

## **SUMMER EDITION 2013**

### **Medicare**

#### **Demand Letters to Medicare Providers and Suppliers Associated with an Item or Service Provided to Incarcerated Beneficiaries**

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated that the beneficiary was incarcerated on the date of service (DOS). Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. Medicare has identified previously paid claims that contain DOS that partially or fully overlap a period when the beneficiary was incarcerated based on information from the Social Security Administration (SSA). A large number of overpayments have been identified and demand letters released with appeals instructions. At this time, CMS asks that providers do not file appeal requests. This issue will be resolved more quickly and efficiently if providers follow the instructions below.

There may be instances where providers believe that the beneficiary was not incarcerated when the service was provided. However, a beneficiary may be “incarcerated” even when the individual is not confined within a penal facility. For example, a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation may, nevertheless, be in the custody of authorities under a penal statute. In such cases, Medicare payment may be barred. Providers receiving demand letters for denial of claims because the beneficiary’s SSA record indicates incarceration on the DOS, and who have reason to believe that the beneficiary was not incarcerated on the DOS, may wish to contact the beneficiary to gather as much information as possible.

#### **Information Gathered Indicates SSA Record May Need to be Updated**

If a beneficiary did not inform the SSA of his or her release from custody, this may result in his or her record being incorrect. If a provider believes this is the case, the provider may wish to encourage the beneficiary to contact his or her local SSA office in order to have his or her records updated.

It can take up to one month for the beneficiary’s Medicare eligibility file to be updated with the revised SSA information. If the beneficiary tells the provider that SSA is updating his or her records, we suggest the provider contact the Medicare Administrative Contractor using the contact information on the overpayment demand letter.

#### **Information Gathered Indicates SSA Record is Current**

If the provider believes that the beneficiary was not incarcerated on the DOS in question and the beneficiary advises that SSA’s records are currently accurate, the provider can contact his or her local CMS Regional Office by fax.

SAVE THE DATE: BACK AGAIN FOR ITS 27<sup>TH</sup> YEAR – SOLVING THE THIRD PARTY PAYOR PUZZLE SEMINAR – WEDNESDAY, NOVEMBER 13, 2013 – SEE REGISTRATION INFORMATION INSIDE THIS ISSUE

At a minimum, providers should be prepared to submit the following information to the appropriate CMS Regional Office:

- Fax Subject: Incarcerated Beneficiary Claim Issue
- Provider Name and Contact information:
- Beneficiary Name:
- Health Insurance Claim Number:
- Dates of Service:
- Claim Number (ICN/DCN):
- Reason why incarceration information for the DOS is incorrect:

### **Signing Medical Records: Know the Rules, Prevent the Denials**

When CGS or the CERT contractor reviews medical records, the most common reasons claims are denied is that medical records are not signed or the signature does not meet Medicare requirements.

- **Submit only SIGNED and dated documentation.**
- Know the rules. MLN Matters article MM6698 includes examples of acceptable signatures, an explanation of the signature attestation process, and other helpful tips.
- Respond timely to CGS requests for an attestation.
- Complete an attestation for illegible or missing signatures:
  - [http://www.cgsmedicare.com/kyb/claims/cert/cert\\_Signature\\_Requirements.html](http://www.cgsmedicare.com/kyb/claims/cert/cert_Signature_Requirements.html)
  - [http://www.cgsmedicare.com/ohb/claims/cert/cert\\_Signature\\_Requirements.html](http://www.cgsmedicare.com/ohb/claims/cert/cert_Signature_Requirements.html)

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below:

- Claim Adjustment Reason Code (CARC) 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)”
- RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”
- RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”
- Group Code-Contractual Obligation (CO).

**NOTE:** This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

**Additional Information** The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2758CP.pdf> on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

## **ICD-10 Updates**

The “ICD-10-CM/PCS The Next Generation of Coding” Fact sheet (ICN 901044) is now available as an electronic publication (EPUB) and through a QR code. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date; ICD-10-CM/PCS – an improved classification system; ICD-10-CM/PCS examples; structural differences between International Classification of Diseases, 9th Edition, Clinical Modification and ICD-10-CM/PCS; continued use of Current Procedural Terminology codes; and use of external cause and unspecified codes in ICD-10-CM.

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) (<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html>). Please note the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. The change from Version 4010 standards to 5010 standards was done to prepare for the switch from ICD-9 to ICD-10.

### **Health care providers, payers, clearinghouses, and billing services must be prepared to comply with the transition to ICD-10, which means:**

- All electronic transactions must use Version 5010 standards, which have been required since January 1, 2012. Unlike the older Version 4010/4010A standards, Version 5010 accommodates ICD-10 codes.
- ICD-10 diagnosis codes must be used for all health care services provided in the U.S., and ICD-10 procedure codes must be used for all hospital inpatient procedures. Claims with ICD-9 codes for services provided on or after the compliance deadline cannot be paid.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims.

### **OPEN PAYMENTS Program News**

As of August 1, 2013, applicable manufacturers and applicable group purchasing organizations (GPOs) will begin formally collecting financial relationship data for OPEN PAYMENTS reporting. *Please note that physicians are not required to take any action right now.* However, like applicable manufacturers and applicable GPOs, physicians should start tracking the following information needed to comply with OPEN PAYMENTS program requirements:

- Payments or other transfers of value made to physicians and teaching hospitals, and
- Certain ownership or investment interests held by physicians or their immediate family members.

For each payment, transfer of value, ownership, or investment interest that is documented, certain data elements should be captured (such as names, dates, etc.). The OPEN PAYMENTS program website includes the data submission file specifications for 2013. Physicians, applicable manufacturers, and applicable GPOs should become familiar with the categories used to describe reportable payments or other transfers of value and ownership or investment interests. These specifications are critical, as they will be needed for data submission in early 2014. The Office of Management and Budget (OMB) control number is 0938-1173.

