

SPRING EDITION 2014

Medicare

AMCNO 2014 Medical Records
Fact Sheet Included in this Issue

An Important Message from the DME Medicare Administrative Contractors for the Centers for Medicare & Medicaid Services - Solicitation by Medical Equipment Suppliers

The Durable Medical Equipment Medicare Administrative Contractors (DME MAC) medical directors frequently receive complaints from physicians about various marketing schemes from DME suppliers. Some of the methods used are:

- Unsolicited orders for medical equipment or supplies, often with wording such as “We received a call from your patient Jane Doe who wants you to order...” and then lists multiple items on a pre-printed order for you to approve.
- Advertisements that Medicare will provide you with payment for referrals of patients.
- Pre-completed medical necessity forms with instructions to just “Sign and Date Here.”

Most of these schemes are obvious in their wording or their attempts to get you to approve unnecessary medical equipment and supplies. **You are under no obligation to support or justify these supplier solicitations or to sign orders for items not initiated by you or that were provided by the DME supplier at a patient’s request without prior consultation. Suspected abuse may be reported to the OIG at HHSTips@oig.hhs.gov, 1-800-447-8477 or via fax at 1-800-223-2164.**

The DME MAC medical directors ask for your assistance by:

- Paying careful attention to orders that cross your desk asking for your signature. Before signing, ask your staff to provide the patient’s medical record so that you can review it before signing an order.
- View with a skeptical eye unsolicited orders for patients no longer in your practice or whom you have not seen in a long period of time.

Document in your patient’s medical record the medical justification for any item of DME ordered for your patient.

CMS Finalizes Physician Payment Rates for 2014

Final Rule Focuses on Improved Care Coordination

CMS has finalized payment rates and policies for 2014, including a major proposal to support care management outside the routine office interaction as well as other policies to promote high quality care and efficiency in Medicare. CMS' care coordination policy is a milestone, and demonstrates Medicare's recognition of the importance of care that occurs outside of a face-to-face visit for a wide range of

beneficiaries beginning in 2015. The final rule sets payment rates for physicians and non-physician practitioners paid under the Medicare Physician Fee Schedule for 2014 and addresses the policies included in the proposed rule issued in July. CMS projects that total payments under the fee schedule in 2014 will be approximately \$87 billion.

As part of CMS' continuing effort to recognize the critical role primary care plays in providing care to beneficiaries with multiple chronic conditions, beginning in 2015, the agency is establishing separate payments for managing a patient's care outside of a face-to-face visit for practices equipped to provide these services. The 2014 payment rates increase payments for many medical specialties with some of the greatest increases going to providers of mental health services including psychiatry, clinical psychologists and clinical social workers.

CMS is finalizing a process to adjust payment rates for test codes on the Clinical Laboratory Fee Schedule (CLFS) based on technological changes. Currently, the payment rates for test codes on the CLFS do not change once they have been set (except for changes due to inflation and other statutory adjustments). This review process will enable CMS to pay more accurately for laboratory tests on the CLFS.

The final rule also includes several provisions regarding physician quality programs and the Physician Value-Based Payment Modifier (Value Modifier). As CMS continues to phase-in the Physician Value-Based Payment Modifier, for 2016 CMS is finalizing its proposals to apply the Physician Value Modifier to groups of physicians with 10 or more eligible professionals, and to apply upward and downward payment adjustments based on performance to groups of physicians with 100 or more eligible professionals. However, only upward adjustments based on performance (not downward adjustments) will be applied to groups of physicians with between 10 and 99 eligible professionals.

CMS also is finalizing several related proposals to the Physician Quality Reporting System (PQRS) for 2014, including a new option for individual eligible professionals to report quality measures through qualified clinical data registries. In 2014, quality measures will be aligned across quality reporting programs so that physicians and other eligible professionals may report a measure once to receive credit in all quality reporting programs in which that measure is used. Additionally, CMS is better aligning PQRS measures with the National Quality Strategy and meaningful use requirements, and transitioning away from process measures in favor of performance and outcome measures. Finally, certain data collected in 2012 for groups reporting certain PQRS measures under the Group Practice Reporting Option (GPRO) will be publicly reported on the CMS Physician Compare website in 2014.

Full text of this excerpted [CMS press release](#)

[Final Rule](#)

[Fact Sheet](#): Final Policy and Payment Changes to the Medicare Physician Fee Schedule for CY 2014

[Fact Sheet](#): Changes for CY 2014 Physician Quality Programs and the Value-Based Payment Modifier

[Physician Fee Schedule](#)

[Physician Value-Based Payment Modifier](#)

[PQRS](#)

CMS Makes Outpatient Facility Policy and Payment Changes

Rule would give hospitals and ASCs flexibility to lower per-case costs

CMS has released a final CY 2014 hospital outpatient and ambulatory surgical center (ASC) payment rule [CMS-1601-FC] that will give hospitals and ASCs new flexibility to lower outpatient facility costs and strengthen the long-term financial stability of Medicare. In addition, CMS will replace the current five levels of hospital clinic visit codes for both new and established patients with a single code describing all outpatient clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and

better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes are designed to distinguish differences in physician work.

