

FALL EDITION 2013

Medicare

Changes to SGR Payment Formula Under Review in Congress

Lawmakers in Washington continue to move toward permanently repealing the Medicare Sustainable Growth Rate (SGR) formula.

Recently, the House of Representatives Ways and Means and Senate Finance Committees released a draft legislative proposal that would permanently repeal the SGR, reform the fee-for-service model and encourage participation in alternative payment models.

The Democratic and Republican leaders of two key congressional committees have agreed on a framework to scrap the problematic Medicare payment formula for physicians and replace it with one that would link physician reimbursement to the quality of care provided, a step that could put an end to the annual "doc fix" debate.

The discussion draft would eliminate the Sustainable Growth Rate, or SGR. Unless Congress acts, the SGR formula, adopted as part of the deficit reduction law in 1997, will reduce Medicare physician payments by nearly 25 percent on January 1, 2014. The proposal would make a major change in doctor payments, in that rather having a system that would pay physicians for volume the system would use financial incentives to encourage physicians to move to alternative payment models emphasizing quality care. The framework would repeal the SGR and hold doctors' pay at current levels as alternative payment models are developed and tested. It would combine some existing Medicare physician quality programs into a new initiative starting in 2017 that would offer doctors additional pay based on their performance on value-based criteria, such as making more same-day appointments for urgent needs and enhancing their use of electronic medical records.

Physicians who receive a major part of their yearly revenue from an alternative payment model would receive a five percent bonus through 2021. Those models could include accountable care organizations, or a patient-centered medical home. The proposal would also establish a process to ensure accurate payment for provider services, reward care coordination for patients with multiple chronic conditions and introduce physician-developed care guidelines to reduce inappropriate care that harms patients. To view the discussion draft [click here](#).

Centers for Medicare and Medicaid Services (CMS) Revising CMS-1500 Form

The Centers for Medicare and Medicaid Services (CMS) recently revised the CMS-1500 Claim Form with changes to more adequately support the use of the ICD-10 diagnosis code set. The revised CMS-1500 form (version 02/12) will replace version 08/05. The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes, which is important as the Oct. 1, 2014 transition approaches.

Physician practices will notice two significant changes on the new form. First, version 02/12 gives physicians the ability to identify whether they are using ICD-9 or ICD-10 codes (a particularly important feature during the transition period). Additionally, the form allows space for as many as 12 codes in the diagnosis field (the current limit is four).

It is important to note that ICD-9 codes must be used for services provided before Oct. 1, 2014, while ICD-10 codes should be used for services provided on or after Oct. 1, 2014. Physicians who submit their claims electronically should be in touch with their software vendors about timelines for updating practice management systems to accommodate the new form.

Only providers who qualify for exemptions from electronic submission may submit the CMS-1500 Claim Form to Medicare. CMS encourages providers who use service vendors to reach out as soon as possible to determine when that vendor will switch to the new form. Medicare will begin accepting the revised form on Jan. 6, 2014. Starting April 1, 2014, Medicare will accept only the revised version of the form.

The AMCNO has partnered with Tri-C to offer discounted ICD-10 classes to our members and their staff. For more information on our discounted classes see page 16 of this update.

AMCNO Participates in Region V State Medical Society Meeting

In September, staff from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) participated in the Center for Medicare and Medicaid Services (CMS) Region V State Medical Society quarterly meeting. Some of the topics covered during the meeting included ICD-10, incarcerated beneficiaries, the value based payment modifier, and the Affordable Care Act.

An update was provided regarding the implementation of ICD-10 in 2014. At this time this is a hard date and there are no indications that the implementation of ICD-10 will be postponed. All health care providers covered by HIPAA must make the transition from ICD-9 to ICD-10 codes by the October 1, 2014, compliance deadline. ICD-10 will affect every aspect of how a physician or group provides care, from software upgrades and patient registration and referrals, to clinical documentation and billing.

Key Steps to Prepare for ICD-10

1. **Inform and educate staff about the transition to ICD-10:** Suggestions include appointing an ICD-10 coordination manager. Additionally we recommend that your staff be notified about upcoming changes and your transition plan. We also recommend that you educate your staff regarding the changes in documentation requirements from health plans. Finally, seek resources from CMS and professional and membership organization to help with the transition.
2. **Perform an impact assessment:** Identify potential changes to existing work flow and business processes by looking at your current use of ICD-9; make a list of staff members who need ICD-10 resources and training, such as billing and coding staff, clinicians, management and IT staff; and evaluate the effect of ICD-10 on other planned or ongoing projects (e.g., electronic health records).
3. **Plan a comprehensive and realistic budget:** Estimate your budget secure funding for items such as software, hardware, staff training, and production costs.

4. **Contact system vendors, clearinghouses, and/or billing services to assess their readiness and evaluate current contracts:** Ask your vendors how they will support you in the transition to ICD-10 and request a timeline and cost estimate.

Once physicians have completed these planning steps prepare to test ICD-10 within your office environment. It is important to conduct internal testing of ICD-10 within a clinical practice as well as external testing with payers and other external business partners.

Incarcerated Beneficiaries

Another item addressed at the Region V meeting involved incarcerated beneficiaries. Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service. Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. A beneficiary may be “incarcerated” even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.

Medicare identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was apparently incarcerated based on information CMS receives from the Social Security Administration (SSA). As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

CMS is working on restoring the original data on the Medicare Enrollment Data Base, identifying all of the claims that were incorrectly demanded or collected, and making changes to claims processing system utilities to effectuate the necessary changes. This automated process will identify the claims that were denied in error and reprocessing will be completed by the Medicare Administrative Contractors.

