

**SUMMER EDITION 2015**

SAVE THE DATE: NOV. 4, 2015  
SOLVING THE THIRD-PARTY PAYER  
PUZZLE SEMINAR – SEE REGISTRATION  
INFORMATION INSIDE THIS ISSUE

ALSO INCLUDED IN THIS ISSUE: THE  
AMCNO 2015 MEDICAL RECORDS FACT  
SHEET

**Medicare**

**Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Overview**

HR 2, the “Medicare Access and CHIP Reauthorization Act of 2015” or “MACRA,” was recently signed into law. This bipartisan legislation permanently repeals the sustainable growth rate (SGR) formula and stabilizes Medicare payments for physician services with positive updates from July 1, 2015, through the end of 2019, and again in 2026 and beyond. It replaces Medicare’s numerous quality reporting systems with a new single “MIPS” program that will make it easier for physicians to earn rewards for providing high-quality health care, and it rewards physicians for participating in new payment and delivery models to improve the efficiency of care while retaining a fee-for-service option.

Specifically the legislation will result in the following:

- Permanently repeal the SGR.
- Positive payment updates of 0.5% each year through 2019.
  - In 2020, payments stay flat for six years, and there will be a 0.0% payment adjustment through 2025.
  - In 2026, physicians will be subject to one of two conversion factors – a 0.75% rate increase for practices that are part of an alternative payment model (APM) or a 0.25% rate increase for physicians not part of an APM.
- Provide for additional financial incentives for providers who move to alternative payment models – with physicians receiving a 5% bonus from 2019 to 2024.
- The fee-for-service model is retained, and physician involvement in APMs is voluntary.
- Funding is provided for quality measure development, at \$15 million per year from 2015 to 2019.
- Technical support is provided for smaller practices, funded at \$20 million from 2016 to 2020, to assist physicians with participation in APMs or the fee-for-service incentive program.
  - Eligible physicians who participate in APMs will be exempt from MIPS. The Centers for Medicare & Medicaid Services (CMS) will develop criteria for APMs by November 2016. MACRA provides for an

annual 5% bonus based on Medicare Part B payments from 2019 to 2024, to physicians who participate in APMs.

- Streamline the Medicare quality reporting programs into the merit-based incentive payment system (MIPS).
  - Beginning in 2019, MACRA will provide bonuses to physicians who score well in the MIPS, which will be a new pay-for-performance program under the Medicare fee-for-service payment system. The penalties that are currently in place for the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBPM) will stop at the end of 2018. In 2019, the MIPS program will be the only Medicare quality reporting program.
  - MIPS is comprised of four assessment categories. Category 1 – Quality Measures – quality will include current PQRS measures and additional measures that will be obtained from professional organizations each year by the secretary of Health and Human Services (HHS). Category 2 – Resource Use – this VBPM program, with an enhanced methodology determined through public input. Category 3 – Meaningful Use – this will be based on current electronic health records/meaningful use reporting requirements. Category 4 – Clinical Practice Improvement Activities – eligible physicians will be assessed on their efforts to engage in these activities.
  - Performance scoring under the MIPS program also provides for performance assessment according to a sliding scale versus the current all or nothing approach now used in the PQRS and MU programs. In addition, physicians can receive credit for clinical practice improvement (CPI) activities and for improving quality of care. Also, the MIPS will allow for risk adjustments for patients' health status and other risk factors, including socio-economic factors.

MACRA establishes far-reaching changes in how physicians will be reimbursed under the Medicare program. The specifications and regulatory rules for the new system have yet to be established and the AMCNO will provide additional information to our members as this process continues.

To view detailed information about the MACRA log on to [www.cms.gov](http://www.cms.gov).

#### **AMCNO Participates in CGS Administrators Provider Outreach and Education Meeting**

The primary function of this advisory group is to assist in the creation, implementation and review of provider education strategies and efforts. At the most recent meeting, CGS staff provided an overview of several key topics, including the myCGS Web Portal, payment issues and compliance matters. The CGS staff shared the Spring and Summer Educational Quarterly Updates as well. These updates contain a wealth of educational materials and can be obtained here – [Spring update](#) and [Summer update](#).

