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

SUMMER EDITION 2014

SAVE THE DATE: BACK AGAIN FOR ITS 28TH YEAR – SOLVING THE THIRD-PARTY PAYER PUZZLE SEMINAR – WEDNESDAY, NOVEMBER 5, 2014 – SEE REGISTRATION INFORMATION INSIDE THIS ISSUE

Medicare

CGS Quarterly Update

CGS has created an interactive Quarterly Update to reduce paper and printing costs. The update includes information on new myCGS enhancements, key CGS contact information, tips on how to handle payment issues and much more. To view the Summer 2014 edition of the CGS Quarterly Update, click here.

Quality Improvement Organization Program Changes Effective August 1, 2014

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) took its first step in restructuring the Quality Improvement Organization (QIO) program in an effort to improve patient care and health outcomes, and save taxpayer resources. QIOs historically have been responsible for numerous quality-improvement functions, including providing an infrastructure for national quality-improvement initiatives across the continuum of care. Effective August 1, 2014, the QIO program structure changed and there are two QIOs in each state.

Quality Innovation Network - Quality Improvement Organizations (QIN-QIOs) are responsible for working with providers and communities on data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care and transparency at local, regional and national levels. The QIN-QIOs will work with physicians, other providers and communities on data-driven, quality-improvement initiatives. Each QIN-QIO will work on strategic initiatives, such as:

- Reducing healthcare-associated infections
- Reducing readmissions and medication errors
- Supporting clinical practices in using interoperable health IT to enable the exchange of essential health information
- Promoting prevention activities
- Reducing the prevalence of heart disease and diabetes

QIN-QIOs also will provide technical assistance for improvements in the physician value-based modifier and other CMS value-based purchasing programs. The QIN-QIO contract for Ohio has been awarded to Health Services Advisory Group and they will also be the QIN-QIO for Arizona, California and Florida.

The Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) will manage all beneficiary complaints and quality-of-care reviews to ensure consistency in the review process

while taking into consideration local factors important to beneficiaries and their families. The BFCC-QIO contract award for Ohio has gone to KEPRO. KEPRO was also awarded the contract for 30 additional states (CMS areas 2, 3 and 4). Obtaining the BFCC-QIO contract made KEPRO ineligible for the QIN-QIO contract.

For more information on the changes to the QIO program, please visit www.qioprogram.org.

Medicare Physician Payment Cut Postponed Again – ICD-10 Implementation Delayed

The Senate has passed H.R. 4302, the "Protecting Access to Medicare Act of 2014," which postpones the 24% Medicare physician payment cut for 12 months, until April 1, 2015. Although many Senators spoke against passing this 17th Medicare payment patch, the Senate passed the bill 64 to 35. The House passed an identical version of the bill by voice vote on March 27, and President Obama signed the legislation into law.

The $21 billion bill delays the next SGR cut and maintains current rates until April 1, 2015. The bill also includes a broad array of other items and policy changes to offset costs associated with implementing the bill. Some of the other provisions of H.R. 4302 include:

- The geographic adjustment (GPCI) "floor" of 1.0 for physician work in the Medicare fee schedule would be extended for 12 months.
- Implementation of the ICD-10 diagnosis coding set would be delayed one year, until October 1, 2015.
- The Secretary would have discretion to continue suspending RAC post-payment audits under the "2-Midnight" policy through June 2015.
- Annual targets of 0.5% in savings from misvalued Medicare physician payment schedule services would be established from 2017 through 2020, for an estimated savings of $4.0 billion.
- Revisions to the payment system for diagnostic tests and the laboratory fee schedule, based on market-based private sector rates, would be made for an estimated savings of $2.5 billion.
- Payments for using CT equipment that does not meet certain dosage standards and implementation of appropriate use criteria for advanced imaging services would save an estimated $0.2 billion.
- Revisions to the Medicare sequester in 2024 that effectively amplify the sequester's impact on all Medicare providers in that year would save an estimated $4.9 billion.