Value-Based Payment Modifier

A presentation was provided to address the 2015 physician value-based payment modifier. A provision of the ACA requires Medicare to establish a value-based payment modifier (VBPM) that provides for differential payment under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared with cost during a performance period. The VBPM is directly tied to PQRS participation. The VBPM will be applied to group practice of 100 or more eligible professionals (EPs) in 2015 and to all physicians in 2017. The 2015 VBPM will be based on 2013 performance in the PQRD Group Practice Reporting Option (GPRO). Groups that are subject to the VBPM and do not successfully participate in PQRS during the 2013 reporting period through the GPRO will be subject to a one percent payment penalty in 2015.

Health Insurance Marketplace

A good deal of the discussion at the Region V meeting revolved around the roll out of the Health Insurance Marketplace as mandated by the Affordable Care Act. As part of the ACA, enrollment in Health Insurance

Marketplaces began on Tuesday, October 1, 2013. The primary goal of the ACA is to help the 16% uninsured and eligible participants gain access to health care. Central to this goal is the Health Insurance Marketplace. The Marketplace is a new way to shop for health coverage. Health Insurance Marketplaces are one-stop shops for consumers to research, compare, and purchase comprehensive health insurance plans. Open enrollment began on October 1, 2013, and ends on March 31, 2014. Coverage can begin as soon as January 1, 2014. Health Insurance Marketplaces will offer low cost coverage options and comprehensive plans with essential benefits. Beginning October 1, many uninsured people will have new options for health insurance coverage and all plans must cover essential health benefits such as preventive and wellness services, emergency services, maternity and newborn care, emergency room care and prescription drugs. The ACA's changes for 2014 mean that plans can no longer deny coverage due to pre-existing conditions and insurance plans will have to show exactly what is covered. Every state will have a health insurance marketplace where individuals can shop for coverage.

Editor's note: *AMCNO members and other health care professionals can help patients understand and navigate the changing health care landscape. Take a moment to review the following resources to get informed on Health Insurance Marketplaces to help answer your patients' questions. Patients who are unaware of the ACA implementation run the risk of not being ready for enrollment deadlines and are likely unaware of the new services and benefits. There are a number of resources available on the following websites:*

www.healthcare.gov

www.marketplace.cms.gov

www.getcoveredamerica.org

Documentation Guidelines for Evaluation & Management (E/M) Services: Reminder

The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) developed Evaluation & Management Documentation Guidelines to assist health care providers that submit claims to Medicare in documenting and correctly coding E/M services. There are two sets of guidelines, commonly known as the 1995 guidelines and 1997 guidelines. <http://a70tscgsiisw001/ohb/pubs/news/2013/1013/COPE23386.html>

Comprehensive Error Rate Testing (CERT) and Physician's Orders

As part of the process to protect the Medicare Trust Fund, the CERT contractor samples a random number of claims submitted to our office. Physician's ordering instructions are an important part of the information needed.

<http://www.cgsmedicare.com/ohb/pubs/news/2013/0913/COPE23292.html>

Submit Redeterminations through myCGS!

The myCGS web portal has been enhanced! myCGS will now allow Part B providers to submit redetermination requests, including supporting documentation, via the portal. This feature will save mailing time, costs and allow you to monitor the status of your appeal requests. <http://www.cgsmedicare.com/ohb/pubs/news/2013/0913/cope23190.html>

2014 HCPCS Annual Update and Release of Final HCPCS Coding Decision Letters

Although CMS is still assessing the impact of the partial government shutdown on completion of the CY 2014 Healthcare Common Procedure Coding System (HCPCS), CMS intends to publish the 2014 HCPCS Annual Update file on the HCPCS website on or before November 27, 2013. New HCPCS codes will be effective January 1, 2014, unless otherwise specified in the file. Final HCPCS coding decision letters will be mailed to individual applicants to coincide with the publication of the HCPCS Annual Update. <http://www.cgsmedicare.com/ohb/pubs/news/2013/1113/cope23723.html>

CMS ICD-10 Webinars now available in video format

Over the summer months, the Centers for Medicaid and Medicare Services (CMS) hosted webinars on “Transitioning to ICD-10.” These **webinars are now available as video slideshows** on the CMS YouTube Channel and cover the background and impact of ICD-10 on industry CMS ICD-10 implementation, how CMS is working with the states, how CMS is partnering with industry, best practices, frequently asked questions and resources and contact information. The change to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act and will take place on October 1, 2014. [Video slideshows are here.](#)

Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8433 in order to update payment allowances, effective August 1, 2013, for seasonal influenza virus vaccines when payment is based on 95 percent of the Average Wholesale Price (AWP). To learn more about this issue [click here](#).

CGS Provider Enrollment and Revalidation Updates

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) staff was informed at a recent CGS Provider Outreach and Education Provider Outreach meeting that CGS provider revalidation will continue through March 2015 and Phase 3 of revalidation efforts will begin soon. Approximately 70% of the J15 Part B providers will be included in Phase 3. Additional information regarding this phase will be released in the near future.

