

**FALL/WINTER EDITION 2012/13**

Medicare

**2013 Medical Records Fact Sheet - to be posted on the AMCNO website in February 2013 at [www.amcno.org](http://www.amcno.org)**

**Tips from the Centers for Medicare and Medicaid Services on How to Successfully Prepare Your Office for Transition to ICD-10 before the October 2014 Deadline**

At a recent seminar held at the AMCNO offices, representatives from CGS Administrators, LLC, provided several tips on how physician offices can begin now to successfully prepare for transition to ICD-10 before October 2014. Listed below are several of the tips provided at the AMCNO hosted CGS seminar in January along with some additional points added by the AMCNO staff:

*Assemble an ICD-10 Project Implementation Team:* Putting together a team to oversee your organization's shift to ICD-10 is instrumental to a successful transition. This team will be responsible for overseeing the ICD-10 planning and implementation process. The team should set an initial task list and set-up lines of communication for keeping the team up to date on the dates and deadlines to keep in mind during the transition. It may be helpful to ask a physician with budgetary authority to serve as a champion who communicates critical information to other clinicians. Peer-to-peer interaction can be very effective. Be sure to include other members of the medical staff (i.e. nursing staff and non-physician providers) along with staff from the coding, billing, and information systems departments). Larger institutions may want to ensure that staff members from research and benchmarking, clinical trials, and possibly other departments that use diagnosis-based data participate on the team as well.

*Develop an ICD-10 Communications Plan and Build Internal Awareness:* A communication plan ensures that employees and departments, as well as external business partners, understand their roles and responsibilities during the ICD-10 transition. This plan should be viewed as a formal roadmap for communicating about ICD-10 throughout the transition. Helpful communications could be a written report posted in common areas, regular oral reports at staff meetings, visual presentations using PowerPoint, timely emails, or a combination of these approaches.

*Prepare an ICD-10 Check In Meeting with the Project Team:* All of the team members will need to update the other members on the process of their assigned tasks. This will also be a good time to establish educational opportunities/training schedules for the other members of the office. These meetings could be used to share and revise implementation plans and establish timelines. Develop backup plans for each implementation and testing point to avoid potential pitfalls, and be sure to establish completion dates and monitor progress.

Review the Use of ICD-9 Codes: Staff should develop a list of processes where ICD-9 codes are used in the workflow. Once the office has a complete list of office needs, identify what changes need to be made prior to the transition.

In reviewing this list, be sure you have accounted for the use of ICD-9 codes in:

- Authorization/pre-certifications
- Physician orders
- Medical records
- Superbills/Encounter forms
- Practice management and billing systems
- Coding manuals
- Public health reporting

Coding transitions: To prepare for the new code set consider the following:

- Identify the diagnoses you most frequently code
- Use an ICD-10 code book or software tool to look up these diagnoses and review the potential new codes for the best match.
- Understand how your clinicians communicate with your coding/billing personnel – what words do they use to describe their routine protocols to coders/billers?
- Identify what additional documentation or descriptive language clinicians might need to include ensuring selection of the correct ICD-10 code.
- Identify how your practice will enter key words, medical notes, and content in medical records so the protocols are clearly communicated.
- Discuss changes that may occur in clinical documentation to support ICD-10 code selection.
- Share your ICD-10 code interpretations and selections with your team to minimize the learning curve and avoid miscommunications.

Working with Your Software Vendor: During planning, set up a budget and timeline for upcoming ICD-10 transition activities. If you already have an Electronic Health Record (EHR) system, check your contract to find out if the ICD-10 upgrade is covered. If your contract does not cover the upgrade, talk to your vendor about options and pricing. If you are already talking to software vendors about installing a certified EHR system or if you have not yet selected an EHR system be sure to ask questions to make sure your current system or the system you do choose will accommodate ICD-10 codes.

Working with Clearinghouses and Billing Services: Contact any third-party billing services you use to make sure they are actively planning for ICD-10. If you already have a certified EHR system, check your contract to find out if the ICD-10 upgrade is covered. If your contract does not cover the upgrade, talk to your vendor about options and pricing.

