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THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO
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Update on the Advisory Committee on Real Time Adjudication and Eligibility

AMCNO Provides Physician Input

In recent months, the AMCNO has been actively involved in an advisory committee set up by the Ohio Department of Insurance (ODI) under HB 125 to address the issue of standardizing communications between doctors and insurance companies in Ohio. AMCNO board member **Dr. Larry Kent** is a member of the committee and AMCNO key staff has also been participating in the meetings on a regular basis.

The task of the advisory committee members, which were appointed by Insurance Director Mary Jo Hudson, is to recommend communication standards between doctors and insurance entities to the Ohio General Assembly. These standards will enable a medical provider to send and receive from insurance entities and other payers sufficient information to enable that provider to determine at the time of the enrollee's visit the enrollee's eligibility for services. Standardized real time adjudication of provider claims for services would also be handled at this time. The report of the findings and recommendations of the Advisory Committee, which was formed pursuant to Substitute House Bill 125, is due by January 1, 2009. The Advisory Committee includes a wide cross-section of members representing insurance entities, employers, medical providers, consumers, technology vendors and the Governor's Office of Information

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If you have not already done so through the weekly AMCNO email communication to our members, please be sure to fill out the AMCNO Physician Charity Care survey included in this issue.

Access to a Medical Home Initiative

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been a participant in recent meetings on the Access to a Medical Home Initiative. The objective of the Access to Medical Home initiative is to determine the scale of uninsured, underinsured and Medicaid-covered individuals living in Cuyahoga County using local emergency departments for non-urgent care of their chronic conditions. The access to a medical home initiative study is funded by the Saint Luke's Foundation.

The rationale for the specific focus of the study is to select a captive patient population that represents a manageable subset of uninsured, underinsured and Medicaid populations with the potential to collaboratively address this issue among the hospital systems, safety net providers and managed care organizations. It is hoped that there will be an ability to highlight issues facing Cuyahoga County in efforts to address healthcare access, utilization and cost related to these target populations. The study is meant to develop a business case on the initiative but it does not include funding for implementation. However, the final report will include recommendations on how to tackle this issue with an objective to re-direct these patients to continuous care through the use of a medical home.

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***Dr. Raymond Scheetz,** AMCNO President, (left) spends a moment with staff from the Office of Health and Human Services working on the medical home initiative, Mr. Rick Werner, Deputy County Administrator, and Sabrina Roberts, Administrator of Health Policy and Programs.*

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AMCNO ADVOCACY ACTIVITIES

Update on the Advisory Committee on Real Time Adjudication and Eligibility

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Technology that are potentially affected by standardizing this exchange of information.

To date, the meetings have included a presentation from the Council for Affordable Quality Healthcare (CAQH). CAQH has been working with multi-stakeholder groups on a national level through a Committee on Operating Rules for Information Exchange (known as CORE) to answer the question "why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?" The short-term goal of CORE is to design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits with an eye on a long-term goal of applying an operating rule concept to other administration transactions in the claims process, using a phased approach. The mission of CORE is to build consensus among the essential healthcare industry stakeholders (they currently have participation from 75% of the commercially insured plans plus Medicare and some Medicaid) on a set of operating rules that facilitate administrative interoperability between health plans and providers. The ODI advisory committee is currently reviewing the CORE initiative as a part of their deliberations.

Other meetings of the advisory committee were devoted to presentations from insurance companies operating in Ohio to obtain additional information regarding how they were handling eligibility and real time claim adjudication and ask for their input and recommendations for the committee. In addition, there were two presentations from vendors providing practice management services for physicians and hospitals as well as real time adjudication and eligibility information.

The advisory committee is continuing to meet and has developed three subcommittees to further evaluate the issues involved in real time eligibility and claim adjudication. The committees are reviewing business process changes and adoption, dispute resolution issues and technology issues. As a part of the review process, it was determined that there was a need to obtain additional information from physicians around the state to get an idea of how many physicians verified insurance information online, what their computer capabilities were in their offices as well as obtain data with regard to the software utilized by physicians in Ohio. To obtain this information the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), along with other professional associations in Ohio sent out a survey to our members to obtain input on the issue of verifying patient's insurance eligibility. This information is being tabulated and will be utilized by the advisory committee as they continue to meet through the end of 2008.