As CMS enters the next phase of this process, here are some tips to remember:

- Revalidation requests are mailed to the provider’s correspondence and special payment addresses.
- Make sure to respond immediately when the revalidation request is received. Revalidate by either using the Internet based PECOS or downloading and sending the most current version of the paper application found on the CMS website. Faxed applications will be returned.
- Checklists are available on the CGS website to assist in revalidation.
- Revalidation information should be completed, whether via Internet-based PECOS or the paper application process, as a “snapshot in time.”
- Documents **not** routinely required when revalidating are: Degrees/diplomas, Reassignment of Benefits applications when all active reassignments are identified in Section 4B of the individual’s CMS 855I application; and reassignment applications when an entity submits the 855B to revalidate.
- When entities and sole proprietors identifying an Employer Identification Number are revalidating, an IRS document is required. This document must identify the legal business name and EIN preprinted by the IRS. Any field on the application that requires the legal business name on the application must match the name from the IRS document.
- If an EFT is submitted, a voided check or letter from the bank is required. The check or bank letter identifying account information must also reflect this legal business name.
- Sending a copy of the signor’s driver’s license or current passport can expedite the process.
- When section 5 of the CMS 855B is completed, a diagram or flowchart is required as an application attachment. This requirement is found in the [CMS Program Integrity Manual \(Pub. 100-08\), chapter 15, §15.5.5 – Owning and Managing Organizations](#).
- If an application is “developed” for missing or incomplete information, this must be provided in full within 30 days from the development request. Providers are encouraged to respond to the development request as soon as possible as this allows more time to ensure that all missing information has been submitted. If CGS does not

receive the requested documentation within 30 days, they may reject the application and terminate billing privileges. If this occurs, a new application and supporting documents must be submitted.

A/B CERT Task Force

The AMCNO was also informed that CMS is now requiring all Medicare Administrative Contractors (MACs) to collaborate on a combined CERT task force. The A/B CERT Task Force focuses on common CERT errors and will be working to develop educational materials to reduce these errors. The group includes clinical and non-clinical members. CGS and all participating contractors have placed a link to the A/B CERT Task Force website on their individual websites. [Click here](#) for the CGS website.

ICD-10 Toolkits and Resources Available from the Centers for Medicare and Medicaid Services (CMS)

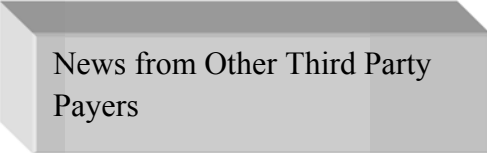
The ICD-10 Regional Office toolkit has been updated to include new/updated resources from CMS. These materials include four new fact sheets and three email updates.

Fact Sheets

- [ICD-10 Basics for Small & Rural Practices](#)
- [Questions to Ask Your Systems Vendor About ICD-10](#)
- [ICD-10 and CMS eHealth: What's the Connection?](#)
- [ICD-10 Resources List](#) (updated)

Email Updates

- [How Will ICD-10 Affect Clinical Documentation](#)
- [Role of Clearinghouses in the ICD-10 Transition](#)
- [Dates of Service: Is it ICD-9 or ICD-10?](#)



News from Other Third Party
Payers

ANTHEM

Anthem updated Provider Manual is available online

An updated Provider Manual has just been posted on the public provider website at anthem.com. To view the new manual, visit www.anthem.com, select "Providers," then choose your state from the drop down box and press enter. On the Provider Home page, select Communications from the horizontal menu at the top, then Publications, then your state's provider manual. If you have any questions, please contact your local Network Relations Consultant.

Update your Anthem Provider Maintenance form

Anthem continually updates their provider directories to help ensure that current practice information is available to Anthem members. When a provider recently joins or leaves a practice, or there is a change in address, phone number, etc., please let Anthem know by completing the Anthem Provider Maintenance Form at anthem.com.

Clinical practice & preventive health guidelines

Anthem has adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on the Anthem website. The guidelines, which are used for Anthem Quality programs,

are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on the Anthem website. To access the guidelines, go to anthem.com>Providers (enter state)> Health & Wellness> Practice Guidelines.

View Anthem professional reimbursement policies at MyAnthem for Providers

Anthem's professional reimbursement policies are available online at MyAnthem, through their secure provider portal at www.anthem.com. The secure provider portal has been updated to allow for a more efficient experience when searching for a particular reimbursement policy. The site now includes in alphabetical order categories for each of the reimbursement policies. The links to access each individual policy is conveniently located under its own category.

Below are instructions for accessing Anthem Professional Reimbursement policies at www.anthem.com:

Non-Registered MyAnthem: If you do not have a MyAnthem user ID and Password, sign onto www.anthem.com, select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. Complete the registration form and your ID and Password will be mailed to you within two weeks. If you are unable to complete the registration online because the provider's tax ID is already registered, you will need to send your request to central.eprovider.rep@anthem.com.

Registered MyAnthem: If you are a registered MyAnthem user, sign onto www.anthem.com, select provider, select state, hit enter, go to left side of the screen and select Login for MyAnthem, enter login and password, select the Administrative Support tab, select the link labeled **Procedures for Professional Reimbursement**.

MEDICAID

Medicaid Expansion Becomes a Reality Through Controlling Board Vote

With less than three months to go before major provisions of the federal Affordable Care Act (ACA) are set to take effect, Ohio has now been added to the list of states that will expand Medicaid under the ACA. When the legislature failed to act upon Medicaid expansion in the months since it was introduced in the Governor's budget, the Governor made a move to bypass the normal legislative process and expand the program through his own executive powers – specifically, through the Controlling Board.

The Kasich Administration asked the Controlling Board to approve funding to expand Ohio's Medicaid system up to 138% of the federal poverty level and the Department of Medicaid asked the panel for authorization to spend federal funds totaling \$561.7 million in FY14 and nearly \$2 billion in FY15 to extend program eligibility. These requests came after the federal Centers for Medicare and Medicaid Services approved Ohio's State Plan Amendment to expand eligibility for the entitlement program, thus making funds available Jan. 1.