Resources:

- Updated ICD-10 implementation information from CMS-MLN Matters article SE1239 <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1239.pdf>
- CMS ICD-10 web site index <http://www.cms.gov/Medicare/Coding/ICD10/index.html>

- CMSICD-10 Transition Basics  
<http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10FAQs.pdf>
- CMS ICD-10 Procedure Coding System (PCS) and General Equivalence Mapping (GEMs)  
<http://www.cms.gov/Medicare/Coding/ICD10/2013-ICD-10-GEMs.html>

### **Provider Enrollment Revalidation Tips**

The Medicare provider enrollment revalidation initiative will continue through March 2015. When you receive a request from CGS to revalidate your enrollment initiative, it is critically important that you respond to the request within **60 days of the postmark date** and that you provide **all the required information**. [Read more...](http://www.cgsmedicare.com/ohb/pubs/news/2013/0113/cope21000.html)  
<http://www.cgsmedicare.com/ohb/pubs/news/2013/0113/cope21000.html>

### **Deadline to Request Exemption from ePrescribing Penalty is Jan. 31**

Physicians who were unable to file for a Medicare ePrescribing hardship exemption by the original deadline have until Jan. 31, 2013 to avoid the 1.5 percent payment penalty in 2013. Physicians may request a waiver of the 2013 penalty under any of the following categories:

- The physician is unable to ePrescribe as a result of local, state or federal law or regulation.
- The physician wrote fewer than 100 prescriptions during the period of Jan. 1–June 30, 2012.
- The physician practices in a rural area that doesn't have sufficient high-speed Internet access.
- The physician practices in an area that doesn't have enough pharmacies that can do ePrescribing.

CMS also added two hardship categories for those participating in Medicare's electronic health record meaningful use program. Physicians do not need to apply for an exemption related to these meaningful use hardship categories; CMS will automatically determine whether physicians meet those requirements.

Visit the CMS [ePrescribing Web page](#) to learn more. Physicians can contact CMS's QualityNet Help Desk at (866) 288-8912 or [via email](#) with questions or for assistance submitting their hardship exemption requests. Support is available from 8 a.m. to 8 p.m., Eastern Standard Time, Monday through Friday. Physicians who use Apple computers may experience technical problems; CMS encourages them to contact the Help Desk for assistance. Hardship exemption requests for the 2014 payment penalty will be accepted during a separate period this year.

### **New Law Includes Physician Update Fix through December 2013**

In January, President Obama signed into law the American Taxpayer Relief Act of 2012. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2013. The new law provides for a zero percent update for such services through December 31, 2013. This provision guarantees seniors have continued access to their doctors by fixing the Sustainable Growth Rate (SGR) through the end of 2013. The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies (with January 1, 2013, or October 1, 2012, effective dates) have been extended.

Section 601 – Medicare Physician Payment Update – As indicated above, the new law provides for a zero percent update for claims with dates of service on or after January 1, 2013, through December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is currently revising the 2013 Medicare Physician Fee Schedule (MPFS) to reflect the new law’s requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2013 conversion factor is \$34.0230.

In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold MPFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). The expectation is that these claims will be released into processing no later than January 16, 2013. The claim hold should have minimal impact on physician/practitioner cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected. Medicare claims administration contractors will be posting the MPFS payment rates on their websites no later than January 23, 2013.

The 2013 Annual Participation Enrollment Program allowed eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2012. Given the new legislation, CMS is extending the 2013 annual participation enrollment period through February 15, 2013. Therefore, participation elections and withdrawals must be post-marked on and before February 15, 2013. The effective date for any participation status changes elected by providers during the extension remains January 1, 2013.

Section 602 - Extension of Medicare Physician Work Geographic Adjustment Floor - The 2012 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2013. As with the physician payment update, this extension will be reflected in the revised 2013 MPFS.