Provisions in the final Hospital Outpatient Prospective Payment System (OPPS) rule encourage more efficient delivery of outpatient facility services by packaging the payment for multiple supporting items and services into a single payment for a primary service similar to the way Medicare pays for hospital inpatient care. Supporting items and services that will be included in a single payment for a primary service to the hospital and not paid separately include drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; drugs and biologicals that function as supplies when used in a surgical procedure, including skin substitutes; certain clinical diagnostic laboratory services; certain procedures that are never done without a primary procedure (add-ons); and device removal procedures.

The CY 2014 final rule with comment period increases overall payments for hospital outpatient departments by an estimated 1.7 percent. The increase is based on the projected hospital market basket—an inflation rate for goods and services used by hospitals—of 2.5 percent, minus both a 0.5 percent adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute. The rule also updates partial hospitalization payment rates for hospitals and community mental health centers.

As part of this broader proposal to consolidate payment for larger groups of services, the final rule with comment period also establishes an encounter-based or "comprehensive" payment for certain device-related procedures like cardiac stents and defibrillators, but in a change from the proposed rule, delays its effective date to 2015.

Full text of this excerpted [CMS press release](#) (issued November 27).

[Final Rule](#)

[Fact Sheet](#)

Updated Information about Incarcerated Beneficiary Claim Denial Corrections

CMS has a new [web page](#) focused on the 2013 claims denials associated with a beneficiary's incarceration status.

Implementation of Health Insurance Portability & Accountability Act (HIPAA) Standards and Operating Rules for Health Care Electronic Funds Transfers

This article is based on Change Request (CR) 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) HIPAA transaction and operating rules for the Health Care EFT and Remittance Advice Transaction. For more information [click here](#).

Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. For more information [click here](#).

Ohio Medicaid ICD-10 Project Update

Compliance Date & Billing

- Ohio Medicaid is on schedule to meet the implementation compliance date of 10/1/14. CMS has stated the date will not be extended.
- The compliance date is based on Date of Service for Outpatient/Professional services and Date of Discharge for Inpatient services.
- Providers cannot bill ICD-9 and ICD-10 codes on the same claim – only one code set per claim will be allowed. Outpatient/Professional services that are billed in span dates (from/through) will need to submit two claims – one claim with ICD-9 codes and one claim with ICD-10 codes.
- There is no transition period – 10/1/14 is a hard date for compliance. However, because of timely filing rules ICD-9 codes will continue to be accepted after go-live for claims with Dates of Service/Dates of Discharge prior to 10/1/14.
- Resubmitted claims will follow the Date of Service/Date of Discharge. If the claim was originally filed with ICD-9 codes and the Date of Service/Date of Discharge was prior to 10/1/14 we will continue to accept that claim through the appeal process with ICD-9 coding.
- All providers that use ICD-9 on a claim will be required to use ICD-10 on a claim.

Activity Update

- HP and the Managed Care Plans (Plans) are currently updating their systems.
- ODM and the Plans have detailed testing strategies and further details will be communicated soon. Generally, testing will occur in Q2 and Q3 of 2014.
- ODM, HP, the Plans, and Sister State Agencies continue to work closely to ensure all of Ohio Medicaid will be ready by 10/1/14.

What Providers Should Do

- Stay updated on Medicaid ICD-10 information:
 - Medicaid ICD-10 webpage: www.medicaid.ohio.gov/PROVIDERS/Billing/ICD_10.aspx
 - FFS RAs
 - ODM Web Portal
 - Email messages from Provider Associations and Trading Partners
 - Managed Care Plan provider field representative
 - Email Medicaid ICD-10 questions to: ICD10questions@medicaid.ohio.gov
- Practice coding in ICD-10. Providers who have indicated that coding staff discovered that practitioners need to include more detailed information in the medical record in order for the coder to properly code the claim.
- Ensure your vendors (HER/Clearing House) are compliant. Contact your vendors to see if you can test with them.
- Update your super-bill – some national provider associations are assisting with this.
- Train your staff. One option is the CMS sponsored Medscape Education ICD-10 Training Modules (Medscape.org). The modules are online, free and qualify for CME/CE credits.
 - Transition to ICD-10: Getting Started
 - ICD-10: A Roadmap for Small Clinical Practices
 - ICD-10: Small Practice Guide to a Smooth Transition
 - ICD-10: A Guide for Small and Medium Practices

o ICD-10: A Guide for Large Practices

Be cautious regarding where you receive ICD-10 information – inaccurate information has been disseminated.

Medicaid 2013 Primary Care Physician Rate Increase FAQ

In accordance with the Patient Protection and Affordable Care Act (ACA), certain physicians practicing primary care are 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 applicable Medicare rate during Calendar Years 2013 and 2014.

Am I eligible for the rate increase?