The ODI now has a link on their Web page for this endeavor which includes testimony and presentations to the advisory committee along with other background information. Physicians interested in learning more about the work of the advisory committee can go to http://www.ohioinsurance.gov and scroll down to the HB 125 forum under featured links — all of the documents and presentations discussed at these meetings are posted on the site. ■

Access to a Medical Home Initiative

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Consultants have been hired to work on the study and meetings have taken place with hospital providers and participants in various access initiatives. In addition, a consumer survey of almost 500 Cuyahoga County residents that use local emergency departments for non-urgent care of chronic disease has been conducted as a part of the study. The data will be aggregated and a final report will be compiled and made available in coming months. The AMCNO is working with the county staff to prepare an article for inclusion in the January/February issue of the *Northern Ohio Physician* magazine on the results of the study. ■

CLASSIFIEDS

Enforcement Activities and Litigation Target Low Out-of-Network Reimbursement Rates

In recent years, patients who have received services on an out-of-network basis, as well as the physicians, hospitals and other healthcare providers who have provided these services, have expressed frustration with the low reimbursement levels paid by managed care plans and the corresponding shift of financial responsibility to patients and their healthcare providers.

This article discusses several recent enforcement activities and litigation aimed at reducing the financial burdens facing patients who find it necessary to obtain healthcare services from out-of-network providers.

Background

It is common for a managed care plan to offer its members the opportunity to obtain healthcare services either within the managed care plan's network or outside the network, but with financial incentives to encourage the members to use healthcare providers within network. Healthcare providers who have not contracted, directly or indirectly, with a managed care plan to provide services at the discounted rates for network providers typically do not participate in the plan's network and are commonly referred to as "out-of-network" or "nonparticipating."

Reimbursement disputes between patients and out-of-network healthcare providers, on the one hand, and managed care plans, on the other hand, often focus on the determination of a rate intended to reflect prevailing charges within the market for comparable services and commonly referred to as "reasonable and customary," "usual and customary" or "usual, customary and reasonable" ("UCR" for short). Managed care plans typically pay out-of-network healthcare providers the lesser of the amount charged by the provider or a specified percentage of the UCR as determined by the managed care plan. The patient will be responsible for the difference between the payment from the payor and the provider's charges. For example, if a managed care plan pays 80% of UCR for out-of-network services, the provider's charge is $5,000 and the managed care plan determines that UCR is $3,000, then the managed care plan would pay $2,400 and the patient would be responsible for the remaining $2,600 in fees (and possibly more, depending on whether a deductible applies).

Out-of-network providers often complain that the UCR amounts utilized by managed care plans underestimate market rates. The patient then faces an out-of-pocket payment amount which is typically larger than anticipated and may create financial hardship for the patient and often indirectly for the healthcare provider as well. Insurers and administrators of managed care plans, on the other hand, defend the right of payors to determine the method for determining reimbursement and identify the UCR process as an important cost-containment tool.

This debate has prompted an ongoing investigation by the Attorney General of New York State and a class action settlement by Health Net, as well as lawsuits against various health plans, including pending cases filed by the American Medical Association and other plaintiffs, by a dialysis provider against Blue Cross and Blue Shield of Georgia, and by a health plan subscriber against Ingenix and some health plans. These developments are discussed briefly below.

New York Investigation

New York Attorney General Andrew Cuomo announced on February 13, 2008, that he intends to sue five United Healthcare companies and is investigating other prominent health insurance companies for defrauding consumers by underestimating the UCR, resulting in underpayments for out-of-network healthcare services and requiring patients to cover a higher share of the costs.

The investigation focuses on Ingenix, Inc., a United Healthcare subsidiary that maintains a database of healthcare billing information used by most major health insurance companies to determine UCR rates and is the largest provider of such information in the U.S. The Attorney General expressed concern that the status of Ingenix as a United Healthcare subsidiary creates a conflict of interest by giving Ingenix an incentive to set low UCR rates. The Attorney General's press release noted that this conflict and the use of inaccurate data "clearly demonstrate a broken reimbursement system designed to rip off patients and steer them towards in-network doctors that cost the insurer less money."

The New York Attorney General also announced that he issued subpoenas to sixteen of the largest health insurance companies in the nation, requesting information on how the companies compute UCR rates, copies of complaints and appeals of members, and communications with members on these calculations.

Health Net Settlement

On August 8, 2008, a federal court judge approved a $255 million settlement of three class action lawsuits against Health Net based on allegations that the company underpaid out-of-network claims due to errors in the Ingenix database. The alleged flaws include use of data voluntarily submitted by insurers, removal of high charges from the calculations without determining the validity of the charges, and inaccurate use of CPT codes.

As part of the settlement, Health Net agreed to change its business practices to promote transparency in the out-of-network claims process, including steps to end its use of flawed Ingenix databases, pay rates above those calculated based on Ingenix data, provide more accurate coverage information, help patients obtain accurate information on UCR charges prior to treatment, negotiate charges prior to treatment and establish an independent appeals process for UCR determinations.