Section 603 - Extension Related to Payments for Medicare Outpatient Therapy Services - Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD), and counts outpatient therapy services furnished in a Critical Access Hospital towards the cap and threshold. Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3:  
<http://www.cms.gov/manuals/downloads/clm104c05.pdf>.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2013. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is \$1,900. There is a separate cap for occupational therapy services which is \$1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013 through December 31, 2013, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of \$3,700 for therapy services, including OPD therapy services, for a year. There are two separate \$3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Read an American Medical Association [summary](#)  of the health care provisions included in the package.

The Centers for Medicare and Medicaid Services (CMS) released [an announcement](#) regarding updated 2013 Medicare payment amounts, claims processing, and reopening of the participation enrollment period which is reprinted in part in this email – to view the entire announcement go to the link above.

By law, Medicare is required to pay physicians the lesser of the submitted charge or the Medicare approved amount. In addition, most commercial health insurer physician contracts contain language that similarly sets the billed charge as the cap on payment. Thus, physicians who accept assignment should review their retail fee schedules and update them to reflect their current practice costs before they bill Medicare in 2013. The AMA is recommending that physicians either defer submission of claims for 2013 dates of service until the new 2013 rates are published, or bill their updated retail rates. In addition, due to relative value changes that will affect some 2013 payment amounts and limiting charges, for unassigned claims practices should probably wait to bill patients directly for cost-sharing amounts until the new 2013 rates are published.

### **Centers for Medicare and Medicaid Services (CMS) Releases Final Requirements for Stage 2 Meaningful Use**

The Centers for Medicare & Medicaid Services and the Department of Health and Human Services (HHS) Office of the National Coordinator for Health IT have released the final requirements for stage 2 that hospitals and health care providers must meet in order to qualify for incentives during the second stage of the program, and criteria that electronic health records must meet to achieve certification.

The requirements are as follows:

- Make clear that Stage 2 of the program will begin as early as 2014. No providers will be required to follow the Stage 2 requirements outlined today before 2014.
- Outline the certification criteria for the certification of EHR technology, so eligible professionals and hospitals may be assured that the systems they use will work, help them meaningfully use health information technology, and qualify for incentive payments.
- Modify the certification program to cut red tape and make the certification process more efficient.
- Allow current “2011 Edition Certified EHR Technology” to be used until 2014.
- The CMS final rule also provides a flexible reporting period for 2014 to give providers sufficient time to adopt or upgrade to the latest EHR technology certified for 2014.

A fact sheet on CMS’s final rule is available at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp).

A detailed fact sheet on ONC’s standards and certification criteria final rule is available at <http://healthit.hhs.gov/standardsandcertification>.

The final rules announced today may be viewed at

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

More information on the Stage 2 rule can be found at the CMS EHR Incentive Programs website at [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms).

### **CGS Provides Important Links – Keep this Information for Use in Your Office**

At a recent CGS seminar hosted by the AMCNO, CGS staff provided a very useful handout to the attendees which included a detailed list of important links to all sorts of Medicare information. These links are listed below – feel free to mark them in your Favorites and use them as needed.

## CMS

### High-Level Links:

- CMS transmittals and MLN Matters articles:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html>

- CMS Internet Only Manuals:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>

- CGS website: <http://www.cgsmedicare.com>

- CGS forms:

- Ohio: <http://www.cgsmedicare.com/ohb/index.html#>

- Ohio: <http://cgsmedicare.com/ohb/coverage/fees/fees.html>

- Link to MPFS final rule: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf>

### Beneficiary Resources

- General Medicare information (including info on Medicare Advantage plans): <http://www.medicare.gov>

- “Medicare & You 2013”: <http://www.medicare.gov/Pubs/pdf/10050.pdf>

Coverage - Find LCDs for Your State:

- Ohio: <http://www.cgsmedicare.com/ohb/coverage/lcd/index.html>

### Electronic Submission of Medical Documentation (esMD):

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html>

### Ordering/Referring Provider Claim Submission

#### Requirements and Edits:

[http://www.cms.gov/MedicareProviderSupEnroll/06\\_MedicareOrderingandReferring.asp](http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp)