You are eligible if you meet one of the following criteria:

1. *You are board-certified in at least one of the following qualifying specialties or subspecialties:*
 - *A specialty in pediatric medicine*
 - *A specialty in family medicine*
 - *A specialty in internal medicine*
 - *A subspecialty of pediatric, family, or internal medicine recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association*
2. *You are board-certified in a non-qualifying specialty, but you provide qualifying primary care services in the community. For example, you are board-certified in surgery or dermatology but you practice in the community as a family doctor.*
3. *You are not board-certified, but at least 60% of the codes for which you received Medicaid payment in Calendar Year 2012 or Calendar Year 2013 were for qualifying Evaluation and Management (E/M) or vaccine administration services.*

You must self-attest that you meet at least one of these criteria. However, you must not self-attest to eligibility for higher payment if you do not actually practice in one of the listed primary care specialties or subspecialties. For more information, please visit <http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html>.

Do primary care services delivered by non-physician practitioners incident to a physician service qualify for the enhanced payment?

Yes, but in order to ensure that eligible physicians receive the enhanced payment for these services, the Ohio Department of Medicaid (ODM) will require that these services be billed under the supervising physician's Medicaid provider enrollment number appended with the appropriate non-physician modifier. Services billed under a non-physician Medicaid provider enrollment number will not be eligible for the enhanced payment. Independently practicing non-physician providers are not eligible for the enhanced payment.

Please Note: *On a January 23 conference call with state Medicaid entities, CMS clarified that this payment is intended for physicians only and that it is NOT intended for independently practicing non-physician providers (advanced practice nurses and physician assistants).*

I am a family physician who is board certified by the American Board of Family Medicine (ABFM) but I do not have a certification number. The MITS online application asks for one. How do I attest that I am board certified?

Physicians who are board certified by ABFM and do not have a board certification number should enter "not applicable" in the board certification number field.

When will the rate increase be in effect?

The ACA mandates that states pay the rate increase for qualifying services provided beginning January 1, 2013 through December 31, 2014.

What if I contract with fee-for-service Medicaid - when will I begin receiving the enhanced payments?

*Effective on July 1, 2013, physicians who are approved by ODM can expect to see increased payments for primary care services provided to Medicaid fee-for-service individuals. CMS has approved Ohio's State Plan Amendment (SPA) to implement the primary care rate increase. Claim adjustments for dates of service between January 1, 2013 and June 30, 2013 have started. Eligible providers will receive the first payment adjustment on February 26th for January 2013 claims. ODM will receive the next batch of adjustments on March 3rd. Providers will receive this payment adjustment on March 19th. This process will continue until all adjustments are completed. ODM is anticipating all of these adjustments will be completed by June 30th. ODM is still working on a solution for the July claims that providers did not receive the enhanced payments. ODM anticipates these adjustments will be completed by June 30th as well. **Qualified physicians approved by ODM who contract with a Managed Care Plan (MCP) will receive the enhanced payment directly from the MCP. These payments may be made retrospectively.***

What if I contract with a Managed Care Plan – when will I begin receiving the enhanced payments?

Managed Care Plans (MCPs) are obligated to begin paying the PCP enhanced payments to physicians who are approved by ODM once MCPs receive the PCP enhanced payment from ODM which is anticipated to be fall 2013. Once MCP enhanced payments to eligible providers begin, they must be made at least quarterly. MCPs have the discretion to make payments to eligible providers more frequently but not less frequently. For further details please contact MCPs directly.

What do I have to do to apply to receive the enhanced payments?

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 can apply beginning on January 1, 2013.

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>

If additional assistance is needed regarding signing up for a MITS account, please call the Medicaid Provider Call Center at 1-800-686-1516 (Monday – Friday 8 a.m. to 4:30 p.m.).

When will I know if I'm approved for the increase?

*Verification of attestation began on June 26th. On July 1, 2013 you will then receive an email stating whether you have been approved or denied for the enhanced payment. **An updated approved provider list will be posted to our website by February 17th.***

What is the deadline to self-attest in order to receive the enhanced payments?

*For physicians who self-attest from January 1, 2013 through May 1, 2013, the effective date for the enhanced payment, if approved, will be January 1, 2013. For approved self-attestations submitted **after August 16, 2013** or later, the effective date of the enhanced payment will be the date of self-attestation.*

What if I contract with a Managed Care Plan – how do I apply and who will pay me?

Providers must still apply to receive the enhanced payment through the MITS portal by self-attesting that they are an eligible primary care provider. Once ODM verifies that a provider is eligible, the MCP will receive notification of a provider's eligibility and the effective date of eligibility. The MCP will pay the provider the enhanced payment directly.

Medicaid Directors Discuss Issues with Associations

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

Ohio Department of Medicaid Launches Benefits Website

More Ohioans are now able to apply for [Medicaid benefits online](#). Children and pregnant women up to 200 percent of poverty and adults with income up to 138 percent of poverty may now apply for Medicaid coverage through the website. The new online enrollment options are part of a new eligibility system that Ohio launched on Oct. 1, 2013. Ohio Benefits is a simple, self-service website that makes it easier for Ohioans to learn what type of health care coverage may be available to them. Ohio's system is designed to interact with the [federal eligibility system](#), once all issues have been resolved at the federal level.