#### **myCGS Offers New Tools for Physicians and Staff**

Whether you work in the front office, billing or the financial department, myCGS has the tools you'll need to make your Medicare lives easier!

- **NEW!** Respond to Medical Review (MR) Additional Documentation Requests (ADRs)
- Submit unlimited number of Part B claims (including attachments)
- Submit requests for Redetermination (including attachments)
- View and print copies of remittance advices
- Check patient eligibility, including MSP and Medicare Advantage enrollment
- Request an "immediate offset" of a demanded overpayment
- View the number of claims approved for payment and the amount approved
- Submit Part B Reopening requests to correct minor errors or omissions on previously processed claims

Have you registered yet? If not, visit the [myCGS registration page](#) TODAY!

#### **Mid-Year Quality and Resource Use Reports (MYQRURs) Now Available**

The 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) recently became available. These reports contain interim information about performance on the six cost and three quality outcomes measures that the Centers for

Medicare & Medicaid Services (CMS) calculates from Medicare claims that are used to calculate the 2016 Value Modifier (VM).

The Physician Feedback/Value Modifier website was recently updated to include more supporting information (Fact Sheets and Measure Information Forms) about the VM. Fact sheets on the following topics were added:

- **Attribution:** The two-step attribution process associates beneficiaries with taxpayer identification numbers (TINs) during the year performance is assessed.
- **Specialty Adjustment:** Starting with the 2014 QRURs and the 2016 VM, CMS will adjust all cost measures for each practitioner's specialty and each TIN's specialty mix to facilitate comparisons in healthcare costs across disparate TINs.
- **Risk Adjustment:** CMS uses risk adjustment to account for differences in beneficiary-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided.

Measure Information Forms (MIFs) were included for the following measures: All Cause Readmission, Total Per Capita Cost Measure, Total Per Capita Cost Measures for Specific Conditions, and Ambulatory Care Sensitive Conditions (ACSCs). These are measures which CMS calculates from Medicare claims. The MIFs are used to document the technical specifications of the measures, such as the numerator and denominator statements, inclusions and potential exclusions for a given measure, and information on risk-adjustment and measure attribution. The Fact Sheets and MIFs can be found on the [Physician Feedback/Value Modifier website](#) and on the [Value Modifier page](#).

#### **ICD-10 Deadline Nears – CMS Provides Education**

The Centers for Medicare & Medicaid Services (CMS) has developed educational information on ICD-10 implementation. To view this information click [here](#).



### ***News from Other Third-Party Payers***

## **Medicaid**

### **ICD-10 Collaborative Tests**

Ohio Medicaid was selected by the Centers for Medicare & Medicaid Services (CMS) to participate in a nationwide ICD-10 collaborative testing initiative known as CollabT. CollabT is an online tool that offers medical coders an opportunity to practice ICD-10 coding and receive instantaneous feedback on their coding efforts (claims adjudication testing is not part of CollabT in Ohio).

Practicing ICD-10 coding not only increases coder confidence by allowing coders to learn from their mistakes, but also helps identify documentation gaps in advance of the transition to ICD-10. Coding practice is one of the most important determinants in whether an organization will experience a smooth transition to the new ICD-10 coding system. There is no cost for Ohio Medicaid providers to practice ICD-10 coding in CollabT. If your organization would like to enroll, please review information by downloading [CMS' CollabT PDF](#).

For information on other types of ICD-10 testing with Ohio Medicaid, please visit Ohio Medicaid's [ICD-10 webpage](#).

## **Payment Innovation**

The Ohio Department of Medicaid has joined the Governor's Office of Health Transformation to engage public and private sector partners in designing a new healthcare delivery payment system that rewards the value of services – not the volume.

In early 2013, the Governor’s Advisory Council for Payment Reform was convened to seek input and set clear expectations for better health, better care and cost savings through improved payment. As part of the effort, Ohio applied for and received a State Innovation Model (SIM) design grant from the Center for Medicare & Medicaid Innovation (CMMI). The State of Ohio’s proposal centers around design payment models that increase access to patient-centered medical homes and support retrospective episode-based payments for acute medical events.