Note: the first OPEN PAYMENTS program cycle (August 1, 2013 through December 31, 2013) is a partial data collection period of only five months, as compared to future program cycles which will run for the entire year. For this

first period, the data collected by applicable manufacturers and GPOs through December 31, 2013 will be submitted to CMS in early 2014. Physicians do not need take any action or submit data to CMS. They will have the opportunity to review the submitted data and work with the applicable manufacturer and applicable GPO to correct their submitted information before CMS makes it public.

### **Medicare Physician Compare Website Undergoes Overhaul**

Medicare's online directory of participating physicians has been reworked and redesigned in an effort to improve the accuracy of information on the site and make the search function easier to use. The Centers for Medicare and Medicaid Services redid its Physician Compare website after errors were discovered throughout the site after its initial launch in December of 2010. CMS technicians have worked to address these issues and build new features for patients to use when searching for medical care. The new version of the site went live June 27.

The new version of the website has what it calls an intelligent search function. A patient can search for physicians in his or her area by ZIP code, city and state, address, or a landmark such as a mall or park. The beneficiary also can find a doctor by last name, specialty, or medical condition or body part. Clicking the "Search Another Way" tab allows the patient to select a body part that needs medical attention.

Information about physicians still relies on CMS' Provider Enrollment, Chain and Ownership System, or PECOS. Errors introduced to Physician Compare stem from incorrect information in PECOS. However, the new version of Physician Compare also will use information from claims for Medicare services submitted by physicians. For instance, addresses submitted on claims can verify addresses as they appear on the website. In addition, Physician Compare will update entries with changes made to enrollment status, such as a move to a new practice, on a quarterly basis.

### **Message to All myCGS Users**

Remember that your myCGS passwords must be changed every 30 days or you will not be able to sign in to myCGS. **If the administrator does not sign into myCGS within a 60-day period, the entire account will be disabled.** If the account is disabled, the following message will display: "This account is inactive."

Once an account is deactivated, the practice has to Re-register for myCGS. You will be given a new username upon completing the registration process. Passwords can be reset when the "Forgot or Change Your Password" link is selected. After entering your User ID you must provide the answers to the security questions that you set up upon registering for myCGS. Please note that these answers are **case sensitive**, and if not entered correctly, it will cause a lockout. General users need to contact their Administrators for lockout issues. Administrators need to call the EDI Help Desk for assistance. For all EDI-related questions and further assistance with myCGS, please contact the EDI Help Desk at 1-866-590-6703 (Jurisdiction 15 PART A).

### **OIG advisory opinion - Laboratory services and federal kickback statute**

***By: Jane Pine Wood, Esq., McDonald Hopkins, LLC***

In a recent opinion (Opinion 13-03) from the Office of Inspector General (OIG) of the Department of Health and Human Services, the OIG expressed concerns regarding a laboratory services arrangement and the federal Medicare and Medicaid kickback statute.

A laboratory requested the advisory opinion from the OIG about a prospective plan. Under the proposed arrangement, the laboratory's owners would form a management company. The management company would be in the business of assisting physician groups in setting up their own laboratories. The management company would lease (or arrange for the leasing of) laboratory suites to each physician group, as well as laboratory personnel and equipment necessary to operate the

laboratory. The management company would also enter into a management agreement with each physician group to manage the laboratory on behalf of the group.

Importantly, the laboratories owned by the physician groups would not perform any testing covered by government payors, such as the Medicare and Medicaid programs. Rather, the physician-owners of the laboratories would refer their government laboratory work to other laboratories. The laboratory requesting the opinion explained that it might receive referrals from the physician groups, but the physician groups would not be required to refer any laboratory testing to the laboratory.

In its request for the advisory opinion, the laboratory represented that the lease agreement and management agreement with each practice would comply with an applicable safe harbor under the Medicare and Medicaid anti-kickback law. Each lease agreement and management agreement would recite fixed, fair market value compensation to be paid to the management company for the leased items, personnel and services.

In its opinion, the OIG explained that it is a crime under the federal kickback statute to knowingly and willfully offer, pay, solicit, or receive anything of value for referring services that are reimbursed by a federal health program. This statute carries with it up to a \$25,000 fine and up to five years in prison. Furthermore, violation of the statute carries additional civil monetary penalties.

The OIG stated that although the laboratory services provided in each physician group's own laboratory did not present a kickback issue because no government testing would be involved, the potential for physicians to order government services through the management company's affiliated laboratory was of concern. The OIG reasoned that a physician may feel obligated to use the management company's affiliated laboratory for its government testing referrals. Although the requestor of the opinion represented that all lease agreements and management agreements would reflect fair market value pricing, the OIG remained concerned that in order to enter into a desirable business arrangement with the management company, a physician group might be more willing to refer its government testing to the affiliated laboratory.

It is important to note the OIG highlighted its concerns about any arrangements that appear to avoid anti-kickback laws by excluding services that are covered by federally-funded programs. The OIG explained that an arrangement does not escape scrutiny under the anti-kickback law simply because it excludes the government work.

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#### AMCNO Partners with CGS Administrators, LLC. to Offer Education Opportunity for Physicians

Recently the AMCNO partnered with CGS Administrators, LLC, to provide an outstanding educational opportunity for Northern Ohio physicians. The program was also offered in Columbus, Ohio and Louisville, Kentucky and in addition to the AMCNO was also supported by the Greater Louisville Medical Society, the Louisville Chapter Kentucky Medical Group Management Association, the Ohio Podiatric Medical Association, the Ohio Hospital Association, the Ohio State Medical Association, the Professional Healthcare Institute of America and the University of Louisville Hospital.