The AMCNO and many other physician organizations urged members of Congress to vote against H.R. 4302 and instead pass bipartisan comprehensive reforms that have been developed in Congress over the past year that would have eliminated the SGR and reform the Medicare physician payment system. Enactment of H.R. 4302 represents the 17th time that Congress has chosen to extend rather than solve the SGR payment problem. The AMCNO and many other medical organizations on both the national and state level will continue to urge Congress to address this issue.

Ohio Physicians will need Prior Authorization for PMDs

Starting October 1, physicians in 12 states will be required to obtain prior authorization from the Centers for Medicare & Medicaid Services (CMS) before a patient can receive a power mobility device (PMD), according to *Part B News*.

The 12 states are: Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee and Washington. CMS determined these states had high spending and improper payments for the equipment.

Seven other states already have the authorization requirement in place: California, Florida, Illinois, Michigan, New York, North Carolina and Texas. And CMS found that in these states prior authorization reduced costs. In fact, in the agency's July 29 Federal Register notice, it stated that spending not only dropped in these original seven states, it also dropped in other states, which CMS attributes to national suppliers changing their policy as well.

Prior authorization requires the physician to have a face-to-face exam with the patient as part of a seven-element order that includes the following:

1. Patient's name
2. Specific description of the device needed
3. Date of the face-to-face exam
4. Diagnosis codes that support medical necessity
5. Length of time the device is needed
6. Physician's signature
7. Date the physician signed the order

Physicians are allowed to bill an E/M visit for the service, as well as G0372 for the need of the PMD. CMS also now allows the durable medical equipment supplier to submit the physician's documentation as part of its request for coverage for the device, according to *Part B News*.

It may take 10 to 20 business days for PMD requests to be processed, but physicians can request a determination within 48 hours if the patient's health is in jeopardy.

Noridian, the Medicare administrative contractor for California, cites four tips to avoid common causes for rejected requests: document upper body insufficiency, note the patient's ability to operate the machine, match the documentation and requested PMD, and show that the non-PMD won't work.

CMS Introduces 4 New Subset Modifiers for Modifier 59 to Reduce Denials in 2015

On August 15, CMS introduced four new subset modifiers to clarify distinct procedural services when using modifier 59. These subsets, which take effect January 1, 2015, should reduce denials and abuse of modifier 59, according to *Part B News*.

CMS cited high rates of misuse as a factor for the change; a 2013 report projected a $770 million loss due to improper payments involving modifier 59.

For more information on the new subset modifiers, click here.

News from Other Third-Party Payers

Medicaid

Office of Health Transformation Ohio Benefits **Medicaid Enrollment Update**

Since October, 546,000 Ohioans have applied for Medicaid through the new *Ohio Benefits* eligibility system. The majority of these cases have been processed already. As a result, more than 308,800 Ohioans have been connected to Medicaid coverage, including 184,000 individuals who are "newly eligible" as a result of the decision to extend Medicaid coverage.

Highlights:

- 73% of *Ohio Benefits* applications processed
- 26,000 beneficiaries transitioned from the MetroHealth Care Plus program to Ohio Medicaid
- More than 20,000 federal marketplace applications automatically processed through *Ohio Benefits*
- 52 Ohio counties have 10% or fewer applications pending more than 30 days

To view more information, click here.

Ohio Medicaid - Coverage of Smoking Cessation Services

Ohio Medicaid has announced coverage information for tobacco cessation services for all of its recipients – that includes in-person, group and phone counseling, and all Food and Drug Administration (FDA)-approved medications. The Ohio Department of Health (ODH) has created a detailed fact sheet that shows how to bill for these services. To view the ODH fact sheet on this issue, click here.

Ohio Takes Next Steps in Healthcare Payment Innovation

Ohio has applied for a federal State Innovation Model (SIM) grant to test innovative payment and service delivery models for Medicaid, state employee and commercial health plan populations. During the past 18 months, OHT has been working with public and private sector healthcare purchasers, plans, providers and consumers to set priorities for payment innovation in Ohio. The result is a bold plan to reset the basic rules of healthcare competition so the incentive is to keep people as healthy as possible, pay for what works to improve and maintain health, and shift to value-based payments that reward patient-centered care coordination and better health outcomes. Click here for more details.