Ohioans who applied for health care benefits on the federal website (www.Healthcare.gov) but were denied because that system determined they might be eligible for Ohio Medicaid instead were notified by the federal government that an application was forwarded on their behalf to Ohio to determine Medicaid eligibility. However, because of glitches in [Healthcare.gov](http://www.Healthcare.gov), the federal government did not transfer those applications to the State.

The Ohio Department of Medicaid has received inquiries from Ohioans who, based on the federal notice, believed their application was pending at the State. Ohio Medicaid is responding to these inquiries to clarify that the federal government did not forward these applications and to encourage individuals who tried to apply on the federal site to now apply directly for Medicaid coverage online at [Ohio Benefits](#).

Potential Ohio Medicaid cases have been accumulating in the federal system since October. On December 10, the Ohio Department of Medicaid was notified by the federal government that Ohio can expect to receive Medicaid applications for more than 20,000 Ohioans from the federal system. Ohio is one of only seven states the federal government identified as ready to receive the federal cases. Ohio is prepared to receive these cases, but will take steps to minimize the impact on county Job and Family Services caseworkers related to the sudden influx of cases.

Medicaid coverage began on January 1 as planned for people who are eligible for the expansion group even if some of the applications are processed after January 1. This is because federal law requires Medicaid to cover allowable expenses in any of the three months prior to the date a person applies, so anyone found newly eligible with allowable expenses who applies before April 1, 2014 will be eligible for Medicaid coverage dating back to January 1, 2014.

UNITED HEALTHCARE

Enhanced HIPAA Edits to Be Applied to Claims Submissions

Effective April 23, 2014, UHC will apply an enhanced level of HIPAA edits to professional (837p) and institutional (837i) claims submitted electronically to most UHC and affiliate payer IDs. Because the new edits will be applied on a pre-adjudication basis, an increase in the number of claims rejections may occur. This will enable physician offices to identify and correct rejected information prior to the claim's acceptance into the UHC adjudication system for processing. This should result in fewer denied claims and less interruption of revenue streams. It will be important that physicians check their claim submission reports regularly – and claims may be rejected by a clearinghouse or UHC so a physician may receive multiple reports per submission. A primary impact will be from edits that will validate code sets (such as diagnosis, procedure, modifier and national drug codes) at a pre-adjudication level. The complete list of enhanced edits has been distributed to clearinghouses and software vendors. Rejections that may occur from the enhanced edits will appear at a clearinghouse level. Your Electronic Data Interchange (EDI) vendor of clearinghouse should be the first point of contact for assistance regarding the edits or to resolve rejections. For more information contact EDI support 1-900-842-1109.

Bureau of Workers' Compensation (BWC)

Ohio Bureau of Worker's Compensation Releases Latest Provider Publication – BWC Board of Directors Receives Data on Pharmacy Costs

The Ohio Bureau of Workers' Compensation (BWC) released the January 2014 edition of the Provider E-News January 2014 edition of *Provider E-News*, the agency's monthly newsletter to providers. Headlines included reminding providers that BWC will implement ICD-10 on time (Oct. 1, 2014) and asking providers to serve as testing partners for the conversion changes. Additionally, BWC's updated online Provider Billing and Reimbursement Manual will be available for release early this quarter. To view this publication [**click here.**](#)

In addition, the OBWC Board of Directors has learned that Workers Compensation Pharmacy Costs are down over \$20 million since 2011. This was achieved by reducing allowed opioid prescriptions, among other changes to the pharmacy management program. Opiate restrictions were put into place in 2010 and in 2012, an update to the program restricted most skeletal muscle relaxants, according to a BWC release. Comparing 2010 to 2013, the changes resulted in a 27% drop in opioid prescriptions and a 72% drop in muscle relaxant prescriptions. On Jan. 1, the newest mandate went into effect. It requires doctors to check the state's automated prescription reporting system (OARRS) before prescribing controlled substances if they're to be covered by BWC.

To view more information on this issue and the OBWC news release [**click here.**](#)



Verifying Patient Coverage in a Health Insurance Marketplace Plan

With the start-up of the Health Insurance Marketplace, also known as Health Insurance Exchange, over a million people will now have a new insurance plan. In many cases, this will be the first time they have had insurance in years. They may not have received their card yet or they may be unaware of the need to carry their insurance information so at times you may find your office needing to verify their coverage.

How do you verify their coverage?

If the marketplace in your state is run by the Federal government, it is best to call their plan's customer service line, a list of all plans and their customer service numbers can be found in this data base. Here's a

fact sheet for using the data base. If you can't find the number, call the Marketplace Call Center (1-800-318-2596).

If your state has its own health insurance exchange, contact your state. To find the website for your state exchange, select the name of your state in the box at the left hand side of the healthcare.gov website.

How else can you help your patient?

Remind your patients to keep all of their paperwork and receipts from all of their doctor's appointments and from the pharmacy as well. They may need them for their insurer. Remind them they should carry their card at all times. If they don't have a card, they can contact their plan to get a card.

If the patient is uninsured, they have until March 31st to sign up for non-employer based coverage. They can go to HealthCare.gov to sign up for a plan and apply for financial assistance. The vast majority of uninsured will qualify for financial assistance to reduce their costs. You can also download copies of fact sheets or educational material for your patients.

