay out-of-pocket for services. To view policy and educational materials, please go to the **Policy tab** under About Us at www.clinisync.org.

State Medical Board of Ohio Adopts Policy on Signing Death Certificates

The State Medical Board of Ohio receives many inquiries concerning the signing of death certificates by attending physicians. The topic has also been the focus of recent state-wide media. The Medical Board adopted a policy "Regarding the Signing of Death Certificates by the Attending Physician" in April 2010.

Ohio law requires the attending physician to sign the death certificate within 48 hours after the death when an individual dies under natural causes. The "attending physician" is the licensed MD or DO who is the physician in charge of the patient's care for the illness or condition that resulted in death. By signing a death certificate, the physician is giving a medical opinion as to the cause of death. There is no requirement that the attending physician be present at the time of death.

View the full Death Certificate policy on the Medical Board's [website](#).

Governor's Cabinet Opiate Action Team (GCOAT) Working with State Regulatory Boards to Finalize Prescribing Guidelines

The AMCNO recently attended the Governor's Cabinet Opiate Action Team (GCOAT) Reforming Prescribing Practices Committee where it became clear that the regulatory boards in Ohio were working toward adopting clinical guidelines addressing the use of medication therapy management for high-dose chronic pain patients. The AMCNO along with other statewide organizations has been an active participant in this process which would establish clinical guidelines for the utilization of medication therapy management for an extended timeframe for high-dose chronic pain patients.

It is important to note that these clinical guidelines would apply to physicians who are using opioids for the treatment of chronic, non-terminal pain for longer than three months at high doses with their patients. It establishes a trigger threshold of 80mg of a Morphine Equivalent Daily Dose (MED) as to when a physician should pause and reassess their treatment plan with the patient. When the patient exceeds the 80mg MED threshold, the prescriber should strongly consider the following actions to optimize therapy and ensure patients safety:

- Reestablish informed consent, including providing the patient with written information on the potential adverse effects of extended-release or long-term opioid therapy.
- Review the patient's functional status and documentation, including the 4A's of chronic pain treatment: Activities of daily living; Adverse effects; Analgesia; and Aberrant behavior.
- Review the patient's progress toward treatment objectives for the duration of treatment.
- Utilize OARRS as an additional check on patient compliance.
- Consider a patient pain treatment agreement that may include more frequent office visits, considering different treatment options including drug screens, use of one pharmacy, use of one provider for the prescription of pain medications, and consequences of non-compliance with the terms of the agreement.
- Reconsider having the patient evaluated by one or more other providers who specialize in the treatment of the area, system or organ of the body perceived as the source of the pain.

It is also important to note that GCOAT and the respective regulatory boards are moving forward with this as a *guideline* to establishing a standard of care rather than as a rule. The AMCNO and various other statewide medical associations voiced our concern last year when it was suggested that these guidelines should be adopted as a mandated rule. As a result of these advocacy efforts, GCOAT revised its position and is moving this forward as a clinical guideline. This will provide the medical associations with the opportunity to promulgate these new standards through educational offerings and encourage voluntary adoption of this practice.

The SMBO and the other regulatory boards are planning to adopt this standard as a position statement at their May board meetings. The GCOAT would then proceed with a July 1 implementation date. The GCOAT is also planning to establish metrics to assess over the course of the next year as to the effect of the trigger threshold clinical guideline. If there is no impact on the prescribing issues in the State of Ohio within a one-year timeframe it is possible that these guidelines could become a rule so it is imperative that the AMCNO and other physician associations educate physicians on these guidelines once they are in effect. The AMCNO will continue to provide our members with information about this important issue.

Ohio Department of Health Releases 2011 Overdose Death Report

Immediately following the last GCOAT meeting the Ohio Department of Health released their 2011 Overdose Death Report. Some of the key findings of the report include –

- Unintentional drug overdoses caused 1,765 deaths to Ohio residents in 2011. This is the highest number of deaths on record for drug overdose and surpasses the previous highest number (1,544) in 2010 by 14.3 percent.
- In 2011, nearly five (4.8) Ohioans died every day from unintentional drug overdose, or one every five hours.
- Unintentional drug overdose continues to be the leading cause of injury-related death in Ohio, ahead of motor vehicle traffic crashes, suicide and falls. This trend began in 2007 and continues through 2011.
- Prescription drugs are involved in most unintentional drug overdoses and have largely driven the rise in deaths. Pain medications (opioids) and multiple drug use are the largest contributors to the epidemic.
- Prescription opioids (pain medications) remain associated with more fatal overdoses than any other prescription or illegal drug including cocaine, heroin and hallucinogens and combined.

For more information on this report, please go to the following links:

- Data News Release
- 2011 Drug Overdose: General Findings
- Number of Unintentional Drug Poisoning Deaths and Average Annual Rate for Ohio Counties 2007-2011

AMCNO PHYSICIAN LEADERSHIP ADOPTS AMERICAN MEDICAL ASSOCIATION (AMA) GUIDELINES FOR PATIENT NAVIGATOR PROGRAMS

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) realizes that the use of patient navigators and patient advocates is on the rise and that these services are meant to help improve access to care and assist patients with the myriad aspects of the healthcare system. The AMCNO also understands that given the diversity of roles and responsibilities assigned to a patient navigator it is important to note that patient navigators should refrain from any activity that could be construed as clinical in nature, therefore, the AMCNO physician leadership has adopted the following AMA guidelines for patient navigator programs:

- The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits and responsibilities.
- Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
- Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of the medical care team.
- Patient navigators should fully disclose relevant training, experience and credentials in order to help patients understand the scope of services the navigator is qualified to provide.
- Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

To view the Federal standards for navigators and non-navigator assistance personnel proposed rule click [here](#).