The Controlling Board is a seven-member panel with the authority to make appropriations outside of the state budget. The Controlling Board panel consisted of six members of the legislature – four Republicans and two Democrats, an administrator, and a governor appointee who also served as president. Four votes were necessary to approve the measure – and just prior to the meeting House Speaker William Batchelder removed the two Republican House members from the panel - Ron Amstutz, Wooster, and Cliff Rosenberger, Clarksville - and replaced them with two other Republican legislators, Ross McGregor, Springfield, and Jeff McClain, Upper Sandusky. The final vote was 5-to-2 in favor of expanding Medicaid eligibility with Controlling Board president Randy Cole, State Rep. Chris Redfern (D-Port Clinton), State Sen. Tom Sawyer (D-Akron), State Sen. Chris Widener (R-Springfield) and McGregor voting yes. State Senator Bill Coley and State Representative Jeff McClain voted no.

The impact of the Controlling Board's decision for physicians, hospitals, and patients cannot be overstated. The Controlling Board's ruling means physicians and hospitals will now receive reimbursement by Medicaid for the healthcare services they already provide to this patient population. It also means many more patients in our community will now have access to preventive and emergency healthcare services. The expansion will be covered 100 percent by the federal government for the first three years before gradually dropping down to 90 percent by the end of the decade, where it levels off. During this period, Ohio's health care system will draw \$13 billion in federal funding to focus on preventive care, improved care coordination and chronic disease management.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) board of directors voted to support Medicaid expansion early in 2013 and at the same time we became a partner in the Northeast Ohio Medicaid Expansion Coalition – a partnership of health care providers, community organizations, medical professionals, associations and other groups committed to expanding Medicaid in Ohio. The AMCNO shared our position of support with the governor and legislative leaders, urging them to also support Medicaid expansion. The AMCNO was pleased when Governor Kasich included Medicaid expansion in his executive budget proposal, but we were disappointed when both the Ohio House and Senate did not approve of the concept and the proposal was not part of the final budget proposal that was approved in late June.

Over the course of the last few months, there have been several pieces of Medicaid reform legislation introduced in both the Ohio House and Ohio Senate. In addition, a coalition of Ohio community organizations, hospitals, businesses, labor unions, religious organizations, and others who supported extending health care coverage to 275,000 uninsured Ohioans through Ohio's Medicaid program launched a ballot initiative through the *Healthy Ohioans Work* campaign and started collecting signatures to place the question of whether Medicaid should be expanded before voters on the November 2014 ballot. This group plans to continue to collect signatures while the discussion on Medicaid reform continues in the legislature.

The AMCNO has also continued to meet with legislators about the importance of expanding Medicaid and we participated in two Lobby Day events with the Northern Ohio Medicaid Expansion Coalition – with one Lobby Day event taking place just five days before the Controlling Board meeting.

Although Republican legislators voiced their opposition to Medicaid expansion and to the Controlling Board move, the Governor remained committed to expand Medicaid and he has spent time over the last few weeks attending meetings and events around the state to garner public support. The AMCNO executive staff and physician leadership were pleased to be on hand when the Governor visited the Cleveland Clinic Foundation to rally support just a few days before the Controlling Board vote. Joining together with physicians, business leaders, law enforcement officials and other advocates at the Cleveland Clinic, Gov. Kasich outlined the benefits of extending Medicaid eligibility up to 138% of the federal poverty level. During the event, the governor commented that the ability for Ohio to reclaim taxpayer dollars to help Ohioans “is the right way to proceed.” He also noted that his aim is not to further dependency on entitlements but rather to “create a bridge” that will encourage Ohioans to improve their lives.

Ohio is now the 25th state to vote for an expansion of the Medicaid program. While lawsuits are likely to ensue challenging the Controlling Board's authority to authorize this expansion of the state's Medicaid program, this decision marks a huge victory for supporters of Medicaid expansion like the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The AMCNO applauds the vote of the Controlling Board and we are confident that the health and well-being of uninsured citizens around the state and in Northern Ohio will be greatly improved by access to the medical coverage provided by an expanded Medicaid program. The AMCNO will continue to monitor the Medicaid reform issue and provide updates to our members.

Medicaid Primary Care Rate Increase Update

As part of the Patient Protection and Affordable Care Act, the federal government will fully finance the difference between the state Medicaid payment rate and the current year Medicare rate for two years (January 1, 2013, through Wednesday, December 31, 2014) for eligible primary care physicians.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has received inquiries from members regarding this issue and in particular questions regarding the final list of physicians that have successfully attested for the rate increase. **The final list of physicians who have successfully attested for the primary care rate increase (PCRI) can be found at on [the ODM website](#)**

Payment Update

The AMCNO received the following status update regarding the enhanced payment increase for physicians eligible for the primary rate increase from the Ohio Department of Medicaid (ODM): Fee-for-Service (FFS) enhanced payments are currently being made; however, the following two batch adjustments still need made for FFS Medicaid. Information on how that will be accomplished will be forthcoming. No action is required on the part of the physician to correct those payments.

For earlier payments (July 1 through July 17):

- The first July Medicaid payments were short due to the new fund codes not being set up in the OAKS system. That issue has been resolved; however, those payments will need to be adjusted so physicians receive the correct payments for the first July Medicaid payment received.
- The ODM is working to automate the adjustments. Once the adjustment plan is finalized, it will be published.