Anthem

The latest email alert sent out by Anthem Blue Cross and Blue Shield (Anthem) outlined how they have streamlined the way users access MyAnthem. Anthem now has a single sign-on process that allows you to register and have access to both Availity and MyAnthem, eliminating the need to log into two separate portals. Anthem has provided the following tips on how to use this new single sign-on process:

- **Know your Health Plan user ID:** Your MyAnthem ID is now called your Health Plan user ID. To log in to MyAnthem, your Anthem Health Plan User ID must be added to Availity within the Anthem Services Registration by your PAA. If you do not have a Health Plan user ID, your MyAnthem Site Administrator must click *Manage My Users* located below Online Services on the MyServices landing page, then select the TIN to which the user will be added. Once the registration is completed, your new Health Plan User ID will show up next to your name on the operator list.

- **Your user name must match exactly on your MyAnthem and Availity profiles:** The Availity PAA needs to connect the Health Plan user ID and Availity ID on the Anthem Services Registration page, and to do that, the user's name must match exactly in both user profiles. If the PAA tries to connect a user's IDs and the names are not an exact match, a message will appear

stating that the action failed. If you are the PAA and receive this message, go to the user's profile on either MyAnthem or Availity to change whichever profile shows incorrect information.

- **Users must have their own unique Health Plan user ID and Availity ID:** We would like to remind all MyAnthem users of the following: the sharing of User ID and Password information on our secure site is not HIPAA compliant. Please ensure that all individuals who access our secure portal have their own individual User ID and password for each system, registered under their name and with their own individual contact information. If you have been using an ID passed down from someone else in your organization, or someone who has left your organization, it is time to register for your own Health Plan user ID and Availity ID.

- **If you are the Availity PAA or Anthem Site Administrator, please keep your user lists up to date:** Please review your user lists at least quarterly to disable the profiles of any individuals who are no longer employed, and ensure all current employees have the access they need to enable them to use our secure web portal. Please take a few moments to do this now. (Also, if you are changing roles or leaving your organization, be sure to assign someone in your organization to replace you.)

For illustrated step-by-step instructions on the entire MyAnthem single sign-on process, click here. Or see "Logging into MyAnthem" at www.anthem.com>Providers (select state)>Answers@Anthem.

UnitedHealthcare

The Centers for Medicare & Medicaid Services (CMS) 2014 Fiscal Year Inpatient Prospective Payment System Final Rule includes a provision that clarified Medicare admission and medical review criteria for hospital inpatient services, known as the Two Midnight Rule.

The Two Midnight Rule is intended to help care providers determine whether a Medicare claim should be billed under Part A (hospital insurance – inpatient) or Part B (medical insurance – outpatient).[1] As communicated previously, including in the January 2014 UnitedHealthcare *Network Bulletin*[2], UnitedHealthcare will fully integrate the Two Midnight Rule into its Medicare Advantage inpatient management medical necessity review process. Integration of the Two Midnight Rule allows UnitedHealthcare to work with its care providers to meet CMS medical necessity requirements related to inpatient admissions. Integration will occur October 1, 2014.

Based on the Two Midnight Rule, if the care provider expects the Medicare Advantage member's medically necessary treatment will span less than two midnights, outpatient/observation status is appropriate. If a Medicare Advantage member requires medically necessary hospital care that is expected to span two or more midnights, inpatient admission is appropriate. The Two Midnight Rule does not apply to services CMS designates as inpatient only.

To facilitate integration of the Two Midnight Rule, facilities must provide to UnitedHealthcare the physician's inpatient admission order, in addition to any other clinical information needed to support hospital stays that span two or more midnights. Please note that facilities that have granted UnitedHealthcare inpatient care managers onsite or remote EMR access do not need to submit clinical information to UnitedHealthcare because its care managers will access this information in the facility's EMR system. Facilities that have fax or telephonic review processes will be required to fax a copy of the care provider's inpatient admission order, when clinical information is requested by the UnitedHealthcare inpatient care manager.