### Incentive Programs

#### PQRS:

- CMS PQRS Web page: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/PQRS/index.html>

- Implementation guide: <http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>

- PQRS Value-Based Modifier: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html>

#### eRx:

- CMS eRx Web page: <http://www.cms.gov/eRxIncentive>

- eRx Quality Reporting Support Page (can submit hardship exemption requests through this site):

[https://www.qualitynet.org/portal/server.pt/community/communications\\_support\\_system/234](https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234)

- Ohio State Board of Pharmacy: <http://www.pharmacy.ohio.gov>

#### EHR:

- CMS EHR Web page: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

- EHR milestones and timelines: <http://www.cms.gov/Regulationsand-Guidance/Legislation/EHRIncentivePrograms/Downloads/HIT-Programs-Timeline-2012-.pdf>



### Provider Enrollment – Revalidation:

- List of providers that have received revalidation notices:  
[http://www.cms.gov/MedicareProviderSupEnroll/11\\_Revalidations.asp](http://www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp)
- More info on revalidation: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>
- Revalidation tips from CGS: <http://www.cgsmedicare.com/ohb/enrollment/Revalidation.html>

### Signatures in Medical Records:

- CMS MLN Matters article SE1237: <http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1237.pdf>
- CMS MLN Matters article MM6698: <http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf>
- CMS Program Integrity Manual, chapter 3, section 3.3.2.4:  
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>
- CGS Signature attestation form:  
[http://www.cgsmedicare.com/ohb/claims/cert/Signatures\\_06%2011%20\(2\).pdf](http://www.cgsmedicare.com/ohb/claims/cert/Signatures_06%2011%20(2).pdf)

### Documentation and Compliance Resources:

- CMS E/M Documentation Guidelines: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>

### Learn more:

- CMS “protect your identity” course: <http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

### Electronic Data Interchange Links:

- Download Medicare Remit Easy Print (MREP):
- Ohio: [http://www.cgsmedicare.com/ohb/claims/edi/easy\\_print.html](http://www.cgsmedicare.com/ohb/claims/edi/easy_print.html)
- EDI Enrollment Packet (with EDI Submitter Agreement form):  
[http://www.cgsmedicare.com/pdf/EDI\\_Enroll\\_Packet.pdf](http://www.cgsmedicare.com/pdf/EDI_Enroll_Packet.pdf)

### **Ohio Immunization Vaccines**

Please refer to the CMS website for the Influenza, Pneumococcal and Hepatitis B Vaccine allowances: [http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1\\_2010aspfiles.asp](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2010aspfiles.asp)

### **2013 Medicare Fee Schedule Released**

The 2013 Medicare Physician Fee Schedule has been released by CGS, Ohio’s Medicare Part B provider. This year, physicians and their staff have the ability to search the database for appropriate codes. To download the PDF or search the database, click [here](#).

News from Other Third Party  
Payers

### **CIGNA**

CIGNA website - Cigna's secure website for health care professionals (CignaforHCP.com) includes a Resources page of practical information including the following items:

- *Forms Center*
- *Clinical Reimbursement Policies and Payment Policies*
- *Reference Guides*
- *Using ID Cards*
- *Medical Resources*
- *eCourses*

If you don't find what you're looking for, click the Feedback button located at the lower right corner of the page.

## **ANTHEM**

### **FAQs Help Explain Upcoming Ancillary Claim Filing Requirements**

Effective October 14, 2012, Anthem implemented claim filing requirements based on ancillary provider type. The requirements reflect a Blue Cross and Blue Shield Association (BCBSA) mandate and apply to the following ancillary provider types: Independent Clinical Lab (Lab), Durable/Home Medical Equipment and Supplies (D/HME) and Specialty Pharmacy.