For January 1 to present:

- The ODM is working on a plan to complete the adjustments in batches based on provider identification number. The plan will be published once it is finalized.

Managed Care Payments - The ODM anticipates sending the managed care plans (MCPs) PCRI payment at the end of October 2013 for the retrospective period January – June 2013. Another payment will be made in November 2013 for the period July – September 2013. After that, the ODM will make payments to the MCPs on a quarterly rolling cycle.

The MCPs must begin paying the enhanced payments to ODM-approved physicians once MCPs receive the enhanced payment from the ODM. The MCP will pay physicians the enhanced payment directly. Once the MCP enhanced payments to eligible physicians begin, they must be made at least quarterly. MCPs have the discretion to make payments to eligible physicians more frequently, but not less frequently. For further details, please contact the MCPs directly.

Eligibility Clarification

According to the final rule published by the Centers for Medicare and Medicaid Services, physicians who qualify for the enhanced payment will not receive it when rendering services in federally qualified health centers, rural health centers, or health departments/clinics.

You Can Still Attest

Please note that physicians can still attest for the enhanced primary care payment, they will just not be eligible to receive retroactive payment back to January 1, 2013. Those attesting and approved after the August 16 deadline (those reflected on the September 24, 2013, [final list](#)) will receive enhanced payment back to their date of attestation.

If you haven't attested yet, you can still do so as long as you have a current [MITS account](#) with an active login and PIN. Those who don't have a MITS account can [sign up](#) for one. If additional assistance is needed regarding signing up for a MITS account, please call the Medicaid Provider Call Center.

MITS UPDATE

The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to control inappropriate payment of claims resulting from the improper reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. NCCI serves as a common model and standard for handling claims for procedures and services that are performed by one provider for one individual on a single date of service.

The claim-processing system of the Office of Medical Assistance (OMA), known as the Medicaid Information Technology System (MITS), uses McKesson ClaimCheck® for its clinical editing function. Because OMA has planned to implement NCCI by the end of June 2013, the ClaimCheck module has been upgraded and is now fully compatible with NCCI. When it processes a claim, MITS applies two types of NCCI tests, which are referred to as "edits":

- A procedure-to-procedure (PTP) "incidental" edit** determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence of or adjunct to) the other.
- A medically unlikely edit (MUE)** determines whether the units of service (UOS) exceed the maximum that a provider would be likely to report under most circumstances. (MUEs mainly affect claims submitted by providers of durable medical equipment and supplies.)

There are circumstances in which it is appropriate for a provider to be paid separately for two procedures but an NCCI edit denies payment for one of them. In those circumstances, NCCI allows providers to append one of several modifiers to the procedure code:

58 - Staged or related procedure or service by same physician during the postoperative period

59 - Distinct procedural service

78 - Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period

79 - Unrelated procedure by same physician during the postoperative period

Claims submitted by several provider types are already subject to ClaimCheck edits. As of June 26, 2013, ClaimCheck/NCCI editing will be applied to claims submitted by seven additional provider types:

- Alcohol and drug treatment center
- Ambulatory surgery center (ASC)
- Chiropractor
- Community mental health center (CMHC)
- Durable medical equipment (DME) provider, basic
- DME provider, orthotics and prosthetics
- DME provider, special license

Moreover, modifiers 58, 59, 78, and 79 will be accepted on applicable claims submitted by any provider of professional services.

It is important to note that there are some significant differences between *Medicaid* NCCI and *Medicare* NCCI. More information about Medicaid is available from <http://www.medicaid.gov>. Details about Medicaid NCCI can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>.

Medicaid Integrated Eligibility System is Now Live

In March 2012, the Office of Health Transformation (OHT) initiated an eligibility modernization project to simplify client eligibility based on income, streamline state and local responsibility for eligibility determination, and modernize eligibility systems technology. The new system went live on October 1, 2013 and over the next two years will replace Ohio's 32-year-old Client Registry Information System (CRIS-E). The goal is for most enrollees to learn of their eligibility for Medicaid and other programs based on income tax information without needing to undergo any additional eligibility tests. The two main features of the plan are to simplify eligibility policy, and to automate eligibility determination systems. Go to this link to learn more: [Integrated Eligibility details](#)

Ohio Medicaid Offers Enhanced Customer Services Options

Customer service at Ohio Medicaid has been enhanced in order to assist physicians and their staff. Physicians and their staff can now expect to get quick answers to any questions you may have about the Medicaid Provider Incentive Program (MPIP). The **phone number for MPIP is: 1-877-537-MPIP (6747)**. You also can email: Mpip@medicaid.ohio.gov or [click here](#) to go to the website for additional information.

Ohio Department of Medicaid Launches New Website

Medicaid.ohio.gov is an easy-to-navigate website for Ohioans who want to know more about Medicaid, including 2.3 million residents covered by the program and a network for 75,000 providers doing business with the program.

Medicaid.ohio.gov

[Get updates from Medicaid](#)

Medicaid Directors Discuss Issues with Associations

The AMCNO regularly participates in meetings with other associations and Medicaid representatives to discuss Medicaid issues/concerns experienced by physicians and their office staff. The next meeting is scheduled for September, and the topic of discussion will be the Medicaid managed care plans. If you or your office staff has any issues/concerns with Medicaid managed care plans, please send this information to the AMCNO offices via email to abell@amcno.org

UNITED HEALTHCARE

UnitedHealthCare Medicare Advantage Network Update

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been hearing from members who have been receiving termination notices from UnitedHealthcare's (UHC) Medicare Advantage network. It is our understanding that UHC has been terminating physicians from their UHC Medicare Advantage Network across the state as well as in other states where UHC does business. This is a national level decision and will cause changes in UHC Medicare Advantage Network.