UnitedHealthcare will continue to use evidence-based guidelines to support consistent and clinically valid decision-making for medically necessary hospital stays, in conjunction with the Two Midnight Rule. Facilities and admitting physicians will be expected to use the Medicare inpatient admission criteria as clarified in the Two Midnight Rule when admitting a Medicare Advantage member as an inpatient for medically necessary acute care services. Care providers are encouraged to work with UnitedHealthcare medical directors to support the provision of evidence-based and medically necessary care for its members.

References

1. Centers for Medicare & Medicaid Services. (2014). *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html*.

2. UnitedHealthcare. (2014, January). *https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/News/January_2014_Network_Bulletin.pdf*

Parental Consent Required when Treating Minors with Opioids

House Bill 314 requires any prescriber to obtain written informed consent from a minor's parent or guardian prior to writing a prescription for medication containing opioids. Go to http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_314 to learn more details regarding HB 314.

HB 341 Requires OARRS Query under Specific Circumstances

House Bill 341 requires prescribers of opioid analgesics and benzodiazepines to register to use OARRS and to query the database under certain circumstances. Mandatory OARRS queries will be required effective April 1, 2015. For more information regarding HB 341, go to http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_341.

Ohio State Board of Pharmacy Provides Guidance Document Regarding Tramadol

In a guidance document recently released by the Ohio State Board of Pharmacy it was noted that effective September 1, 2014, tramadol and products containing tramadol will be classified as Schedule IV controlled substances in the state of Ohio pursuant to Ohio Administrative Code 4729-11-03. Section 3719.44 of the Ohio Revised Code authorizes the Ohio State Board of Pharmacy (OSBP) to add a previously unscheduled compound, mixture, preparation or substance to any schedule.

Tramadol is an opioid analgesic that produces its primary opioid-like action through an active metabolite, referred to as the "M1" metabolite (O-desmethyltramadol). Since March 1995, tramadol has been available as a non-controlled and centrally acting opioid analgesic under the trade name ULTRAM® approved by the Food and Drug Administration (FDA). Subsequently, the FDA approved generic, combination and extended-release products of tramadol.

Data from the Ohio Automated Rx Reporting System (OARRS) comparing tramadol and other analgesics in terms of annual prescriptions dispensed show a substantial increase (93.8%) since 2007 in tramadol prescriptions compared to hydrocodone combination products (0.7% increase) and oxycodone (29.9% increase). This increase may be explained by an awareness of the addictive nature of controlled substance opioids by the prescriber community, resulting in a switch to tramadol, which is currently non-controlled.

However, studies show that while tramadol has a currently accepted medical use, it has abuse potential similar to that of Schedule IV controlled substances as well as mimics the effects of controlled substance opioid analgesics. By classifying tramadol as a Schedule IV controlled substance, the board seeks to educate prescribers and patients on the potential adverse effects of this medication and to provide additional legal and regulatory oversight to protect the health and safety of Ohioans.

Once adopted, Ohio will join the following states (and the U.S. Military) that have added tramadol as a Schedule IV controlled substance: Arkansas, Georgia, Illinois, Kentucky, Mississippi, New Mexico, New York, North Dakota, Oklahoma, Tennessee and Wyoming. For more information documenting the rationale for scheduling tramadol, click here.

Ohio State Board of Pharmacy Offers Video Resource About Prescription Drug Diversion

The Ohio State Board of Pharmacy offers a new video resource to help identify the warning signs of prescription drug diversion. The video can be viewed on the Board of Pharmacy's website http://www.pharmacy.ohio.gov, the Ohio Automated Rx Reporting System's website https://www.ohiopmp.gov and is also available for download by visiting http://www.pharmacy.ohio.gov/OHIO-redflag.mp4.

State Medical Boards Adopt Policy Guidelines for Safe Practice of Telemedicine

Representatives of state medical licensing boards have approved updated guidelines to help ensure the safety and quality of medicine when it is practiced using telemedicine technology, which can connect a patient in one location with a care provider in another location. The Model Policy on the Appropriate Use of Telemedicine technologies in the Practice of Medicine, adopted by the Federation of State Medical Boards (FSMB), provides guidance and a roadmap that state boards can use to ensure that patients are protected from harm in a fast-changing healthcare-delivery environment.