October 2012 5 of 21

The BCBSA requirements stipulate the correct Local Plan to process the above ancillary type claims.

- Independent Clinical Lab claims should be filed to the Plan in whose service area the referring provider is located as determined by the zip code of the referring provider NPI.
- D/HME claims should be filed to the Plan in whose service area the equipment was shipped to, or purchased/rented at a retail store.
- Specialty Pharmacy claims should be filed to the Plan in whose service area the ordering provider is located, i.e., the address of the ordering physician.

You can find the FAQs on the Anthem website at [www.anthem.com](http://www.anthem.com)

### **Proper Coding for "Admission Date" and "Statement Covers Period"**

Anthem's claim processing systems have been enhanced and now incorporate the proper billing guideline for the reporting of the "Admission Date" and "Statement Covers Period" for electronic inpatient claims. This guideline was implemented October 1, 2011, by the National Uniform Billing Committee (NUBC).

See the links below for detailed descriptions concerning the proper claim filing procedures for these fields.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1254CP.pdf>

[http://www.nubc.org/public/whatsnew/11\\_17\\_10%20NUBC%20Billing%20Alert.pdf](http://www.nubc.org/public/whatsnew/11_17_10%20NUBC%20Billing%20Alert.pdf)

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1117.pdf>

In accordance with your provider agreement with Anthem, in order for your claims to adjudicate appropriately, you are required to file your claims as provided in the above-referenced NUBC billing guideline. If you have further questions, please contact your local Network Relations consultant.

### **New Process for BlueCard® Claims Submitted with Modifier 22**

In an ongoing effort to receive and address medical records in a timely manner, Anthem has a new process within their BlueCard department for claims submitted with Modifier 22 that have the supporting medical records attached to the claim. The following new process was implemented for the BlueCard line of business:



Any claim received with the modifier 22 (with the exception of anesthesia field avoidance) is automatically routed for review if appropriate medical records are attached. For full details, please see the Rapid Update Announcing New Process for BlueCard Claims Submitted with Modifier 22 at [www.anthem.com](http://www.anthem.com)

## **BWC**

### **Provider DeCertification Procedures**

The following rule became effective January 1, 2013:

- Ohio Administrative Code (OAC) 4123-6-02.7 Provider decertification procedures;
- OAC 4123-6-16.3, Reimbursement of retroactive medical treatment requests.

Healthcare providers must pay special attention to these rules as they impact BWC's certification and reimbursement processes. OAC 123-6-02.7 is a new progressive compliance rule and beginning Jan. 1, 2013, the BWC will monitor providers about rule infractions. A rule infraction could lead to a provider submitting a correction plan. If the infractions continue, decertification could occur. In addition, OAC 4123-6-16.3 authorizes discounted reimbursement of 75 percent of an otherwise payable fee for failing to follow BWC's prior-authorization policies. Please review and print these rules from the [Rules and Statutes](#) section of our website.

### **Timely Bill Filing Changes Effective – Providers Must Bill Within One Year**

Some health-care providers may have noticed that BWC is denying bills for untimely filing. Workers' compensation service providers are reminded that in 2011 the time frames for submitting bills and bill adjustments changed by statute and rule. Providers are seeing these denials because the changes became effective more than one year ago. Please note the changes and code citations:

Ohio Revised Code 4123.52, which became effective July 29, 2011, changed the allowable time for submitting a workers' compensation bill with a date of service on or after July 29, 2011, from two years to one year. The statute also provides BWC jurisdiction to create exceptions by rule.

Though OAC 4123-3-23 limitations on the filing of fee bills were effective Sept. 12, 2011, BWC provided exceptions to the one-year filing time frame. These exceptions included:

- Payments to the United States Department of Health and Human Services (DHHS) under the Medicare Secondary Payer Act;
- Bills submitted outside the time frame due to managed care organization or BWC administrative error (i.e., BWC had the wrong claim status on a condition causing a payment error);
- Bills initially submitted to another health plan, insurer or the patient, but it's determined they are not responsible for the cost of the services. Providers must file exceptions to this rule (other than DHHS) within two years of the date of service.