This informative session entitled "*The Medicare Landscape and the Physician's Perspective*" was presented by Dr. Earl Berman, Chief Medical Officer, Part B, Dr. Michael Montijo, Chief Medical Officer, Part A and Jim Szarzynski, Director of Medical Review. The objectives for the session were to identify key data sources for errors in Medicare claims and documentation, review topics and issues under increased scrutiny by Medicare contractors, define the role of physicians in responding to challenges regarding documentation and payment errors and to provide physicians with current and future areas of focus with respect to Medicare claims, documentation and payment.

Dr. Montijo led off the discussion noting that Ohio has 1.1 million beneficiaries with allowed charges of over \$111 million. He noted that in the near future Medicare plans to continue to utilize new payment methodologies, documentation, and process of care and team care as a condition for payment. He stressed that documentation is critical

and if not done correctly will have an impact on payment, cause further data analysis by contractors and further scrutiny by recovery auditors and the Medicare administrators.

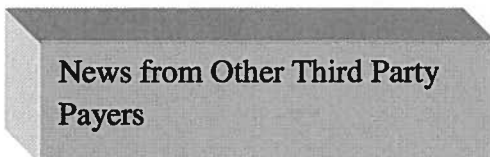
Dr. Berman stressed the importance of demonstrating medical necessity in the patient record including why a patient is seen, what is being done for the patient and the importance of performing an assessment and providing a treatment plan. He also noted that signatures continue to be a problem area in all provider types and that there are a significant number of signature errors. Dr. Berman reminded the physicians in the audience that every service provided to a Medicare beneficiary requires a signature – and a stamped signature is not acceptable.

Dr. Montijo discussed hospitalization challenges and payment issues related to elective admissions, one-day stays, outpatient procedures, and skilled nursing facility qualifying stays reminding the physicians that they are ultimately responsible for all coding and signing off. He also noted that an order for observation status must include the rationale and an order simply documented as “admit” will be treated as an inpatient admission. With regard to home health benefits for Medicare patients, he noted that in order for payment to be made a physician must certify that a patient is confined to his/her home and meet certain requirements.

With regard to coding, the presenters outlined that the physician is in control of the coding and a coder cannot do anything that is not clearly documented without querying the physician. The role of the coder is to select CPT/HCPCS codes and modifiers and ICD-9 codes based on the physician’s documentation and with the physician’s input – and medical necessity is the overarching criterion. The physician’s key role with regard to documentation is timeliness and the presenters strongly encouraged all health care providers to enter information into the patient’s medical record at the time the service is provided to the patient; that is, contemporaneously. In all cases, regardless of whether the documentation is maintained or submitted in paper or electronic form, any medical records that contain amendments, corrections or addenda must: clearly and permanently identify any amendment, correction or delayed entry as such; indicate the date and author of the amendment, and not delete, but instead, identify all original content.

Mr. Jim Szarzynski wrapped up the evening with a presentation on medical review issues. He noted that medical reviewers determine whether a service is a covered benefit, reasonable and necessary and accurately codes. He assured the audience that the purpose of medical review is not meant to be a means to deny claims or conduct fraud investigations. Their current area of focus is highest level of office visits and one day stays. In the near future their focus will be cross-claim review, elective surgeries, skilled nursing facility admissions, statistical sampling with overpayment estimation, and predictive modeling. He stressed the importance of physicians and their staff staying informed on the Medicare review process and be proactive and correct a problem if it is brought to their attention.

The AMCNO wishes to thank CGS and the presenters for partnering with us and the other medical organizations to provide this informative session for physicians. The AMCNO plans to work with CGS in the future to partner on other similar sessions – we will provide information to our members when the future sessions are scheduled.



## **ANTHEM**

### **Critical Change for Anthem Members on Service with CuraScript - Medical Benefit Specialty Drugs**

If Anthem Blue Cross and Blue Shield (Anthem) members receive specialty medications at your office, and are receiving drugs dispensed by **CuraScript**, Express Scripts Specialty Pharmacy, and these drugs are covered by the member's medical benefit, please note this important information.

**Effective September 1, 2013, CuraScript will leave the Anthem medical specialty pharmacy network.**

The prescription(s) for your impacted patient(s) will be transferred to Coram Rx Specialty Pharmacy or CVS Caremark Specialty Pharmacy by September 1, 2013. Previously received authorizations for these medications will also transfer to Coram or Caremark as appropriate.

**IMPORTANT TO NOTE: CuraScript will continue to dispense specialty medications covered under the pharmacy benefit (which are typically self-administered drugs).**

### **Critical Change for Medical Specialty Pharmacy New Starts**

For members who will begin office-administered specialty drug therapy on or after September 1, 2013, please contact Coram or CVS Caremark Specialty Pharmacy with referral information and prescriptions.

Please fax referral and prescription information to:

- Coram Rx Specialty Pharmacy - 1-877-513-7847
- CVS Caremark Specialty Pharmacy - 1-800-323-2445

**PLEASE DO NOT SEND PRESCRIPTIONS UNDER MEDICAL BENEFIT COVERAGE TO CURASCRIPT FOR ANTHEM MEMBERS AFTER SEPTEMBER 1, 2013.**

### **Questions?**

For questions **after September 1**, contact Coram and CVSCaremark at the following phone numbers:

- Coram Rx Specialty Pharmacy - 1-877-267-2679
- CVS Caremark Specialty Pharmacy - 1-800-237-2767

### **New features enhance Interactive Care Reviewer (ICR), our new self-service provider web tool**

The Anthem ICR tool now makes it even easier for you to request online pre-certifications. The ICR tool now has a new look and feel to the dashboard and a more user-friendly layout. The enhancements include:

- Display of an immediate message to indicate if you can continue on with the request for your patient
- Comprehensive dashboard with additional fields to sort by
- A bar across the top of the page to define where you are in the request process
- Easy access to "Create New Request" and "Quick Links"
- Expanding and collapsing menus for quick navigation to any section
- Additional functionality to search for ordering and servicing provider detail, and to select data rather than manually typing it
- Ability to edit or cancel a submitted request
- Most National Account members now available for precert
- Ability to precert until the end of the member's benefit period

For more information, attend informational webinars to learn more about the *features and benefits* of our new tool and how to navigate within it. Our FREE webinars provide physicians with an overview of the ICR tool or give in-depth training on utilizing our ICR's many features. To register, click [here](#) or go to <https://www144.livemeeting.com/lrs/1100001891/Registration.aspx?pageName=83vbn5cvr00ngx4>

Access to the ICR tool is free of charge. It is available via Availity's Web Portal. If your organization has not yet registered for access, go to [www.availity.com](http://www.availity.com) and click on Register Now. If your organization already has access to

Availity's Web Portal, your Primary Access Administrator can grant you access to Authorizations and you can start using our tool right away.

For questions regarding our ICR, please contact your local Network Management consultant. For questions on accessing our tool, call Availity Client Services at 800-AVAILITY (800-282-4548) or email questions to [support@availity.com](mailto:support@availity.com). Availity Client Services is available Monday-Friday, 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions.

*\*Note: ICR is not currently available for Medicare Advantage, Medicaid, FEP, BlueCard®, and some National Account members; requests involving Behavioral Health or transplant services; or services administered by AIM Specialty Health<sup>SM</sup>. For these requests, follow the same precertification process that you use today.*

## **MEDICAID**

### **AMCNO Continues to Urge Lawmakers to Extend Medicaid Benefits**

The President of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Dr. George Topalsky, joined other advocates supporting extension of the Ohio Medicaid program for the Northeast Ohio Medicaid Expansion (NEO-MEC) Coalition Lobby Day at the Ohio Statehouse. The purpose of the Lobby Day was to encourage lawmakers, to extend Medicaid benefits to 275,000 Ohioans.

Dr. Topalsky and other NEO-MEC participants stressed that time is of the essence for Medicaid expansion. Major portions of the the Affordable Care Act will go into effect on January 1, 2014, and if extension of Medicaid is authorized, it will take several months for the state to properly prepare for implementation of the program and additional coverage.

In addition to the NEO-MEC, other organizations from around the state, including hospitals and health systems, patient advocates, physicians, social service groups, and faith communities, have worked tirelessly to educate legislators and the public on the economic and health benefits of extending Medicaid.

The AMCNO and other supporters of Medicaid expansion have encouraged the Ohio legislature to find a bipartisan solution to this issue. During his legislative visits, Dr. Topalsky stressed to legislators that the AMCNO and the physicians we serve recognize the need for health care reform, and have long advocated for change in the health care delivery system. He noted that physicians see the negative impact that inadequate health care can have on patients, and that the AMCNO is confident that the health and well-being of uninsured members of the Northern Ohio community will be greatly improved by access to the medical coverage provided by an expanded Medicaid program. The AMCNO will continue to work through NEO-MEC and other statewide coalitions, and stress to the legislature the importance of this issue. It is our hope that Ohio will decide to support the Medicaid expansion in order to improve patient access to care and establish a more efficient and complete health care delivery system for the citizens of Northern Ohio and the rest of the state.

Although the budget bill did not include a provision for Medicaid expansion, legislation has been introduced to address this issue, and lawmakers continue to review this issue with the intent of other bills getting introduced in both the Ohio House and Ohio Senate. The AMCNO will continue to post updates on this issue on our website at [www.amcno.org](http://www.amcno.org).

### **Ohio's New Medicaid Managed Care Program Gets Statewide Roll-Out**

*Medicaid beneficiaries across the state now able to choose from among five plans*

State Medicaid Director John McCarthy recently announced the launch of a revamped Medicaid managed care program that will serve more than 1.6 million residents across Ohio. Managed care plans participating in the new program are



expected to create approximately 1,000 new jobs in order to address increased staffing needs in various regions of the state. The program's July 1 implementation date coincides with the creation of the Ohio Department of Medicaid (ODM) – the state's first executive-level Medicaid agency.

In line with the Kasich Administration's commitment to place performance and value over volume, a request for applications (RFA) was held last year in an effort to reform the way managed care organizations serve Ohio's Medicaid population. Ohio Medicaid evaluated the prospective plans and their past performance coordinating care and improving the health outcomes of beneficiaries. Ultimately, the following five managed care plans were awarded contracts to serve the state's Medicaid population:

- Buckeye Community Health Plan
- CareSource
- Molina Healthcare
- Paramount Advantage
- United Healthcare

All five of the selected plans will be made available across the state by way of three service regions. As a result, Medicaid managed care beneficiaries will now have greater choice in selecting a plan that best suits their individual health care needs. Medicaid managed care plans will provide coverage to Covered Children and Families (CFC) and Aged, Blind, and Disabled (ABD) populations, as well as approximately 37,000 children with special health care needs. As an added term of the new managed care contracts, each plan is now required to maintain and operate a member service call center in Ohio. Increases in new call center staffing and case management personnel will further bolster job creation in multiple regions of Ohio. For more information on Ohio's new Medicaid's managed care program or to enroll, please visit <http://www.ohiomh.com/>.

July 1, 2013 marked the launch of the Ohio Department of Medicaid (ODM) - the State of Ohio's first executive-level state Medicaid agency.