The following information is from the Ohio Medicaid website.

## [Transforming Payment for a Healthier Ohio](#)

### **Information for Providers**

#### [Episode Definitions](#)

Detailed definitions for perinatal, asthma, chronic obstructive pulmonary disease, total joint replacement, percutaneous coronary intervention (acute and non-acute) episodes.

**Detailed Business Requirements:** Detailed definitions of and associated coding algorithms for:

- [Perinatal](#)
- [Asthma and Chronic Obstructive Pulmonary Disease](#)
- [Total Joint Replacement](#)
- [Percutaneous coronary intervention \(acute and non-acute\) episodes](#)

**Code Tables:** Excel spreadsheets of code detail for:

- [Perinatal](#)
- [Asthma](#)
- [Chronic Obstructive Pulmonary Disease](#)
- [Total Joint Replacement](#)
- [Percutaneous Coronary Intervention \(acute and non-acute\) episodes](#)

**Risk Adjustment Document:** Detailed description of principles and process of risk adjustment for episode-based payment model.

## [Episode Frequently Asked Questions](#)

### **Guides:**

[How to Access Your Report](#)

[How to Read Your Report](#)

**Sample Reports:** Illustrative sample reports, intended to demonstrate format and content of future, actual episode reports.

[Asthma \(Fee-for-Service\)](#)

[COPD \(Fee-for-Service\)](#)

[Perinatal \(Fee-for-Service\)](#)

### **Additional Resources**

#### [Episodes Overview](#)

Background to healthcare payment innovation in Ohio, overview of episode-based payment model, summary definitions for perinatal, asthma, chronic obstructive pulmonary disease, total joint replacement, percutaneous coronary intervention (acute and non-acute) episodes.

#### [Multi-Payer Episode Charter](#)

Multi-payer charter describing payer alignment on design of episode-based payment model.

*Applications:*

[State Health Innovation Plan](#) (October 2013)

[State Innovation Model Test Grant Application](#) (July 2014)

For more information on Ohio's Payment Innovation efforts, please visit the [Governor's Office of Health Transformation](#).

**Ohio Department of Medicaid – Recovery Audit Contract Issue**

The Ohio Department of Medicaid contract with their Recovery Audit Contractor (RAC) ended in July 2014. As a part of ending that contract, they have made significant progress in the process of reconciling all of the RAC work performed to identify the various scenarios that need to be addressed. Medicaid is still working on the other areas of Ohio Medicaid and Medicaid providers to rectify inappropriate recoupments. Here are a few frequently asked questions regarding the RAC issue, as provided by the Ohio Department of Medicaid:

1. **Q:** The RAC vendor recouped entire claims in error or recouped more funds than noted on their notification letter. How do I get these claims corrected?  
**A:** There is no action required on part of the provider. The Department is working internally to correct inappropriate recoupments.
2. **Q:** The RAC vendor requested medical records and they were submitted; however, we never received a decision on the medical record. How is this being handled?  
**A:** The Department is not taking action on any medical record reviews that were not completed by the RAC vendor.
3. **Q:** How is interest being accrued? Will we be penalized for delays in the process?  
**A:** Interest will only be accrued for a total of 405 days. The number of days to accrue interest was determined by calculating the **shortest** time frame that interest would have accrued for any provider that had claims appropriately recouped.
4. **Q:** We requested an appeal from the RAC vendor but we never received a response to our request. What happens next?  
**A:** Outstanding appeals will be handled on a case-by-case basis.
5. **Q:** When can we expect the corrections to our payments?  
**A:** We will be starting the correction to payments in batches. Providers will first be notified by mail with a letter explaining the situation, and the letter will be accompanied by the detail behind any refund due to the provider. The actual refund will appear as a lump sum on a future remittance advice.
6. **Q:** What is the status of procuring a new RAC for Ohio Medicaid?  
**A:** The new RAC RFP went live on May 29, 2015.

Questions not answered above can be directed to 1-866-841-0002, option 2.