AMCNO Collaborates with HIMSS on Meaningful Use Regional Event

Recently, an event was held at the Global Center for Health Innovation where the Healthcare Information and Management Systems Society (HIMSS) hosted a session entitled "Beyond Stage 1 Meaningful Use". The AMCNO collaborated with HIMSS and other organizations to present the event which also included a networking reception which was held in the new HIMSS Innovation Center at the Global center where participants were given a tour of the facility including the many exhibits.

Presenters included Dr. David Kaelber, a practicing internist and pediatrician and the Chief Medical Informatics Officer of the MetroHealth System in Cleveland, Ohio, and the Director of the Center for Clinical Informatics Research and Education (CCIRE); Cathy Costello, JD who currently heads the Regional Extension Center program provided by the Ohio Health Information Partnership and its seven Regional Partners; Dan Paoletti, CEO of CliniSync and the Ohio Health Information Partnership; and Dr. Diane Butler, a board certified pediatrician and a member of the Academy of Medicine of Cleveland & Northern Ohio.

Topics of discussion included some of the major Meaningful Use changes beyond Stage 1 criteria. Participants were provided with resources, tools, guidance, and the practical know-how to continue on a successful path towards achieving Meaningful Use initiatives throughout 2014 and beyond.

Presentations during the evening included an overview of Meaningful Use Stage 2 criteria, an in-depth discussion on Clinical Quality Measures (CQMs), as well as information on Clinisync's statewide and local health information exchange initiatives.

Participants were provided with a wealth of information on what CMS Meaningful Use Stage 2 criteria need to be implemented in order to achieve Stage 2 MU criteria and attest for Stage 2 EHR Incentives, and which Clinical Quality Measures were required for Meaningful Use Stage 2, as well as new CMS reporting capabilities. During the discussion on CQMs participants were cautioned that before they start planning for 2014 to make sure to talk to vendors – this is a critical area of CQM – physicians need to know what their vendors can track clinically and whether or not they have the technology to track it. Participants were also offered a website to go to where they can search by vendor and product to obtain the certification information and what items each vendor is certified to do what and which CQMs they can track. There is a slow uptake on

certification of vendors for Stage 2 with just over 200 vendors certified at this time so it is imperative that physicians check out their vendor certification and capabilities. A panel discussion followed the presentations where presenters discussed best practices that can be utilized when working to achieve EHR meaningful use.

The AMCNO was pleased to be a participant and collaborator for this important event and we plan to work with HIMSS in the future on other regional initiatives.

Helpful websites mentioned during the presentations:

For information on vendors: <http://oncchpl.force.com/ehrcert?q=chpl>

For information on Stage 2 meaningful use and other resources:

<http://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2>

www.clinisync.org

<http://www.himss.org/meaningfuluse>

Physicians should also be aware that the Centers for Medicaid & Medicare Services (CMS) have extended the deadline for Stage 2 of the federal government's incentive program to encourage the adoption and meaningful use of electronic health records through 2016. The delay is intended to allow ONC and CMS to focus on helping providers meet the criteria of Stage 2, which include patient engagement, interoperability and information exchange, as well as use data collected during that phase to inform policy decisions for Stage 3. CMS and ONC said they will revise the meaningful use program's timeline so that Stage 3 will not begin until 2017. That means physicians who have completed at least two years in Stage 2 will have an extra year before they have to make the transition to the next level of requirements. The start of Stage 2 was Oct. 1 this year for those hospitals that had already met Stage 1 criteria for at least the prior two years. For physicians and other eligible professionals, Stage 2 began Jan. 1, 2014.

AMCNO Participates in “Start Talking” Kick-Off Event Featuring Lt. Governor Mary Taylor

AMCNO physician leadership were on hand for a regional kick-off event for Ohio's new youth drug abuse prevention initiative – “Start Talking” – a campaign which focuses on ways to reduce the likelihood of youth drug use before it even starts. “Start Talking” is inspired by research that shows youth are up to 50 percent less likely to use drugs when parents and adults talk with them about substance use and abuse.

The regional kick-off event was held at Mentor Ridge Middle School where Lt. Governor Mary Taylor was joined by a panel of presenters which included Senator John Eklund, Tracy Plouck, Ohio Mental Health and Addiction Services, Orman Hall, Ohio Department of Drug and Addiction Services and representatives from the school administration and law enforcement.

Presenters stressed the importance of implementing prevention strategies to curb the use of opiates among youth. The campaign features four programs aimed at preventing and reducing drug abuse, including prescription drug abuse, among youth. The Start Talking has two main themes – stressing resiliency and self-confidence for young people to make the right decisions and implement prevention strategies to curb the use of opiates. The program encourages physicians, parents, teachers, coaches and other adults to talk openly to children about drugs. The plan is to engage adults in the community to interact with young people and talk about the dangers of drug use.