Ohio Medicaid provides health care coverage to more than 2.3 million Ohioans through a network of 100,000+ providers. Under the direction of state Medicaid Director John B. McCarthy, ODM continues its work to modernize Ohio's Medicaid program. Over the next few months, Medicaid will continue to build their new website at [www.Medicaid.Ohio.gov](http://www.Medicaid.Ohio.gov) with the intent to make it an all-in-one resource for the latest news, information, and updates pertaining to consumer and provider communities. In the meantime, continue to visit <http://jfs.ohio.gov/OHP/> for up-to-date news and info on Ohio's Medicaid program.

## **UNITED HEALTHCARE**

### **UnitedHealth Premium® Designation Assessment Update**

Updated UnitedHealth Premium designation assessment results will be available this fall and are based on an updated methodology and new time frame of paid claims (January 1, 2010 -February 28, 2013). UnitedHealthCare will send the Premium designation assessment result letters to physicians and practice administrators in markets where the program is available, and who are practicing in one of the 27 Premium-eligible specialties. Letters will include assessment results and instructions on how to access assessment reports.

### **Program and Methodology Updates**

#### **Enhanced Quality:**

- o Addition of appropriateness and outcomes measures for the OB-GYN specialty.

o Addition of UnitedHealthcare Medicare and Retiree data to assess physician quality. New feature allows creation of separate Commercial and Medicare and Retiree benchmarks.

**Enhanced Cost Efficiency:**

- o Evaluation of risk-adjusted population cost (total cost of care) in addition to episode cost for both primary care and select non-surgical specialist physicians.
- o Addition of surgical episodes for the OB-GYN specialty.

**Addition of New Specialties\*:**

- o General Surgery
- o General Surgery - Colon/Rectal
- o Ophthalmology
- o Ear Nose Throat
- o Urology

For more information, call 866-270-5588 or go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) and select "UnitedHealth Premium" on the top navigation bar to find resources and tools explaining the program. Be sure to check the Program News

section on a regular basis for program updates. \*The number of included specialties is subject to change if we conclude that data is insufficient for assessment of any of the following specialties: Ear Nose Throat, General Surgery, General Surgery - Colon/Rectal, Ophthalmology and Urology.

Revision to the Assistant Surgeon and Co-Surgeon/Team Surgeon Policies

To further align with CMS and the American Medical Association (AMA), the Assistant Surgeon and the Co-Surgeon/Team Surgeon Policies will be revised to reflect that assistant surgeon, co-surgeon and team surgeon services are not eligible for reimbursement when reported by surgical technicians/technologists. Assistant at surgery eligible services should only be reported by:

- o Physicians, using modifiers 80, 81, or 82 as appropriate.
- o Physician assistants, nurse practitioners and clinical nurse specialists, using modifier AS.

Assistant at surgery services reported by surgical technicians/technologists are included in the payment to the facility and not separately reimbursed. According to coding guidelines, co-surgeon and team surgeon services are only reimbursable to a physician and are identified by appending modifier 62 to the eligible procedure code. These changes will be effective in the fourth quarter of 2013.

Reminder: Revision Coming to Rebundling Policy – Edits Being Added

**Effective third quarter 2013**, to align with CMS' National Correct Coding Initiative (NCCI) and the AMA's CPT, UnitedHealthcare will deny Evaluation and Management (E/M) services (CPT 99201-99380, 99401-99499) when

reported on the same date of service as an immunization administration service (CPT codes 90460-90461 and 90471-90474). If the 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 an E/M code for the counseling provided when a vaccine is administered. At this time, this policy change will not apply to preventive medicine services (CPT codes 99381-99397, HCPCS code G0402).



### **SGR Repeal Legislation Still Under Review –AMCNO Members Urged to Contact Congress Now**

Draft legislation to repeal Medicare's sustainable growth rate (SGR) formula is moving forward in the U.S. House of Representatives. The current bill under review repeals the SGR and replaces it with annual updates of 0.5%. Beginning in 2019, physicians would be able to report data under a new Quality Update Incentive Program (QUIP) and earn up to an additional 1% update. Those that score poorly on quality measures could face a net cut of 0.5%. The bill would require medical professionals to play a key role in designing the quality metrics and also creates an avenue for physicians to design and participate in Alternative Payment Models (APMs) under which they would be exempted from the QUIP requirements.

It is expected that the U.S. House “Ways and Means Committee” and the U.S. Senate Finance Committee will produce their own versions of the legislation after the recess, also with the aims of repealing the SGR formula, enhancing quality, and making available new models of care delivery and payment. Physicians should take the time to contact their lawmakers and build momentum toward repeal of the SGR formula. The AMCNO has written to Northern Ohio Congressional leaders urging their support of legislation to repeal the SGR, and encourages our members to contact their Congressional representatives as well to urge them to finally act to repeal the SGR payment formula. To view the AMCNO letter to Congress [click here](#)

### **AMCNO Signs Onto Joint Letter to Congress Regarding Medicare Part B Drug Reimbursement**

The AMCNO joined over 17 medical associations from across the State of Ohio in sending a letter to Ohio Congressional Representatives about the need to oppose additional cuts to the Medicare Part B drug reimbursement program that covers injectable and infusible drugs administered by physicians and community health centers. Our organizations, representing seniors, patients and healthcare providers in Ohio, strongly urged Congressional representatives to oppose any congressional action that would make further cuts in Medicare payments for cancer care and the treatment of other serious illnesses. We noted that deeper cuts, on top of those imposed by the sequester, will cause significant and lasting damage to Ohio's community-based cancer care infrastructure.