**Anthem**

**Paper Claims**

Effective October 1, 2015, Anthem Blue Cross and Blue Shield (Anthem) will no longer accept the old CMS 1500 Claim Form version 08/05 for paper claims. Paper claims will only be accepted on the CMS 1500 Claim Form version 02/12.

Any paper claims received on or after October 1, 2015, using the old CMS 1500 Claim Form version 08/05 will be rejected. This applies to claims that may have been submitted prior to the Oct. 1 effective date, but have not been received by Anthem by the Oct. 1 effective date.

Anthem began accepting the CMS 1500 Claim Form version 02/12 in January 2014. They suggest that you transition to using the updated CMS 1500 Claim Form version 02/12 now, if you have not already done so.

For information on how to complete the updated 1500 Claim Form version 02/12, follow the guidelines set forth by the National Uniform Claim Committee (NUCC). Please visit the NUCC website at [www.nucc.org](http://www.nucc.org), which provides helpful resources, such as a list of changes between the 08/05 and 02/12 claim form versions and the 1500 Instruction Manual.

### **Anthem to Discontinue Paper Remittances to ERA Providers**

Anthem plans to discontinue the mailing of paper remittances to all providers currently registered for electronic remittance advices (ERA) beginning October 1, 2015. In-network providers can continue to access copies of paper remits online via the Availity Web portal [here](#). ERA providers should complete the steps needed to access copies of paper remits online via Availity. For more information [click here](#).

### **ICD-10 Information Available from Anthem**

Anthem has created an ICD-10 Updates webpage. It includes free coding practice tools, important updates and end-to-end testing information. To view this page [click here](#).

## **UnitedHealthcare**

### **UHC Offers ICD-10 Webinar Series**

These webinars give an overview of ICD-10 implementation, along with specialty-specific tips for documentation and coding and are designed to aid with the ICD-10 code adoption.

For more information about these webinars go to UHC's website [here](#). Under the Quick Links section, choose ICD-10 and Regulatory Outreach.

## **Bureau of Workers' Compensation (BWC)**

### **Enhanced Care Program Began as Pilot in Northeast Ohio on July 1**

BWC worked with stakeholders to prepare for the launch of the Enhanced Care Program, which began July 1. The program is designed to encourage higher quality, better-coordinated care, and is being done as a pilot in Northeast Ohio for state-fund claimants who have knee injuries only. BWC plans to expand the program thereafter.

How the Enhanced Care Program works - Claimants in northeastern Ohio who have an allowed claim for knee injuries only will be automatically eligible to participate in the Enhanced Care Program. The physician of record (POR) will have 60 days from the initial determination to treat the allowed conditions in the claim and medical issues causally related to the allowed conditions. BWC expected the POR to coordinate care where appropriate and document a comprehensive care plan, which the managed care organization (MCO) must approve. This program also separates the medical and legal components of the workers' compensation process without affecting any party's due-process rights. For complex claims, this approach can reduce delays by as much as five weeks. This means claimants will get back to work faster and healthier than before.

Why a physician should participate - The Enhanced Care Program provides three tangible benefits to physicians who agree to serve as a POR in the program. They are:

1. Improved outcomes: PORs can treat causally related conditions without having an explicitly allowed condition with assurance of payment;
2. Simplified process: PORs only have to submit one comprehensive care plan. They will only have to file the Physician's Report of Work Ability (MEDCO-14) if there's a change in the claimant's restrictions or the claimant's compensation period needs to be adjusted; and
3. Increased reimbursement: PORs will be eligible for a 15% incentive payment over and above what BWC pays for evaluation and management codes as part of its current fee schedule.

What's the catch? There are additional expectations of PORs participating in the Enhanced Care Program. By signing an addendum, they agree to, among other things: Provide timely access to claimants seeking care for workplace injuries; coordinate care for the claimant comprehensively; and agree for BWC to measure their performance.

More information - To inquire about signing up or to get more information, email [feedback.medical@bwc.state.oh.us](mailto:feedback.medical@bwc.state.oh.us). Also, continue to check the [BWC website](#) for more detailed information.