If you receive a termination letter it will contain information on how to appeal the decision. Physician practices should consider including information in their appeal letter outlining special services or procedures provided by the practice; the type of patients treated in the practice that may not be able to obtain treatment elsewhere; and also include how many patients are seen in your practice that are part of the UHC Medicare Advantage plan. In addition to sending an appeal letter directly to UHC, physicians may want to contact the Northern Ohio regional medical director of UnitedHealthcare, Dr. Edward Isla at Edward_Isla@uhc.com.

In addition to appealing the UHC decision, physicians may also want to consider contacting their UHC Medicare Advantage patients to apprise them of the situation and let them know that you have received a termination letter from UHC and that your practice may be terminated from the network. Physicians may also suggest that patients contact UHC if they so desire, and at the same time let patients know what other plans are currently accepted in the physician practice. Physicians may also want to inform their patients that the open enrollment period for Medicare runs through December 7th and patients can review their options and change their coverage if they so desire. Patients can visit www.medicare.gov for more information.

Rebundling Policy Update

Effective in the first quarter 2014, to align with CMS' National Correct Coding Initiative (NCCI) and the AMA's CPT, UnitedHealthcare will deny Preventive Medicine Evaluation and Management (E/M) services (CPT 99381-99397, HCPCS code G0402) when reported on the same date of service as an immunization administration service (CPT codes 90460-90461 and 90471-90474). If the Preventive Medicine E/M code is reported with Modifier 25 indicating it is a significant and separately identifiable service provided on the same day, both codes would be reimbursed. According to correct coding guidelines, it is not appropriate to additionally report a Preventive Medicine E/M code for the counseling provided when a vaccine is administered.

Online Member Payments Now Available

UnitedHealthcare recently introduced online Member Payments, a new payment option that allows your patients who are our members to make online payments directly to you and all their health care providers through our member portal at myuhc.com®.

This online payment capability was designed in collaboration with InstaMed, a leading health care payments network, to help you get paid faster and easier while allowing members to manage and pay all of their health care bills in one place.

How Member Payments works:

Registered Providers:

- You must register to receive patient payments electronically, which are then deposited directly into your bank account(s).
- Registered providers pay a transaction fee, similar to what they pay today when patients pay with a credit/debit card or eCheck from a bank account.
- The fee is a flat rate of 2.99 percent per transaction when patients pay using credit/debit cards, and 1.5 percent when patients pay using their bank account.
- There are no sign-up fees, no monthly fees, and no minimum fees.
- InstaMed (the payments processor) sends email notifications to registered providers when patient payments have been made, and automatic posting of these payments can be made directly to practice management or other accounts receivable systems.

Non-Registered Providers:

- Patients can pay any provider online from myuhc.com even if the provider hasn't registered to receive patient payments electronically.
- Providers who are not registered will receive these patient payments by mail in the form of a one-time use MasterCard debit card payment.
- Providers will incur their usual costs to process these payments through their existing merchant account. No additional fee is charged.
- Providers will need to manually process and post these payments to their patients' accounts.

Go to **UHCMemberPayments.com** to register now to receive payments directly deposited into your bank account. If you have questions, contact Instamed at **info@instamed.com** or 215-789-3682. Or contact your UnitedHealthcare Physician or Hospital Advocate. You can also attend a **training webinar**.

BWC

Bureau of Workers' Compensation September 2013 Provider E-News Now Available

The September 2013 Bureau of Workers' Compensation Provider e-news is now available - to view the September BWC e-news [click here](#)

CIGNA

Patient Experience Hospital Ratings Now Available on **mycigna.com**

Cigna has added patient experience ratings for hospitals to its online physician and hospital directory. The ratings include an overall patient experience rating of the hospital and if they would recommend the hospital to family or friends. If you have questions about the hospital ratings available you may call Cigna Customer Service at 1-800-88Cigna (882.4462).



AMCNO Continues to Offer Information to our Members through our AHRQ Partnership

The Academy of Medicine of Cleveland & Northern Ohio and the Agency for Healthcare Research and Quality (AHRQ) are pleased to work together to share AHRQ's "Patient-Centered Outcomes Research", also known as "Comparative Effectiveness Research", with you and your patients. AHRQ is a Federal agency of the U.S. Department of Health and Human Services charged with improving the quality, safety, efficiency and effectiveness of health care for all Americans. The Academy of Medicine of Cleveland & Northern Ohio is an ideal partner to help disseminate this research, which is designed to inform health care decisions by providing unbiased comparisons of drugs, medical devices, tests, surgeries, or delivery methods for various health conditions.

AHRQ conducts and translates patient-centered outcomes research into a number of valuable patient and professional materials. These evidence-based tools include plain language consumer and clinician research summaries, continuing medical education/continuing education (CME/CE) activities, faculty slide sets, web conferences, audio podcasts, and more. All of these tools are designed to encourage and support shared decision making between clinicians and patients, with a goal of better care and increased patient satisfaction.

As the Academy of Medicine of Cleveland & Northern Ohio focuses on medical care grounded in evidence-based research, this partnership with AHRQ ensures timely access to these valuable free resources and connects all of us with national efforts to improve health care outcomes. As part of the partnership, AHRQ links to the consumer and clinician research summaries and CE modules are available on our website, along with a link to the AHRQ website, www.effectivehealthcare.ahrq.gov, where you can learn more about AHRQ's Effective Health Care Program.