Currently, physicians providing Part B-covered drugs, which are a limited subset of drugs that generally must be injected or infused by a health care professional, are reimbursed under the Average Sales Price (ASP) plus 6%, formula. This formula was established by the Medicare Modernization Act of 2003 and resulted in significant savings to the government and to patients. The 6%, on top of the ASP, recognizes that physicians incur costs for shipping, handling and storage of these drugs according to FDA guidelines, helps with costs associated with drug preparation and clinical monitoring, as well as variations in acquisition cost by physicians due to their purchasing agreements. MedPAC has noted that the ASP+6% payment formula generally results in a slim difference between acquisition cost and Medicare reimbursement, and in some cases doesn't fully compensate physicians for the costs of some drugs.

During the previous deliberations on deficit reduction, there was a proposal to further reduce Medicare Part B payments for drugs from ASP+6% to ASP+3%. There is a possibility that ASP cuts could be reconsidered when Congress revisits deficit reduction, especially since the President includes a cut to ASP+3% in his latest budget proposal. Physicians and patients are already being impacted by across the board Medicare payment reductions of 2% under sequestration, which essentially reduces Part B drug reimbursement to ASP+4%. The AMCNO and other medical organizations pointed out

how devastating any additional cuts would be for millions of seniors nationwide as well as many seniors here in Ohio and noted that since other sequester cuts are already being absorbed by those who provide care to Medicare beneficiaries, it is vital that Congress refrain from further cuts that would weaken our capacity to fight cancer and other life-threatening diseases. To view a copy of the joint letter [click here](#).

### **Medical Board Names Executive Director**

Anita M. Steinbergh, D.O., President of the State Medical Board of Ohio, announced that Aaron E. Haslam, J.D., has been named Executive Director of the Medical Board effective July 1, 2013. Since February 2011, Mr. Haslam has worked with Attorney General Mike DeWine as a Senior Assistant Attorney General and Chief of the Attorney General's Prescription Drug Abuse Initiative. He also served as Coordinator for Special Prosecutions - Prescription Drug Unit. Mr. Haslam is formerly the Adams County Prosecuting Attorney. Mr. Haslam obtained his law degree from Cleveland-Marshall College of Law and is admitted to practice law in Ohio and the United States District Courts of Ohio.

### **CMS Finalizes Policies for Health Insurance Marketplace Navigators**

The Centers for Medicare & Medicaid Services (CMS) took the next step in moving toward implementation by finalizing a proposed rule outlining the standards for Navigators, the in-person assisters in Federally-facilitated and State Partnership Marketplaces. State-based Marketplaces have the option of using this guidance or developing their own. The rule identifies training, conflict of interest standards, and standards for serving people with limited English proficiency and people with disabilities. Navigators and similar in-person assisters will provide unbiased information to consumers about health insurance, the new Health Insurance Marketplaces, qualified health plans, and public programs including Medicaid and the Children's Health Insurance Program.

CMS will ensure that all consumers who need Marketplace customer service can receive it from trained professionals. Millions of Americans will be eligible for new coverage opportunities through the Marketplaces beginning January 2014. Navigators will provide accurate and impartial assistance to consumers shopping for coverage in the new Marketplace, including consumers who are not familiar with health insurance, have limited English proficiency, or are living with a disability.

In addition to Navigators, Marketplace consumers will have access to assistance through services such as a call center, where consumers can receive help with the eligibility and enrollment process. The call center will also provide referrals to the appropriate state or federal agencies, or other assistance programs including in-person assistance personnel, certified application counselors, and agents and brokers. The final rule also outlines the standards for certified application counselors, including training, qualifications, and requirements to ensure that they provide quality, sound, consumer-protective assistance. Open enrollment in the Marketplace begins Oct. 1, 2013, with coverage to begin Jan. 1, 2014. To access the final rule [click here](#)

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

Join other Academy of Medicine of Cleveland & Northern Ohio members already seeing their annual workers' compensation premium reduced by participating in group rating, group retrospective rating or other alternative discount programs available in Ohio.

Let CompManagement, our Workers' Compensation third party administrator, work harder for you for your best cost savings solution for the 2014 policy year.

[Click here](#) for a FREE, NO OBLIGATION analysis today!

CompManagement ensures participation for eligible organizations in programs that will garner the most premium savings as well as proper use of cost reduction strategies that annually save their clients \$100 million in premiums paid. Ask them how to stack discounts for optimizing your savings today!

**To speak to a customer service representative directly, please call (800) 825-6755, option 3.**

### **2013/14 AMCNO Lawyer Referral Brochure Now Available**

When legal questions or issues arise, the AMCNO believes it is important for our members to obtain sound advice from legal counsel who are knowledgeable in relevant areas of the law, and who have a commitment to representing physicians and their practice groups. To that end, the AMCNO has prepared a Lawyer Referral Brochure for use by our members. We encourage our members to make use of these lawyers (or other practitioners similarly qualified) whenever they encounter significant legal issues. The AMCNO does not endorse any one law firm over another – this information is provided to our members as a service only. Members are free to choose an attorney from this brochure or from other sources. To view the AMCNO Lawyer Referral Brochure [click here](#).

### **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](http://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 the following new information to our members. "*Explore, Compare, Prepare*" – is a new consumer information initiative – and the purpose of the initiative is to encourage people living with health conditions and their caregivers to explore treatment options for their conditions, compare the benefits and risks of each, and prepare to discuss them with their health care providers. The initiative also provides outreach materials for the health care professional community to encourage the use of EHC Program clinician tools and resources as well as patient education materials.