In addition, self-insuring employers may negotiate with a provider for a time period other than the one-year filing timeline.

OAC123-3-23 also includes language on submission of adjustments. Providers must submit requests for adjusting bills initially submitted timely and adjudicated with dates of service on or after Sept. 12, 2011—within one year and seven days of the initial bill's adjudication. This is the date the bill or line item became denied, or BWC paid it at a rate different than expected. If providers don't meet this time frame, their requests are forever barred.

### **Send BWC your National Provider Identification (NPI) number**

BWC is preparing to move to the new 5010 electronic data interchange (EDI) billing protocols. In preparation for the transition, BWC must receive NPIs from all eligible providers and organizations currently having an NPI. Therefore, the BWC is requesting that physicians send their individual NPI number and their organizational NPI number to BWC. If you do not have your original notice, please include the National Plan and Provider Enumeration System (NPPES) verification sheet. You may search for your number(s) [here](#). To ensure our records are accurate and we pay your bills correctly, please fax this information along with your BWC provider number to our provider enrollment unit at 614-621-1333.

### **BWC Fee schedule updates**

Beginning Jan. 1, 2013, BWC will implement the new Medical Services and Professional Provider fee schedule. It will include the new 2013 CPT© and Healthcare Common Procedure Coding System (HCPCS) codes. For more information, view the current and proposed fee schedules [here](#).

### **How to Get Information into a BWC Claim File**

BWC has observed there is misinformation or confusion among providers regarding sending medical information to BWC and the managed care organizations (MCOs). The medical information you send must go into the injured worker's claim file. Healthcare providers must mail or fax documentation requested by BWC or the MCOs to the MCO managing the claim using the [MCO Directory](#). In addition, the website also includes [forms](#) such as the Physician's Report of Work Ability (MEDCO-14). BWC operates a medical repository behind the scenes with fax numbers from the MCO Directory. They copy all information faxed to MCOs, thus eliminating the need to send faxes to both BWC and MCOs. In addition, BWC will index the appropriate information into the injured worker's claim file within 48 hours or less, so physicians need to send their information only once. For more information about this process, send an [email](#) to the BWC staff.

## **MEDICAID**

### **Medicaid Payment Boost for Primary Care Services**

In accordance with the Patient Protection and Affordable Care Act (ACA), certain primary care physicians will soon be eligible to receive increased Medicaid payments for primary care services provided to Medicaid-eligible individuals. The federal government will fully finance the difference between the state Medicaid payment rate and the current year Medicare rate during these two years.

Physicians must request the reimbursement by self-attesting that they are an eligible provider by applying through the MITS portal on Ohio Medicaid's website. In order to register, applying physicians must have a current MITS account with an active login and PIN. Providers could apply beginning on January 1, 2013.

For physicians who complete the self-attestation process by January 26, 2013, the effective date of the increased payment will be January 1, 2013. For self-attestations made after January 26, 2013, the effective date of the increase will be the date of self-attestation. **Please note that original attestation deadline of January 13, 2013, has now been extended to February 2, 2013.** Verification of attestation will begin in mid-January. Providers will receive an email stating whether they have been approved or denied for the reimbursement increase.

Physicians who are approved by the Ohio Office of Medical Assistance can expect to see increased payments beginning in April, 2013, when the Office of Medical Assistance anticipates the Centers for Medicare and Medicaid Services (CMS) will approve Ohio's state plan amendment to implement the primary care rate

increase. Qualified physicians approved by the Office of Medical Assistance who contract with a managed care plan (MCP) will receive the enhanced payment directly from the MCP.