The AMCNO through our partnership with AHRQ is pleased to offer new resources to our members on the topic of childhood obesity prevention. This valuable information can be used to help parents explore treatment options on how to keep their child from becoming overweight or obese. In addition, there is information for use by clinicians which summarizes research findings on childhood obesity prevention. All the resource materials described are free. The new items available to our members through the AHRQ EHC program are now available on our website. [Click here](#)

For clinicians

[**Childhood Obesity Prevention Programs: Comparative Effectiveness**](#): which summarizes the research findings to quickly give health professionals the clinical bottom line.

For consumers

[**Keeping Children at a Healthy Weight**](#): a resource which can help parents explore treatment options on how to keep their child from becoming overweight or obese, compare the benefits and risks of these options, and prepare to discuss these options with their health care provider.

Department of Health and Human Services (HHS) Releases Checklist for Pandemic Planning

Pandemic influenza presents a unique threat to all communities and affects schools, businesses, healthcare systems, and individuals in ways that are distinct from other emergency events. In response, the Department of Health and Human Services, Assistant Secretary for Preparedness and Response (HHS/ASPR), National Healthcare Preparedness Programs (NHPP) developed the Healthcare Coalition Checklist for Pandemic Planning (HCCPP) with input from internal and external stakeholders.

The HCCPP recommends actions to develop and/or improve coalition-based emergency response plans for pandemic influenza and encompasses all stages of a potential H1N1 ("swine flu") or other infectious disease outbreak. In conjunction with other tools, the HCCPP can help a HCC expand its pandemic influenza emergency response plan to include a diverse mix of partners including schools, businesses, community organizations, and government agencies. To make the best use of available information and resources, HCCs should integrate their efforts with pandemic preparedness plans. The HCCPP assists HCCs in assessing, developing, and improving their preparedness and response plans for a pandemic event.

To view the HCCPP [click here](#).

New Opioid Prescribing Guidelines Adopted in Ohio – Online Education and Seminars Available

As part of an ongoing effort to curb the misuse and abuse of prescription pain medications and unintentional overdoses, today Gov. John R. Kasich has announced the adoption of new opioid prescribing guidelines for treating patients with chronic, non-terminal pain. Developed by the Governor's Cabinet Opiate Action Team (GCOAT), and in conjunction with more than 40 professional groups, state licensing boards and state agencies, (including the Academy of Medicine of Cleveland & Northern Ohio), the opioid prescribing guidelines encourage Ohio's clinicians to fully evaluate a patient's situation before prescribing high levels of opioids for long-term use.

Prescription opioids account for more fatal overdoses than any other prescription or illegal drug, including cocaine, heroin and hallucinogens combined. The number of Ohio lives lost to unintentional drug overdose has risen from 369 lives in 1999 to 1,765 in 2011, a 440% increase. Prescription drugs are involved in most of the unintentional drug overdoses and have largely driven the rise in deaths. Prescription pain medications (opioids) and multiple drug use are the largest contributors to the epidemic.

These guidelines use 80 mg morphine equivalency dosing (MED) as a “trigger threshold,” as the odds of an overdose are significantly higher above that dose. The clinical guidelines recommend that at the 80 MED range or above the clinician “press pause” and re-evaluate how to optimize therapy and ensure patient safety. This pause also is a good time to consider potential adverse effects of long-term opioid therapy. The guidelines are intended to supplement, and not replace, the prescriber’s clinical judgment.

When prescribing an opioid, pharmacists must record the prescription in the online Ohio Automated Rx Reporting System (OARRS). These new guidelines encourage prescribers to use the data in OARRS so that they will know how much pain medication a patient already is receiving, perhaps from multiple prescribers. A new OARRS tool launched with these prescribing guidelines assists prescribers by calculating a patient’s opioid prescriptions into a single MED score for comparison to the 80 MED threshold.

The guidelines also strongly advise prescribers to talk with their patients about managing their chronic pain, the risks of an unintentional overdose from their prescription pain medication, the potential for pain medication abuse, and secure storage of their pain medications to prevent misuse by others.

A new a prescriber-focused website – opioidprescribing.ohio.gov – will help prescribers learn more about the guidelines. The website includes a one-hour online Continuing Medical Education video module outlining the scope of the prescription opioids problem; recommended prescribing clinical guidelines; action steps for healthcare providers; metrics to assess the guidelines; and other resources. [Click here](#) to read a fact sheet on the new Rx prescribing guidelines.

Model Notices of Privacy Practices Released

The Office of the National Coordinator (ONC) and the HHS Office for Civil Rights (OCR) have released [model Notices of Privacy Practices](#) for health care providers and health plans to use to communicate with their patients and plan members.

Developed collaboratively by ONC and OCR, and with input from consumers and key stakeholders, the model Notices are provided in three different styles and are customizable by users. Covered entities may use these models by entering some of their own information into the model, such as contact information, and then printing for distribution and posting on their websites.

The three options for Privacy Notices are:

- A notice in the form of a booklet
- A layered notice with a summary of the information on the first page and full content
- A notice with the design elements of the booklet, but that is formatted for full-page presentation

A text-only version is available for covered entities who only wish to use the content.

You can access the notices [here](#).

Find more information about the [HIPAA Privacy Rule and the Notice requirements](#) on the OCR webpage.