As a partner in the AHRQ's EHC Program, the AMCNO connects patients and caregivers to information they can use to improve their health and health care experiences. 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](#)

### **Ohio Department of Insurance Provides Information on Rates for Plans – Health Insurance Marketplace Now Available**

The Health Insurance Marketplace, made available to consumers under the federal Affordable Care Act is now open for business for consumers living in states that are part of the federal insurance exchange, which includes the state of Ohio. Patients can now open a personal account at the Healthcare.gov website, in order to begin the process to purchase coverage effective Jan. 1, 2014. In addition, the Ohio Department of Insurance has released rates for individual health plans that will be sold in the Ohio marketplace. The average 2014 monthly premium rate will be \$332.58, which is 41 percent higher than 2013 rates. However, the ODI data does not include federal premium subsidies, which the

Congressional Budget Office says will be available to 80-90 percent of patients using the marketplace. To view the ODI information [click here](#)

States were required to submit insurance rates to the Department of Health and Human Services by July 31, with the premiums to be approved by the federal government prior to the opening of the marketplaces in the fall of 2013. For additional information about the Healthcare.gov health insurance marketplace [click here](#)

In addition, WebMD has also established a Health Care Reform Center which guides users through the basics of the ACA, and how to purchase health insurance on the new exchanges. For more information [click here](#)

**State Medical Board of Ohio Releases FY13 Annual Report**

Due in part to the efforts of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the State Medical Board of Ohio (SMBO) now provides an annual report that will be disseminated to the public and to healthcare providers throughout Ohio via their website. To review a copy of the most recent SMBO annual [click here](#)

**Ohio Health Information Partnership (OHIP) Provides Information on Ohio’s Adoption and Meaningful use of Electronic Health Records**

Nationally, more than 50 percent of doctors and 80 percent of hospitals have switched from paper to electronic patient health records over the past several years, according to a recent federal [announcement](#) from the U.S. Department of Health and Human Services (HHS). In Ohio, 61 percent of physicians and 94 percent of hospitals have gone electronic – either by purchasing, installing or upgrading to a certified electronic health record (EHR) system – and the numbers continue to rise each month. The [Ohio Health Information Partnership](#), which is the state-designated entity that has assisted more than 6,000 physicians in the adoption of electronic health records over the past two years, has worked alongside Cincinnati-based [HealthBridge](#), [Ohio Medicaid](#), the [Ohio Department of Health](#) and workforce development programs to accelerate the adoption of electronic health records and the achievement of meaningful use.

As of April 2013, calculations show that 16,508 payments have been to Ohio providers, totaling \$607 million from CMS. The collaborative surpassed a 2012 goal established with the ONC to assist 10,000 providers in reaching federal “meaningful use” requirements. Meaningful use is a way to report health data that shows how medical professionals are measuring and tracking the care they give to patients, especially through the use of electronic communications and exchange. The collaborative work can be found in a federal and state white paper entitled *Putting the Pieces Together: How Ohio Is Leveraging Health IT for Better Health, Better Care, and Lower Costs*.

<b>Ohio’s Adoption and Meaningful Use of Electronic Health Records</b>	
<b>Medicare and Medicaid Payments Combined</b>	
<b>16,508 provider payments</b>	Total number of CMS payments made to doctors, clinicians and hospitals
<b>\$607 million</b>	Total amount of incentive payments from CMS to Ohio providers
<b>Medicare Only</b>	
<b>11,085 provider payments</b>	The number of Medicare payments made to doctors, clinicians and hospitals
<b>\$389.6 million</b>	Amount of Medicare incentive payments from CMS to Ohio providers
<b>Medicaid Only</b>	
<b>5,423 provider payments</b>	The number of Medicaid payments made to doctors, clinicians and hospitals
<b>\$217.2 million</b>	Amount of Medicaid incentive payments from CMS to Ohio providers through Ohio Medicaid
<b>Hospitals Only</b>	

<b>288 payments to 144 hospitals</b>	CMS made 288 payments to Ohio hospitals for Medicare, Medicaid or both. 144 hospitals out of 152 eligible hospitals received payments, which is 94 percent.
<b>\$315.6 million</b>	Amount of payments made to 144 Ohio hospitals for Medicare, Medicaid or both.
<b>Physicians Only</b>	
<b>16,206 payments made to physicians 15,185 physicians received payments (61%)</b>	Number of payments made to physicians (some could have received a second year payment.) There are approximately 25,000 physicians in Ohio. 61 percent or 15,185 received payments.
<b>\$291.4 million</b>	The amount of money physicians and clinicians received from CMS.

In 2015, physicians and hospitals who work with Medicare and Medicaid patients will have the payments they receive for patient care reduced if they do not use electronic health records.

The Ohio Health Information Partnership also manages CliniSync – the statewide health information exchange that allows physicians to receive reports and test results directly from hospitals. To date, 89 hospitals have contracted with CliniSync and 37 are live. This infrastructure also has been federally funded through ONC and HHS.

### **Health Information Exchange Expands in Ohio**

HealthBridge and the Ohio Health Information Partnership have announced the successful launch of connectivity between the two organizations through the use of Direct, an emerging national standard for securely exchanging health information among health care providers. The announcement is just one of a series of steps aimed at building health care connectivity across Ohio that ensures that medical information follows patients wherever they go for care. Both organizations are working to connect hospitals and health care providers via electronic health information exchange (HIE) across Ohio. By using Direct, doctors, nurses and other providers across Ohio will be able to share a summary of a patient’s medical record, medication information or send information about referrals electronically. Better information in the hands of providers at the point of care can lead to better decision making and faster, more effective treatment, more accurate diagnosis, and more positive outcomes for their patients.

Direct is based on a new national technology protocol fostered by the Office of the National Coordinator (ONC). Direct is specifically designed for simple, secure communication of health information in today’s health care context. It allows a provider to share a patient’s health information with another provider of care easily.

Any provider with an Internet connection could utilize Direct to exchange patient information securely, electronically and instantaneously without having to establish expensive interfaces and removing the time-consuming process of printed, faxed or mailed exchange of patient information. Direct protocols are now used by electronic health record vendors, state and federal agencies. Direct is also an accepted standard for meeting federal meaningful use requirements.