### **Be Prepared for the BWC Implementation of Prospective Billing**

*Private Employers Began July 1*

The Ohio Bureau of Workers' Compensation (BWC) is transitioning to a prospective billing system. It went into effect July 1, 2015, for private employers.

Private employers should be in receipt of their Estimate of Premium Notice from BWC, which is for the first prospective billing period, covering July 1, 2015 – June 30, 2016.

To prevent employers from being "double-billed," BWC will help to limit the financial impact to employers during the transition by applying both a payroll transition credit and a prospective transition credit.

The payroll transition credit will be for the last reporting period of the retrospective billing era (January 1, 2015 – June 30, 2015). Employers will receive a 100% credit towards this premium payment due in August.

The prospective transition credit will assist in your transition to the prospective billing era. The credit equates to 1/6th of the billed premium for the July 1, 2015 – June 30, 2016, period.

To receive the credit, however, your policy must be current, which means that you have done the following:

1. Paid all outstanding premium, late fees and penalties for past due premium (or request a payment plan from BWC for any amount that cannot be paid) prior to July 1, 2015.
2. Filed your January 1, 2015 – June 30, 2015, payroll report prior to August 31, 2015.

For resources related to the implementation of prospective billing, please also visit the website of our workers' compensation partner, CompManagement, at [www.compmgt.com](http://www.compmgt.com) and click on the "Are You Ready?" button under Quick Links on the home page. You will find informational podcasts to watch as well as documents outlining key dates and frequently asked questions to assist you.

If you have additional questions or concerns regarding the implementation of prospective billing, please feel free to contact CompManagement's Customer Support Unit at (800) 825-6755, option 3.



## ***News You Can Use***

### **AMCNO Partners with Local ADAMHS Board on QPR Training**

The ADAMHS Board of Cuyahoga County requested that The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) partner with them to sponsor and help promote the Board's QPR Training to physicians in the county. The AMCNO Board of Directors agreed to sponsor this program. The ADAMHS Board has already set up several training sessions around the county.

Question, Persuade, and Refer (QPR) teaches three simple steps that anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

For more information on this program, click [here](#).

#### **AMCNO Medical Records Fact Sheet with 2015 Fees Now Available**

The Ohio Department of Health has released the revised edition of their cost determination for providing medical records in accordance with Ohio Revised Code 3701.742. A full-page detail of amended charges is available now to download from the AMCNO website at [www.amcno.org](http://www.amcno.org). A copy of the AMCNO medical records fact sheet is also available for members in the recent May/June *Northern Ohio Physician*.

To view the 2015 AMCNO Medical Records Fact Sheet, [click here](#).

#### **AMCNO Community Resource List Now Available**

Each year, the AMCNO contacts community organizations, healthcare centers, health departments, hospitals and other entities throughout the Northern Ohio region to compile our list of community resources.

To view the updated AMCNO Community Resources list, [click here](#).

#### **Reduce Your Workers' Compensation Premiums through the AMCNO Group Rating Program**

Join other AMCNO members already seeing their annual workers' compensation premium reduced by participating in group rating, group retrospective rating or other alternative discount programs available in Ohio.

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 [click here](#) to complete the Temporary Authorization to Review Information (AC-3) form or contact CompManagement at (800) 825-6755, and select option 3 to speak to a customer support representative. Let CompManagement, our Workers' Compensation third-party administrator, work harder for you for your best cost savings solution for the 2015 policy year.

#### **CliniSync Provides Information on Legality of e-Prescribing Controlled Substances**

CliniSync is informing physicians around the state that it *is* legal to e-prescribe controlled substances in Ohio, as well as in 48 other states. To ensure that you and other prescribers have the most up-to-date information possible, CliniSync has convened an Ohio E-Prescribing Task Force with representatives from Ohio and national entities to work through misconceptions and align procedures for the medical community.

Read an [introductory story](#) on the work of the Ohio E-Prescribing Task Force.

Here is a flyer for [physicians and other prescribers](#).

This is a flyer for [institutional organizations](#), such as clinics and hospitals.

Here is a flyer for [pharmacists](#).