Lt. Governor Mary Taylor stated that Governor Kasich has focused on the opiate abuse issue since the beginning of his administration and he immediately began to address this important issue by working with the

medical community and others to establish new guidelines for physicians to utilize in the emergency room and in their practice. The Governor has now launched the “Start Talking” initiative in order to focus on preventing and reducing drug abuse in youth. She thanked Governor Kasich for recognizing this important issue and encouraged everyone in the State to get behind this initiative in order to help young people make the right decisions.

The AMCNO supports any effort that will eliminate opiate abuse and we plan to work with the state agencies to promote the program to the Northern Ohio community and to our members. The AMCNO was integrally involved in the Governor’s Cabinet Opiate Action Team (GCOAT) in the development of the opioid prescribing guidelines and statistics were mentioned during the “Start Talking” event which show that the health care community has already made strides to address this problem with a 41% decline in the number of Ohioans exposed to high doses of prescription opiates. However, there is more that can be done to address this issue and the AMCNO plans to continue to work with the Governor and the state agencies to promote the prescribing guidelines for physicians as well as the “Start Talking” initiative. To learn more about the “Start Talking” campaign, visit www.StartTalking.Ohio.Gov. To learn more about the opioid prescribing guidelines visit opioidprescribing.ohio.gov

The Ohio State Board of Pharmacy Can Now Provide Patient Information to Prescribers

The Ohio State Board of Pharmacy has announced that prescribers can now obtain a Practice Insight Report from the Ohio Automated Rx Reporting System (OARRS). This report provides prescribers with easy access to information about their patients including which patients are visiting multiple prescribers and which patients have the highest morphine equivalent doses. In addition the report can provide a list of the drugs most commonly prescribed by the clinician as well as a list of the clinician’s patients that have received a prescription for an OARRS reportable drug in the past year.

The Ohio State Board of Pharmacy noted that the Practice Insight Report was designed to provide prescribers with a wealth of new information. Additionally, the Ohio State Board of Pharmacy expects additional information to be added to the Practice Insight Report over the coming months and years as new sources of data become available.

To access your Practice Insight Report follow these simple steps:

- Step 1: After logging into OARRS, press the “Submit” link in the Requests Menu. This is the same link you press to request a Patient Rx History Report.
- Step 2: In the upper left-hand corner of the request screen, above where you would enter your patient’s last name, there is a drop-down box that currently says “Patient.” Change this to “Practitioner.” After the screen changes, press the “Submit” button. There is no need to enter any additional information; the form is pre-populated.
- Step 3: After your request has been submitted, click “View” from the requests menu. You will now see your “Practitioner” request listed among your normal “Patient” requests. Within a minute or two, your report will be ready for you to review.

The Ohio State Board of Pharmacy has designed this report in order to provide prescribers with additional new information, however, they Board is also aware that physicians would like to be able to access additional information from the OARRS system. As a result, the Board plans to make new sources of data available in the future. Also please note that the Practice Insight Report is run based on the DEA number that you provided on your OARRS registration. If you did not provide this number, or if it is out of date, please contact the Ohio State Board of Pharmacy at info@ohiopmp.gov to update your information.

The AMCNO is pleased to see that these reports are now available and in fact the AMCNO made several suggestions about possible OARRS changes in our recent testimony to the legislature and in a joint letter sent to the legislature by the AMCNO and other medical associations. One of our suggestions was for the OARRS program to initiate unsolicited reports for physicians – and the AMCNO believes that the Practice Insight Report now offered by OARRS is a step in the right direction. Some of the other AMCNO suggested enhancements to the OARRS system were as follows:

- Consider avenues to maintain sufficient funding for the OARRS program over time and conduct periodic review of the OARRS performance to ensure efficient operations and identify opportunities for improvement,
- Integrate OARRS data with electronic health records, health information exchanges, and pharmacy dispensing systems to facilitate prescriber and dispenser access, and assist in letting prescribers and pharmacists communicate electronically,
- Encourage the OARRS program to implement the use of physician memos or scorecards to provide physicians that are checking the database with information as to where they match up with their peers and show if they may be an outlier with their prescribing to patients.

The Pharmacy Board encourages OARRS users to provide feedback and suggestions regarding their reports or other system improvements. The AMCNO will continue to advocate for additional changes to the OARRS system. AMCNO members are also encouraged to send their suggestions regarding OARRS improvements to info@ohippmp.gov or send your suggestions to the AMCNO staff at abell@amcno.org and we will forward them to the Board of Pharmacy.

Joint SGR Repeal Bill Moving Through Congress

New joint legislation to repeal Medicare's failed SGR formula is advancing to both chambers of Congress following an agreement announced by the three committees. The agreement was reached by the U.S. House Energy and Commerce Committee, the U.S. House Ways and Means Committee, and the U.S. Senate Finance Committee and the congressional Doctors Caucus which showed bipartisan support for eliminating the flawed SGR program. In addition to repealing the SGR formula, the bill includes automatic positive payment updates of 0.5 percent for five years, a consolidated and restructured Medicare quality reporting program, and transitions to alternative payment models. Congress now has to act before the March 31 deadline, at which point the SGR formula calls for a 24 percent cut to physician payments. The AMCNO will continue to provide information on this issue as the discussion continues.