Among its key provisions, the model policy states that the same standards of care that have historically protected patients during in-person medical encounters must apply to medical care delivered electronically. Care providers using telemedicine must establish a credible "patient-physician relationship," ensuring that patients are properly evaluated and treated and that providers adhere to well-established principles guiding privacy and security of personal health information, informed consent, safe prescribing and other key areas of medical practice.

The policy adopted by the FSMB's House of Delegates, which represents all of the nation's 70 state and territorial state medical licensing boards, is advisory, meaning state boards are free to adopt it as is, modify it or retain their own current policies regarding telemedicine.

Key Provisions of the FSMB Telemedicine Policy are as follows:

- Standards of care that protect patients during in-person medical interactions apply equally to medical care delivered electronically

- Providers using telemedicine should establish a credible "patient-physician relationship" and ensure that their patients are properly evaluated and treated

- Providers should adhere to well-established principles guiding privacy and security of records, informed consent, safe prescribing and other key areas of medical practice

The new policy is available at www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf.

Ohio State Board of Pharmacy Alert – DEA Re-Classifies Tramadol

In a previous email alert, we notified AMCNO members that the Ohio State Board of Pharmacy re-classified tramadol and products containing tramadol as a Schedule IV controlled substance, effective September 1, 2014. The AMCNO recently learned that the United States Drug Enforcement Agency (DEA) has also classified tramadol as a Schedule IV controlled substance. For more information on this issue, click here.

Change in Ohio Revised Code Allows Prescribers to Access OARRS to Address Neonatal Abstinence Syndrome

Per Ohio Revised Code Section 4729.80(A)(12), as enacted by Ohio HB 483 of the 130th General Assembly, physicians or their delegate are now authorized to request information from the Ohio Automated Rx Reporting System (OARRS) relating to the mother of a patient, if the prescriber or his/her delegate certifies that it is for the purpose of providing medical treatment to a newborn or infant patient diagnosed as opioid dependent. This change was adopted by the Ohio General Assembly in order to address the growing issue of neonatal abstinence syndrome (NAS) in Ohio newborns. NAS is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb.

According to data from the Ohio Departments of Health & Mental Health and Addiction Services, approximately 5,100 hospitalizations resulted from Neonatal Abstinence Syndrome (NAS) in inpatient and outpatient settings between 2004 and 2011. In 2011 alone, there were 1,649 admissions to both settings, which equates to nearly five admissions per day. The rate of NAS grew six-fold from 14 per 10,000 live births in 2004 to 88 per 10,000 live births in 2011. The most common conditions associated with NAS were respiratory complications, low birth weight, feeding difficulties and seizures. If you have not already done so, you may register for OARRS by visiting www.ohiopmp.gov.

Ohio State Board of Pharmacy Offers New OARRS Feature

The Ohio State Board of Pharmacy is pleased to announce an exciting new feature that will enhance patient care from the Ohio Automated Rx Reporting System (OARRS), the active cumulative morphine equivalent graph. This graph allows healthcare providers to view a patient's ACME score for up to 24 months. To learn more about this new feature, including a sample of the new graph as part of a patient's Rx history report, please visit http://pharmacy.ohio.gov/MEDGraph.

New Leadership Appointed at the Ohio Department of Health

Gov. John R. Kasich recently named a new team to lead the Ohio Department of Health (ODH), appointing Rick Hodges as director and Mary Applegate, MD, as interim medical director. Their charge will be to elevate the agency's operational effectiveness as well as its medical expertise in helping create conditions in which Ohioans can be healthy.

A former state legislator, Hodges has served in a range of management roles including senior roles in healthcare organizations in northwest Ohio. He currently serves as executive director of the Ohio Turnpike and Infrastructure Commission, where he has successfully overhauled the turnpike's operations to reduce costs and led a new bonding

effort to help improve the quality of Ohio's roads linking to the turnpike statewide. Hodges officially started at ODH on Aug. 11; he replaces Ted Wymyslo, MD, who left ODH earlier this year.