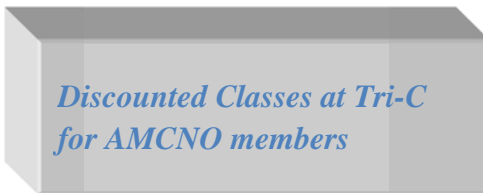
Food and Drug Administration Releases Mobile Medical Application Guidance

The U.S. Food and Drug Administration issued final guidance for developers of mobile medical applications, or apps, which are software programs that run on mobile communication devices and perform the same functions as traditional medical devices. The guidance outlines the FDA's tailored approach to mobile apps. To view the new guidance information [click here](#).

National Healthcare Preparedness Program Releases MERS-CoV Guidance

The Assistant Secretary for Preparedness and Response (ASPR) is always concerned when emerging new diseases, such as Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV), threaten human health. To better prepare for MERS-CoV and similar threats, ASPR worked with the Centers for Disease Control and Prevention to develop the guidance documents.

There have not been any reports of MERS cases in the United States, and in July the World Health Organization's second Emergency Committee determined that the current MERS-CoV situation is serious but does not constitute a Public Health Emergency of International Concern at this time. ASPR and the CDC continue to monitor the situation closely, and asks that healthcare providers remain vigilant and take steps to be as prepared as possible to protect our communities and our nation from emerging new infectious diseases including MERS-CoV. ASPR guidance documents are available [online 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	Price	Location
1/6/14	9:30-12:30 pm	Medical Terminology – Mon & Wed	\$332	UTC
1/6/14	9:00-12:00 pm	Comprehensive Patient Access Specialist Program – MTWRF	\$2280	UTC
1/6/14	9:00-12:00 pm	Comprehensive Patient Access Specialist Program – MTWRF	\$2280	UTC
1/6/14	9:00-12:00 pm	Comprehensive Patient Access Specialist Program – MTWRF	\$2280	UTC
1/7/14	6 – 9 pm	Medical Terminology – Tues & Thurs	\$332	CCE
1/13/14	9:00-12:00 pm	Health Care Navigator – M,T,W,TH	\$1995	UTC
1/14/14	6-9:00PM	Anatomy and Physiology Exploratory: Preparation – T, TH	\$451	CCE
1/21/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
1/21/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
1/21/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
1/27/14	6-9 pm	Health Care Navigator – Mon & Wed	\$1995	UTC
1/27/14	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Mon & Wed	\$1662	UTC
2/3/14	6-9:00pm	Cancer Registry Principles, Practices and – MW	\$261	UTC
2/4/14	6-9:00PM	Overview of ICD-10-CM and ICD-10-PCS – T,TH	\$379	UTC
2/4/14	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs	\$280	CCE
2/5/14	6 – 9 pm	Fundamentals of Billing Reimbursement – Mon & Wed	\$404	UTC
2/8/14	9-3:00PM	ICD-9-CM Fundamentals and More – S	\$189	UTC
2/25/14	9:30-12:30 pm	Essentials of Electronic Health Records – Tues & Thurs	\$309	CCE
	9:30-12:30 pm	Essentials of Electronic Health Records – Tues & Thurs	\$309	UTC
3/3/14	6 – 9 pm	Medical Terminology – Mon & Weds	\$332	UTC
3/4/14	9:30-12:30 pm	Medical Terminology – Tues & Thurs	\$332	CCE
3/8/14	9-3:00PM	CPT Coding Fundamentals and More – S	\$189	UTC

3/18/14	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Tues & Thurs	\$1662	CCE
3/24/14	1:30-4:30 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
3/24/14	1:30-4:30 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
3/24/14	1:30-4:30 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
3/26/14	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Wed	\$474	UTC
4/7/14	6-9:00PM	Anatomy and Physiology Exploratory: Preparation – Mon & Wed	\$451	CCE
4/15/14	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs	\$404	CCE
4/21/14	6 – 9 pm	Essentials of Electronic Health Records – Mon & Weds	\$309	CCE
4/21/14	6-9:00PM	Overview of ICD-10-CM and ICD-10-PCS – T,TH	\$379	UTC
4/22/14	9:30-12:30 pm	Essentials of Electronic Health Records – Tues & Thurs	\$309	CCE
4/22/14	6-9 pm	Health Care Navigator – M,T,W	\$1995	UTC
5/6/14	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs	\$280	CCE
	6 – 9 pm	Medical Terminology – Tues & Thurs	\$316	CCE
5/12/14	9:00-12:00 pm	Health Care Navigator – M,T,W,TH	\$1995	UTC
5/13/14	9:30-12:00 pm	Medical Front Office Fundamentals – Tues & Thurs	\$332	UTC
6/2/14	9:00-12:00 pm	Comprehensive Patient Access Specialist Program – MTWR	\$2280	UTC
6/3/14	6 – 9 pm	Patient Access Specialist Fundamentals – Tues & Thurs	\$474	CCE
6/7/14	9-3:00PM	Overview of ICD-10-CM and ICD-10-PCS – S	\$379	UTC
6/16/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
6/16/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
6/16/14	9:00-12:00 pm	Professional Coding Program – M,T,W,TH	\$3277	UTC
6/17/14	9:30-12:30 pm	Medical Front Office Fundamentals – Tues & Thurs	\$332	UTC
6/19/14	9:30-12:30 pm	Medical Terminology – Tues & Thurs	\$316	UTC
6/24/14	6 – 9 pm	Essentials of Electronic Health Records – Tues & Thurs	\$293	CCE
	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs	\$404	UTC
	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs	\$332	CCE
6/30/14	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Mon & Wed	\$1662	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

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

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

site at www.amcno.org

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