Ohio Takes the Next Step to Reward Better Health Outcomes

Over the past 12 weeks, OHT convened more than 100 clinical professionals, including an AMCNO board member, for 19 meetings to design and discuss how to improve value in 5 high-cost episodes of care. The results are being used by Anthem, Aetna, Medical Mutual of Ohio, UnitedHealthcare and five Medicaid health plans as a starting point for future performance reporting and reimbursement changes that reward better care. To view an overview of the results [click here](#).

Ohio State Medical Board Promulgates New Regulations With Respect To The Termination Of A Physician-Patient Relationship And The Notification Of Patients When A Physician Leaves A Medical Practice.

By: John Mulligan, Esq., McDonald Hopkins, LLC

On December 13, 2013 the Ohio State Medical Board promulgated final regulations with respect to the process whereby Ohio physicians can terminate a physician-patient relationship. These regulations also addressed the

notice of termination that a physician or a physician group must provide where a physician leaves a practice, sells a practice, or retires from the practice of medicine. These regulations amend existing Board regulations, and follow a statute enacted by the Ohio General Assembly in March, 2013 which dealt specifically with the notice that must be delivered to patients where a physician's employment with a health care entity is terminated. The new regulations were effective December 31, 2013.

In addition, the Board published FAQs that provide additional information concerning the new regulations.

Compliance with these regulations is mandatory. Violations can subject a physician to disciplinary action by the Board.

1. Regulation Relating to the Termination of the Patient-Physician Relationship. (Ohio Administrative Code Section ("OAC") 4731-27-02.)

The amended regulation is largely unchanged from the prior regulation. It provides that a physician who desires to terminate a physician-patient relationship must send a notice to the patient that includes all of the following:

- (a) A statement that the physician-patient relationship is terminated.
- (b) A statement that the physician will continue to provide emergency treatment and access to services for up to thirty days from the date the letter was mailed to allow the patient time to secure care from another licensee.
- (c) An offer to transfer records to a new provider upon the patient's signed authorization.

In the FAQs that accompanied the new regulation, the State Medical Board made it clear that the term "emergency treatment and access to services" does not mean that, after providing notice, the physician is required to see the patient for routine medical services. However, the physician is required to provide emergency care to the patient.

According to the FAQs, the phrase "access to services" generally contemplates that the physician will provide the patient a short-term prescription for maintenance medication. The phrase "for up to thirty days" anticipates that there may be situations where a patient's actions or threats may compromise the safety of the physician and/or office staff. Under these circumstances, the physician may terminate the physician-patient relationship immediately and is not required to provide further services. These are welcome clarifications to the regulation.

The notice can be sent in one of two ways:

- (1) Via certified mail, return receipt requested to the last address for the patient on record. A copy of the letter, the certified mail receipt, and the mail delivery receipt must be maintained in the patient record;
or
- (2) Via electronic message sent using a HIPAA compliant electronic medical records system or HIPAA compliant electronic health records system that provides a means of electronic communication. However, if the electronic message is not viewed within ten (10) days of having been sent, then a certified letter must be sent.

The requirement to provide this notice does not apply in the following common situations:

- (1) Where the physician rendered medical service on an “episodic basis or in an emergency setting”, and the physician should not reasonably expect that related medical services will be rendered by the physician to the patient in the future.
 - (2) Where the physician formally transferred the patient’s care to another health care provider who is not in the same practice group.
 - (3) Where the termination of the relationship is because physician is leaving a practice, selling a practice, retiring from medical practice, or whose employment with a health care entity has ended for any reason – in these situations a notice described below in this article must be sent.
 - (4) When the patient has terminated the relationship, either verbally or in writing or has transferred care, and the physician maintains documentation of the termination in the patient’s records.
2. Notification Requirements in a Situation in Which a Physician Departs From a Group Practice Due to Resignation, Involuntary Termination, or Retirement. (OAC Section 4731-27-03, and Ohio Revised Code Section 4731.228.)

When a physician leaves a group practice, notice must be sent either via regular mail to the last address of the patient on record, with the date of mailing of the letter documented in the patient’s file, or by an electronic message sent via a HIPAA compliant electronic medical records system, or a HIPAA compliant electronic health records system.

The obligation to provide notice rests with the practice. However, the practice may require that the physician make the notification. In such case, the practice must provide the physician with a list of the patients and the patient contact information. The physician must then provide the notice either via regular mail or via a HIPAA compliant electronic method. In addition, the physician “may, but is not required to” publish a notice of termination in local newspapers.

Taken in combination, the requirements of the regulation and the statute obligate the group or the physician to provide notification to patients the physician has seen within the prior two years (except those seen in an emergency or episodic basis) in the following three circumstances:

- (1) Where an employed physician’s employment with the group terminates unless the physician continues to provide service to the practice as an independent contractor.
- (2) Where a physician who is an independent contractor of the practice terminates that relationship with the practice.
- (3) Where the physician has an ownership interest in the entity and terminates that ownership interest – it may be that this was intended to deal with a partnership or a limited liability company situation in which the physician was not, technically, an “employee” of the practice.