Dr. Applegate currently serves as the medical director at the Department of Medicaid and is board certified in both pediatrics and internal medicine. She is a fellow of the American Academy of Pediatrics and the American College of Physicians, with 20 years of experience in rural primary care practice. At Medicaid she has overseen the development of Ohio's new quality initiative to help improve health outcomes for low-income Ohioans. Dr. Applegate also officially started at ODH on Aug. 11. She will work with Hodges to recruit a team of clinical professionals to inform all aspects of the department's work in both policymaking and regulating Ohio's healthcare system. Once that team is in place, Dr. Applegate will resume her role at Medicaid.

Physician Input Needed on CG-CAHPS

The Center for Health Affairs (The Center) and the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) are interested in learning about your practice's familiarity with CG-CAHPS (Clinician and Group – Consumer Assessment of Healthcare Providers and Systems). The CG-CAHPS survey is a standardized tool developed by the Agency for Healthcare Research and Quality (AHRQ). The survey measures patients' perceptions of care in the physician office setting. With the national implementation of other survey tools developed by AHRQ (H-CAHPS and HH-CAHPS), CG-CAHPS is being adopted as the standard for measuring patient perceptions by physician offices. National initiatives, such as NCQA's Patient-Centered Medical Home recognition survey, are using CG-CAHPS as the foundation, while several states have instituted public reporting programs for their providers using the CG-CAHPS survey.

In addition to these various initiatives, CMS launched its Physician Compare website in 2011, which allows individuals to search for a physician by specialty, type of professional and location. The website was launched to meet the requirements of the Patient Protection and Affordable Care Act of 2010 and was required to consider the inclusion of patient experience ratings in 2013.

We would appreciate your input. Please take a moment to complete a short survey about CG-CAHPS by clicking here. Based on the responses received, The Center and the AMCNO may offer a series of skill-building sessions aimed at improving communication in your practice, with the ultimate goal of positively impacting CG-CAHPS. Thank you in advance for your time and response.

Be Prepared for Changes Coming to BWC
Changes to Incentive/Premium Discount Program Enrollment Deadlines

In continuation of the "Billion Back" campaign from the summer of 2013, the Ohio Bureau of Workers' Compensation (BWC) has announced additional changes to come this year and in 2015.

A "Billion Back" was a one-time dividend released to eligible private and public taxing districts equating to $1 billion in June 2013 and completed in October 2013. It was made possible because the financially strong Ohio State Insurance Fund exceeded the target funding ratio of assets to liabilities established by the BWC board in 2008.

Included in the Billion Back campaign was a plan for the BWC to transition to a prospective billing system that will align it with standard industry practices. The transition is effective for the July 1, 2015, policy year for private employers.

To implement, BWC has changed the incentive/premium discount program enrollment deadlines. For private employers, the enrollment deadlines are listed below for the 2015 policy year:

Program	New Enrollment Deadline	Previous Enrollment Deadline
Group Rating	November 24, 2014	Last business day of February
Group Retrospective Rating	January 30, 2015	Last business day of April
Individual Retrospective Rating	January 30, 2015	Last business day of April

Deductible Program	January 30, 2015	Last business day of April
One Claim Program	January 30, 2015	Last business day of April
Destination Excellence - Drug Free Safety Program - Individual Specific Safety Program - Transitional Work Bonus	May 29, 2015	Last business day of April
Destination Excellence - Safety Council	July 31st No change made to this deadline	July 31st
Destination Excellence - Go Green - Lapse Free	No enrollment deadline	No enrollment deadline
EM Cap	No enrollment deadline	No enrollment deadline

Through our workers' compensation third-party administrator, **CompManagement, Inc**., your organization can see how participation in a program will impact your costs as well as how these programs can be stacked together to achieve the **maximum savings** available for your organization.

Don't miss your opportunity to be evaluated for participation in an incentive/premium discount program. Discounts vary by program but are as high as 53%, which was the maximum discount allowed by BWC for the 2014 policy year.

The time to act is now due to the earlier enrollment deadlines for the 2015 policy year. Take this free, no-obligation opportunity to explore your options today!