HealthBridge is an HIE organization located in Cincinnati, Ohio, that serves more than 30 hospitals and 7,500 physicians in Southwest Ohio as well as parts of Indiana and Kentucky. The Ohio Health Information Partnership began connecting hospital systems in December 2011. Since its inception, it now has 90 hospitals contracted, 37 live and more than 1,200 physicians who have joined CliniSync, Ohio’s statewide health information exchange located in the Columbus area. More about how the Direct Project is helping to build a secure, trusted Nationwide Health Information Network (NwHIN) is available through ONC.

### **2013 Statewide Immunization Conference**

Presented by immunizeohio.org™ – The Consortium for Healthy & Immunized Communities Inc. “Keeping your vaccines, your community and your bottom line healthy...”

The recent introduction of the Affordable Care Act and changes to billing and coding practices has substantially impacted physicians, providers, health care workers and the public alike. The 2013 Statewide Immunization Conference focuses on effective strategies to improve the systems for immunizing adults, teens and children.

**Topics Include:** Immunization Update, Billing and Coding, Impact of Health Care Reform on Vaccine Payment and Delivery, New Recommendations in Storage and Handling, Vaccination of Pregnant Women and more.

**We invite you and your colleagues to join us in discussion and learning so that we can collectively make a difference to our community.**

**Who should attend?** Physicians, nurses, nurse practitioners, office staff and public health professionals.

**Date:** October 18, 2013

**Venue:** 100th Bomb Group Restaurant  
20920 Brookpark Road, Cleveland, Ohio 44135

**Time:** 7:30 AM – 4:15 PM

**Cost:** \$75.00 (non physician)  
\$85.00 (physician)

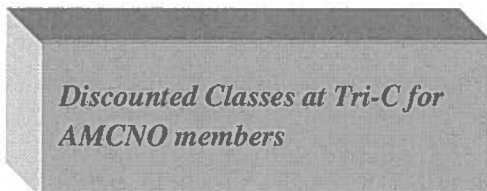
**REGISTRATION OPENS JULY 01, 2013 – CLOSES OCTOBER 01, 2013**

#### **About immunizeohio.org™**

Expanding the scope of its mission to encompass all of Ohio, the Consortium for Healthy & Immunized Communities Inc. established immunizeohio.org as the masthead for promoting statewide immunization education.

The 2013 Statewide Immunization Conference is the platform for building a strong network of health care workers and legislators, whose shared goal is to make vaccines pertinent and accessible to all.

**For more information please visit our website: [www.immunizeohio.org](http://www.immunizeohio.org)** *Note: This event is supported by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and our foundation – the Academy of Medicine Education Foundation (AMEF).*



### **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>
9/21/13	9 am – 3 pm	ICD-9-CM Fundamentals and More – Saturday (UTC)
9/23/13	6-9 pm	Fundamentals of Billing Reimbursement – Mon & Wed (UTC)
9/28/13	9 am – 3 pm	Overview of ICD-10-CM and ICD-10-PCS – Saturday (UTC)
10/7/13	6-8 pm	Hospital/Facility Billing Reimbursement – Mon & Wed (UTC)
10/19/13	9 am –	CPT Coding Fundamentals and More – Saturday (UTC)



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

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

**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](http://www.amcno.org)*

6100 Oak Tree Blvd. Suite 440 Independence, Ohio 44131

[www.amcno.org](http://www.amcno.org)

216.520.1000 Executive Offices 216.520.0999 Facsimile

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

**SPACE IS LIMITED – CONFIRM YOUR PARTICIPATION NOW!**

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

*is pleased to present:*

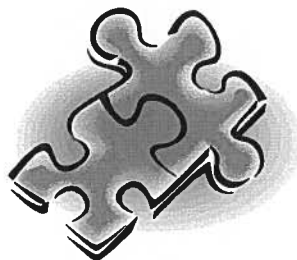
## **Solving the Third Party Payer Puzzle 2013**

Co-Sponsored by **The Academy of Medicine Education Foundation**

**Wednesday, November 13, 2013**

Registration: 7:30 a.m. – 8:00 a.m.

Seminar: 8:00 a.m. – 4:00 p.m.



**WHERE: AMCNO Executive Offices  
Park Center Plaza I**

6100 Oak Tree Blvd – Lower Level Meeting Room  
Independence, Ohio 44131

**COST: AMCNO Members and their staff: \$50 per participant**

Non-members: \$100 per participant

**\*LUNCH WILL BE PROVIDED\***

**Speakers have been confirmed from:**

Anthem Blue Cross & Blue Shield

CIGNA HealthCare

Humana Inc.

Medicaid (Ohio Department of Job & Family Services)

Medical Mutual of Ohio

Medicare (CGS LLC)

United Health Care

For more information, contact the AMCNO at 216.520.1000 or register online at [www.amcno.org](http://www.amcno.org)

**← TO REGISTER FOR TPP, PLEASE COMPLETE & RETURN WITH PAYMENT. DEADLINE: NOVEMBER 8, 2013**

# of Attendees \_\_\_\_\_ Amount due \$ \_\_\_\_\_

Name(s) of Attendee(s): \_\_\_\_\_

Physician(s) Name(s): \_\_\_\_\_

Office Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

\* Phone: \_\_\_\_\_ \* Email: \_\_\_\_\_

**Make check payable and mail to:**

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Account # \_\_\_\_\_ Exp. date: \_\_\_\_\_ ID # \_\_\_\_\_

**SEATING IS LIMITED; LIMIT two people per office. CUTOFF: 75 People  
REGISTRATION REQUIRED PRIOR TO DAY OF SEMINAR.**

Note: Payment also accepted day of seminar at registration