Physicians can access the MITS portal

here: <https://www.ohmits.com/prosecure/authtam/login?HOSTNAME=portal.ohmits.com>

Physicians who do not have a MITS account can sign up for one

at: <https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>

## **UNITED HEALTHCARE**

### **New Patient Visit Policy – Source Clarification**

Recently, UHC clarified the New Patient Visit Policy language to indicate alignment with CMS. Consistent with CMS the policy defines a new patient, for whom a physician may submit a new patient E&I code claim, as one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. In contrast, the 2012 CPT book defines a new patient as one who has not received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. UnitedHealthcare, like CMS, does not consider a physician’s subspecialty in determining reimbursement for a new patient E&M code.

### **Same Day Same Service Policy**

Effective first quarter 2013, this Policy has been updated, implementing edits between CPT code 99291 and Evaluation and Management (E/M) codes or other medical services reported by physicians of the same group and specialty on the same date of service. In keeping with the current E/M code edits administered through this policy, UnitedHealthcare will allow modifier 25 to indicate a significant and separately identifiable E/M service when appropriate. Additionally CPT code 99291 will be added to the identical code logic, allowing this service to be reimbursed only once per day when reported by physicians of the same group and specialty on the same date of service. These edits follow correct coding guidelines, as set forth by the American Medical Association and the Centers for Medicare and Medicaid Services.

Telemedicine – Addition of clarifying language relating to “originating sites” and Modifier GT  
This policy has been updated by incorporating language defining “originating site” and noting which originating sites are appropriate for reporting modifier GT. Modifier GT should only be reported when the patient is located in one of the following originating sites:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital
- A rural health clinic
- A federally-qualified health center
- A hospital-based or critical access hospital-based renal dialysis center (including satellites)
- A skilled nursing facility
- A community mental health center
- A federally-qualified health center
- A hospital-based or critical access hospital-based renal dialysis center (including satellites)
- A skilled nursing facility
- A community mental health center

### **Clinical Information Required for Notification Submission**

When submitting an online notification request for UHC coverage, please ensure that the clinical notes section of the medical record is complete and accurate so that UHC can best determine coverage. Clinical notes may include lab or imaging results, pain assessments or functional impairment assessments. Lack of complete clinical information often results in delays in pre-service review and coverage denials, causes extra work for clinician offices, and increases member and physician dissatisfaction. Coverage for a service or procedure must be determined per any applicable federal or state regulatory requirements, the member's benefit plan and UnitedHealthcare's Coverage Determination Guidelines (CDG) and Medical Policies. These Policies and CDGs are available at [www.Unitedhealthcare.com](http://www.Unitedhealthcare.com). Each CDG lists specific clinical information that UnitedHealthcare needs up front to confirm coverage. Complete, accurate clinical information as outlined in the Medical Policy or CDG is required to fulfill the clinical coverage review requirements. Failure to submit the requested documentation may result in coverage denial.



### **State Medical Board of Ohio Provides Telemedicine Interpretative Guidelines**

The State Medical Board of Ohio has in recent months received numerous inquiries concerning the requirement to "personally physically examine and diagnose a patient" prior to prescribing, as set forth in Ohio Administrative Code Rule 4731-11-09. The inquiries raise questions regarding the ability to use the internet or other forms of telecommunication to complete the physical examination of a patient that is the basis for a diagnosis and follow through on a plan of treatment for the individual patient. The interpretation of Rule 4731-11-09 and the requirement to personally physically examine and diagnose a patient applies solely to cases that involve prescribing or personally furnishing non-controlled substances. To view the Medical board interpretive guideline click [here](#)

### **New AHRQ Materials Available on AMCNO Website**

As a key partner with the Agency for Healthcare Research and Quality (AHRQ), the AMCNO has made a library of AHRQ mental health materials available for download on our website. Highlights of the mental health resources in AHRQ's Effective Health Care Program library include:

- Easy-to-read summaries comparing the risks and benefits of antipsychotic medications for adults and children, as well as the use of medications and non-pharmacological treatments for depression
- Continuing education modules (CME/CE) on traumatic brain injury interventions, alcohol misuse counseling, depression treatments, and antipsychotic medications. To view this information [click here](#)

### **State Medical Board of Ohio Approves Two New Policies**

The SMBO recently sent out two new policies – "Prescribing to Persons not seen by the Physician" and "Prescribing for a Family Member." Both of these policies are available on the AMCNO website. To view these two new policies [click here](#).