The notice must include the following:

- (a) A statement that the physician will no longer be practicing medicine with the practice.
- (b) The date on which the physician ceased or will cease to provide medical services at the practice.

- (c) If the physician will be practicing medicine in another location, contact information based on information provided by the physician. The requirement to provide this contact information does not apply where the practice has a “good faith concern that the physician’s conduct or the medical practice provided by the physician would jeopardize the health and safety of patients” The statute contains no other exceptions – for example, there is no exception for a situation in which the departing physician will be practicing in violation of a covenant not to compete.
- (d) Contact information for an alternative physician or physicians employed by the practice, or contact information of a group practice that can provide care for the patient.
- (e) Contact information that enables the patient to obtain information on the patient’s medical records.

There seems to be an inconsistency between the requirements of the regulation and those of the statute in terms of the timing of the notice. Ohio Revised Code Section 4731.228, relating to the termination of “employment” of a physician, provides that the notice must be sent not later than the later following two events:

- (1) The date of the termination of employment of the physician; or
- (2) Thirty (30) days after the practice “has actual knowledge of termination or resignation of the physician”

On the other hand, if the terminating physician is a partner in the practice, or a member of a limited liability company (which would mean that, technically, the physician was not an “employee” of the practice), then the notice is governed by OAC Section 4731-27-03. In this case, the notice must be sent not later than the earlier of the following two events:

- (1) Thirty days prior to the last day the physician will see patients; or
- (2) Upon actual knowledge by the practice that the physician “will be leaving, selling, or retiring from” the practice.

This inconsistency gives rise to a couple of questions:

- Why should there be a timing difference at all?
- What if a physician is a shareholder-employee of a practice structured as a corporation? Is the physician an “owner” and thus OCR Section 4731-27-03 and its notice requirement applies, or is the physician an “employee” and thus R.C. Section 4731.228 applies?

Taken literally, this would appear to mean that if a physician who was a partner in a partnership or member of a limited liability company (and, perhaps, a shareholder-employee of a corporation) had announced to the practice an intent to resign one year hence, the required notice would need to be given to patients at that point. Whether this was the intended consequence of this regulation is not clear. Often physicians and practices prefer not to provide such lengthy notice. Practices should be more cognizant of the notice requirements when discussing possible retirements or transitions with physician owners.

Medical groups should review their physician employment contracts to confirm that the provisions in those contracts are consistent with current Ohio statutory law and regulation.

3. Patient Notification Requirements in a Situation in Which the Physician is Terminating a Solo Medical Practice. (OAC Section 4731-27-03.)

In a situation in which a physician is retiring from or otherwise terminating a solo practice (regardless of whether the practice is simply being closed or was sold to someone else with the selling physician no longer practicing) there are patient notification requirements. In such case, notice to the patients is to be sent by regular mail to the last address for the patient on record with a date of the mailing of letter documented in the patient's file. An electronic message sent via a HIPAA compliant electronic medical record system is also permitted.

The notice must be sent no later than thirty days prior to the last day the physician will see patients or upon actual knowledge that the physician will be leaving, selling, or retiring, whichever is earlier. As mentioned above, this would create an issue, for example, for a physician who has informally established in his or her own mind a somewhat far-off retirement date. At what point must the notice be given? At what point does the physician's future planning process become "actual knowledge" of retirement? In the case of a physician who, due to acute illness or unforeseen emergency is unable to provide the advance notice, the notice is to be provided not later than thirty days after it is determined that the physician will not be returning to the practice.

The patients to whom the notice must be sent are those to whom the physician had provided services in the two year period prior to the last day the physician will see patients.

The notice must include all of the following:

- (a) A statement that the physician will no longer be practicing medicine at the location.
- (b) The date on which the physician cease or will cease to provide medical services.
- (c) Contact information for an alternative physician or physicians who could provide care for the patient.
- (d) Contact information that would enable the patient to obtain information in the patient's medical records.

These requirements do not apply in a situation in which the physician provided services only on an episodic basis or in an emergency department or urgent care center when it would not be reasonably expected that related medical service would be rendered by the physician to the patient in the future. John T. Mulligan (216/348-5435 – jmulligan@mcdonaldhopkins.com).

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

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



Medical Records Fact Sheet - New Fees Effective January 2014

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Current Opinion **7.05**. Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.742** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2014, the maximum fees that may be charged, are as set forth below.

(1) The following maximum fee applies when the request comes from a patient or the patient's representative.

- a) No records search fee is allowed;
- b) **For data recorded on paper or electronically:** \$3.02 per page for the first ten pages; \$0.63 per page for pages 11 through 50; \$0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: \$2.07 per page
- c) Actual cost of postage may also be charged

(2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.

- a) A \$18.61 records search fee is allowed;
- b) **For data recorded on paper or electronically:** \$1.22 per page for the first ten pages; \$0.63 per page for pages 11 through 50; \$0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: \$2.07 per page

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| <p>c) The actual cost of postage may also be charged. Ohio Law requires the Director of Health to adjust the fee schedule annually, with the adjustment to be not later than January 31st of each calendar year, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext. 102.</p> |
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The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

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