For more information, contact Cathy Costello at [ccostello@ohionline.org](mailto:ccostello@ohionline.org) or Dottie Howe at [dhowe@ohionline.org](mailto:dhowe@ohionline.org).



### **The Ohio Board of Pharmacy Releases Semi-Annual Report on OARRS**

To address the growing misuse and diversion of prescription drugs, the Ohio General Assembly adopted legislation in 2004 authorizing the State of Ohio Board of Pharmacy to create a Prescription Monitoring Program (PMP), known as the Ohio Automated Rx Reporting System (OARRS). Established in 2006, OARRS collects information on all outpatient prescriptions for controlled substances dispensed by Ohio-licensed pharmacies and personally furnished by licensed prescribers in Ohio. Drug wholesalers are also required to submit information on all controlled substances sold to an Ohio licensed pharmacy or prescriber. The data is reported every 24 hours and is maintained in a secure database.

The report is divided into the following sections:

**Section 1** - Opioid prescriptions dispensed by pharmacies to Ohio patients;

**Section 2** - Opioid pain relievers that have been personally furnished to a patient by an Ohio prescriber, other than a prescriber who is a veterinarian; and

**Section 3** - OARRS registration and usage statistics.

The [report includes](#) some positive indicators that Ohio's prescription drug abuse epidemic is being taken seriously by physicians and that healthcare providers are working to correct the issue. Section 1 of the report includes data that shows a decrease in the average quantity, as well as the average daily morphine equivalent dose (MED) per prescription. Additionally, Section 3 shows a dramatic increase in OARRS registration and usage by physicians and other healthcare providers.

The report can also be accessed from the Board's special topics website, under the Ohio Automated Rx Reporting System header: [www.pharmacy.ohio.gov/Pubs/Special.aspx](http://www.pharmacy.ohio.gov/Pubs/Special.aspx)

### **Ohio Pharmacy Board Provides Updates on Drug Compounding Rules**

On May 1, 2015, Ohio Administrative Code (OAC) Chapter 4729-16 went into effect. This new chapter consolidates and updates many of the existing rules regarding drug compounding. In order to provide an overview of this new rule chapter, the Board recently updated its "Compounding in Ohio" guidance document. The document outlines both state and federal laws and regulations as it pertains to compounded medications.

The document can be accessed here: [www.pharmacy.ohio.gov/compoundingOhio](http://www.pharmacy.ohio.gov/compoundingOhio)

### **2015 AMCNO Lawyer Referral Brochure Now Available to AMCNO Members and Staff**

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

The AMCNO does not endorse any one law firm over another – this information is provided to our members as a service only. Members are free to choose an attorney from this brochure or from other sources.

[Click here to view the AMCNO Lawyer Referral Brochure](#)

### **Practice Insight Report Now Available in OARRS**

The Ohio State Pharmacy Board recently announced the availability of the Practice Insight report in the Ohio Automated Rx Reporting System (OARRS). The report provides a list of the prescriber's patients, if any, who are visiting multiple prescribers; a list of the prescriber's patients who have the highest morphine equivalent doses; the drugs most commonly prescribed by the clinician; and a list of the prescriber's patients who have received a prescription for an

OARRS reportable drug in the past year. More information on how to access this report is posted on the Pharmacy Board website at [www.pharmacy.ohio.gov](http://www.pharmacy.ohio.gov).

**AMCNO is Hosting Annual Third-Party Payer Seminar Nov. 4**

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is holding its annual “Solving the Third-Party Payer Puzzle” seminar on Wednesday, November 4, at the AMCNO offices. This unique program brings together representatives from various payers to provide input and updates from health insurance companies. This annual event is typically well-attended and a great venue to bring together physicians and office staff to get the latest news from the third-party payers that operate in the Northern Ohio area.

For more information and to register, [click here](#).

***Discounted Classes at Tri-C for  
AMCNO Members***

**Tri-C Classes for AMCNO Members and Staff – 2015 Cuyahoga Community College Center for Health Industry Solutions**

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. For the 2015 summer curriculum, [click here](#).

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](mailto:abell@amcno.org).

**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 websites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our website at [www.amcno.org](http://www.amcno.org).*

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