Simply complete the Temporary Authorization to Review Information (AC-3) online on the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) website or contact CompManagement at (800) 825-6755, select option 3 and speak to a customer support representative.

View the September 2014 edition of the Provider E News, BWC's electronic monthly provider newsletter

Discounted Classes at Tri-C for AMCNO Members

TriC Classes for AMCNO Members and Staff - 2014 Cuyahoga Community College

Do you or your staff need information on the upcoming changeover to ICD-10? Does your staff need to learn more about the essentials of electronic health records? AMCNO members and their staff can receive discounted rates on classes at Tri-C covering these topics and much more. Click here for a list of the 2014 curriculum. In order to take advantage of the Member-Fee listed you must obtain a member course number from the AMCNO. *Please contact the AMCNO at 216-520-1000 for exclusive AMCNO member course numbers* to register and obtain a discounted price **or email Abby Bell for more information at** abell@amcno.org.

The Role of the Prescriber in Prescription Drug Abuse Seminar, November 8, 2014

The Academy of Medicine of Cleveland and Northern Ohio, The Cuyahoga County Board of Health, the ADAMHS Board of Cuyahoga County, The Academy of Medicine Education Foundation, the William E. Lower Fund and St. Vincent's Charity Medical Center are pleased to sponsor *The Role of the Prescriber in Prescription Drug Abuse* on November 8, 2014. The session is intended for physicians and healthcare providers in the following specialties: Family Medicine, Internal Medicine, Emergency Medicine, Addictionology, Pain Medicine, Psychiatry, Dentistry, Obstetrics, and Nurse Practitioners

The AMCNO has obtained CME accreditation (3.75 credits) for the program from St. Vincent Charity Hospital.

Mark your calendar now and plan to attend this event November 8, 2014. To view details and to register for this event click here.

For information on the AMCNO Solving the Third Party Payor Puzzle session scroll down to the next page.

This is your opportunity to hear representatives from private payors, Medicare and Medicaid regarding their latest rule changes and claims submission issues that will impact your practice.

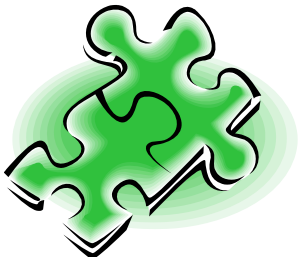
SPACE IS LIMITED – CONFIRM YOUR PARTICIPATION NOW!

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

is pleased to present:

Solving the Third Party Payer Puzzle 2014

Wednesday, November 5, 2014



Registration: 7:30 a.m. – 8:00 a.m.
Seminar: 8:00 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

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

LUNCH WILL BE PROVIDED

Speakers have been confirmed from:

Anthem Blue Cross & Blue Shield	Medicaid (Ohio Department of Job & Family Services)
CIGNA HealthCare	Medicare (CGS LLC)
Medical Mutual of Ohio	

For more information, contact the AMCNO at 216.520.1000
Register online at www.amcno.org or scan the code with your mobile device.

TO REGISTER FOR TPP, PLEASE COMPLETE & RETURN WITH PAYMENT. DEADLINE: October 29, 2014

# of Attendees _____ Amount due $_____

Name(s) of Attendee(s): _____

Physician/Group Name: _____

Office Address: _____City, State, ZIP:_____

* Phone: _____* Email:_____

Make check payable and mail to:
AMCNO 6100 Oak Tree Blvd., #440, Independence OH 44131 or by credit card: fax to 216.520.0999

AMEX MASTERCARD VISA

Account # _____ Exp. date: _____ ID #_____

***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. AMCNO, 6100 Oak Tree Blvd, Suite 440, Cleveland, OH 44131

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

The AMCNO Practice Management Matters newsletter includes items that have been published by Medicare and other third party payers online or in their newsletter and may contain links that provide direct access to Internet sites other than our own. The AMCNO takes no responsibility for the content or the information obtained on other Web sites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our Web site at

www.amcno.org

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

www.amcno.org

216.520.1000 Executive Offices 216.520.0999 Facsimile