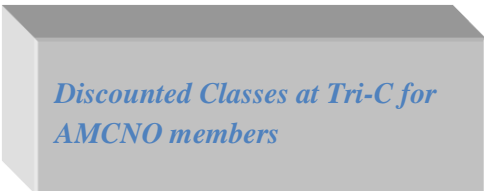
### **Save Money on Your Practice Workers' Compensation Coverage**

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to offer a Workers' Compensation group rating plan to our members that can help you save money on the premiums you pay to the Ohio Bureau of Workers'

Compensation. This plan is made possible through our longstanding partnership with CompManagement, Inc., (CMI) a Sedgwick CMS Company. CMI has begun the review process for 2013 group participation, which means you can find out how much you can save! AMCNO practices already enrolled in the AMCNO Group Rating Program will receive a letter regarding review for renewal with the program as well as contact information for CompManagement.

CompManagement will review the application and determine your potential savings and contact you with a cost analysis. If you decide you want to participate, all you need to do is sign and send in the enrollment paperwork included in your cost analysis. This is a no-cost, no obligation review. If you are currently a member of another medical association in the state and participating in a group rating plan other than through the AMCNO you are probably paying higher member dues to remain in that plan. Upon review, you may find that the AMCNO dues are substantially less per member and we provide group discounts which cost effectively enables our physician members to take advantage of the worker's comp group rating program along with other AMCNO benefits and services at reduced cost. If you have questions regarding the program contact Ms. Linda Hale at the AMCNO offices at 216-520-1000, ext. 101.

To receive a free, no obligation savings quote, contact CompManagement's Customer Support Unit at (800) 825-6755, option 3 or visit <http://resources.compmgt.com/AC3/GroupRating.aspx?Organization=AMCNO> to complete online.



**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.*

<b>Date</b>	<b>Time</b>	<b>Title/location</b>
2/5/13	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs (CCE)
2/18/13	6 – 9 pm	Essentials of Electronic Health Records – Mon & Wed (UTC)
2/19/13	6 – 9 pm	Patient Access Specialist Fundamentals – Tues & Thurs (CCE)
3/5/13	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs (UTC)
3/6/13	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Mon & Wed (CCW)
3/11/13	6 – 9 pm	Medical Front Office Fundamentals – Mon & Wed (CCE)
3/19/12	6 – 9 pm	Medical Terminology – Tues & Thurs (CCE)
4/1/13	6 – 9 pm	Essentials of Electronic Health Records – Mon & Wed (CCE)
4/23/13	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs (UTC)
4/29/13	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Wed (UTC)
4/30/13	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs (UTC)
5/7/13	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs (CCE)
6/13/13	6 – 9 pm	Medical Terminology – Mon & Wed (UTC)
6/10/13	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Wed (CCE)
6/25/13	6 – 9 pm	Essentials of Electronic Health Records – Tues & Thurs (UTC)
	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs (CCE)

**Course Locations: Corporate College East** 4400 Richmond Rd, Warrensville Hts, OH 44128  
**Corporate College West** 25425 Center Ridge, Westlake, OH 44145  
**Unified Technologies Center Rd** 2415 Woodland Ave, Cleveland, OH 44115



## *Practice Management Matters*

**The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)** can provide you information on topics from balance billing to managed care to terminating the physician/patient relationship.

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

Visit *Practice Management* at [www.amcno.org](http://www.amcno.org)

For a “Third Party Payor Review Form”.

Call us at 216.520.1000 or email [amcno@amcno.org](mailto:amcno@amcno.org)

*The AMCNO Practice Management Matters newsletter includes links that provide direct access to Internet sites other than our own. The AMCNO takes no responsibility for the content or the information obtained on other Web sites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our Web site at [www.amcno.org](http://www.amcno.org)*

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