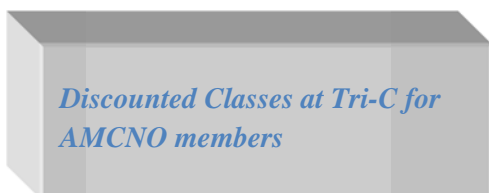
AMCNO Scores a Victory with Ohio Supreme Court Decision

In 2012, The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) filed an amicus brief in the Ohio Supreme Court to support what is commonly referred to as the "I'm Sorry Statute" (ORC 2317.43).

The language was originally enacted as part of HB 215, effective September, 2004, and was part of comprehensive tort reform passed by the Ohio General Assembly that year. It specifically applies to Ohio's medical community and precludes communications or gestures of empathy or consolation by doctors to patients or their families from being used to establish liability against the physician. In this case, *Johnson v. Smith*, the trial judge heard testimony of the witnesses outside the presence of the jury to determine whether the statements

made by the physician fell within the statute and should be excluded as a result. Based on the testimony of all the witnesses, the judge determined the doctor’s statements should be excluded. The Court of Appeals then reversed the jury verdict to allow the “apology testimony” to be presented to the jury. The amicus brief supported the position that the Court of Appeals erred in its decision and the apology testimony should have been excluded.

The Ohio Supreme Court has decided *Johnson v. Smith* and held that the apology statute applied to cases filed after the statute’s effective date (September 13, 2004) and that the trial court did not err in excluding the physician’s words—“I take full responsibility”—as words of condolence and sympathy. Reviewed under an abuse-of-discretion standard, the Supreme Court said the Eleventh District Court of Appeals should have accorded the trial court’s decision deference because “[t]he trial court had determined that Dr. Smith was faced with a distressed patient who was upset and made a statement that was designed to comfort his patient.” Therefore, the Court reversed the Eleventh District’s judgment Court of Appeals and remanded with instructions to reinstate the jury’s defense verdict. Simply put, the statements made by the physician were determined to be made as words of comfort, however phrased. To view the Court’s opinion go to [Click Here](#)



TriC Classes for AMCNO Members and Staff - 2013 Cuyahoga Community College Center for Health Industry Solutions

Take advantage of discounted classes for AMCNO Members and their staff. *Contact AMCNO at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price.*

Date	Time	Title/location
6/13/13	6 – 9 pm	Medical Terminology – Mon & Wed (UTC)
6/10/13	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Wed (CCE)
6/25/13	6 – 9 pm	Essentials of Electronic Health Records – Tues & Thurs (UTC)
	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs (CCE)
7/8/13	9 am – 12 pm	Comprehensive Patient Access Specialist Program – Monday-Friday (UTC)
7/15/13	6 – 9 pm	Medical Terminology – Mon & Wed (UTC)
7/16/13	9 am – 12 pm	Professional Coding Program – Monday - Friday (UTC)
7/17/13	6 – 9 pm	Fundamentals of Billing Reimbursement – Mon & Wed (UTC)
7/22/13	6 – 9 pm	Health Care Navigator – Tues, Wed, Thurs (UTC)
8/5/13	1:30 pm – 4:30 pm	Cancer Registry Principles, Practices and Application – Mon, Tues, Wed (UTC)
8/15/13	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Thurs (UTC)
8/22/13	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Thursday (Westshore)
8/22/13	6 – 9 pm	Essentials of Electronic Health Records – Thursday (UTC)
9/21/13	9 am – 3 pm	ICD-9-CM Fundamentals and More – Saturday (UTC)
9/23/13	6-9 pm	Fundamentals of Billing Reimbursement – Mon & Wed (UTC)
9/28/13	9 am –	Overview of ICD-10-CM and ICD-10-PCS – Saturday (UTC)

	3:00 pm	
10/7/13	6-8 pm	Hospital/Facility Billing Reimbursement – Mon & Wed (UTC)
10/19/13	9 am – 3 pm	CPT Coding Fundamentals and More – Saturday (UTC)
11/1/13	9 am – 12 pm	Medical Front Office Fundamentals – Mon, Wed & Fri (UTC)
11/2/13	9 am – 3 pm	Overview of ICD-10-CM and ICD-10-PCS – Saturday (UTC)
11/6/13	6-9 pm	Patient Access Specialist Fundamentals – Mon & Wed (UTC)
11/7/13	6-9 pm	Medical Front Office Fundamentals – Thursday (UTC)
11/7/13	8:30 pm	Hospital/Facility Billing Reimbursement – Thursday (UTC)

Course Locations: **Corporate College East** 4400 Richmond Rd, Warrensville Hts, OH 44128
Corporate College West 25425 Center Ridge, Westlake, OH 44145
Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 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 amcno@amcno.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

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6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

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