Pending Litigation

The AMA and other plaintiffs filed a class-action lawsuit in 2000 against various United Healthcare companies as well as Met Life and American Airlines challenging the calculation of UCR by Ingenix as flawed. The plaintiffs filed a Fourth Amended Complaint in July, 2007, alleging that the Ingenix databases systematically result in inaccurate and reduced UCR amounts. The complaint further alleges (among other things) that the United Healthcare companies breach their contractual and fiduciary obligations by making UCR determinations without valid or appropriate data to support reduced payments, automatically reducing coverage for multiple procedures performed on the same day, and failing to disclose their UCR data and the basis for their determinations. On August 22, 2008, the court dismissed some claims but allowed other claims to proceed.

In January, 2008, the National Renal Alliance, which owns and operates 43 dialysis centers in the U.S., announced that it filed a complaint

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Enforcement Activities and Litigation Target Low Out-of-Network Reimbursement Rates

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in a federal court in Atlanta against Blue Cross and Blue Shield of Georgia, alleging that the insurer refused to contract at fair rates and underpaid for out-of-network care when it cut out-of-network reimbursement by 88%. The complaint was amended in February, 2008, to include allegations that insurer manipulated UCR rates to deny out-of-network benefits to dialysis patients.

A health plan subscriber, Jeffrey Weintraub, filed a class action lawsuit in April, 2008, alleging that Ingenix and various health plans conspired to fix low UCR rates between 2004 and 2008 based on flawed Ingenix data and to conceal information from subscribers.

* * *

While it is too early to predict the outcome of the investigation and pending litigation, these developments have the potential for providing some clarity to the process of determining reimbursement amounts for out-of-network healthcare services and reducing the financial hardship facing consumers who find it necessary to use out-of-network providers. Healthcare providers, insurers, administrators and patients may therefore find it worthwhile to monitor these developments, as well as future litigation and regulatory actions which are likely to follow, for their impact on out-of-network healthcare providers and their patients, while keeping in mind that developments may be specific to particular circumstances or limited to a particular state and therefore may not necessarily apply in other states or in different circumstances. ■

AMCNO Reviews Out-of-Network Issue

As noted in this article, there is litigation taking place around the country that will impact the out-of-network issue. One of those suits is being prosecuted by attorney David Scott with the firm Scott + Scott. The AMCNO lobbyist, staff and physician leadership have had the opportunity to discuss this case directly with Mr. Scott. His plaintiff is a plan member of a health care plan from Aetna insurance. Part of the claim in this case is that the plaintiff is a fiduciary under ERISA. The Plaintiff's plan allowed him to go "out-of-network" for services and then he would be refunded for such services at an amount equal to 80% of the "usual and customary rate" for services in that area.

However, to determine that usual and customary rate ("UCR"), Aetna uses a database maintained by Ingenix, a wholly owned subsidiary of UnitedHealth Group, that contains information (provided by the insurance companies themselves) which generates intentionally low and artificial rates not actually related to the true amount paid. Therefore, the Plaintiff (and physician) is under-reimbursed for those services. As an example, an insured may pay $200 for an out-of-network doctor's visit. The number generated by Ingenix and provided to the insurer could say, for example, that the UCR for that service is only $80, therefore reimbursing the insured only 80% or $64. The insured therefore must pay $136 for the doctor's visit. In the case, Mr. Scott has alleged that Aetna, and its co-conspirators (major national insurance companies) worked together to create and maintain this database, a violation of antitrust laws, in order to grossly underpay the class of insureds and that Aetna, in particular, breached its fiduciary duties under ERISA to Plaintiff and other Aetna insureds.

The case is in the preliminary stages. Defendants have raised issues about the Plaintiff's complaint and the Court has allowed Mr. Scott to amend the complaint before it decides the merits of Defendants' claims. The AMCNO will continue to monitor this case and provide additional information to our membership.

NORTHERN OHIO PHYSICIAN

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Infantile Nystagmus Syndrome

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SEARCH TERMS:
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Introduction
Infantile nystagmus syndrome (INS), also known as congenital nystagmus, is common and usually occurs in isolation, although it can be associated with other nervous or visual system abnormalities. It is characterized by abnormal ocular oscillations that are often first noted at the time of birth or in infancy. While patients may be asymptomatic, visual acuity is often decreased as a result of the constant eye oscillations. Significant progress has recently been made in understanding the pathogenesis of INS and in developing treatments. In this article, we review INS, focusing on the clinical features, investigation findings, and therapy options.

Clinical Features
INS is characterized by the presence of to-and-fro eye oscillations called ***nystagmus.*** The eye oscillations may have a sinusoidal (pendular) or jerk waveform, where there are slow and quick phases (Fig. 1). Whereas the entire eye movement is abnormal in pendular waveform infantile nystagmus, only the slow phase is abnormal in the jerk waveform; the slow phase moves the eye away from the fixation target, while the quick phase, a compensatory saccadic (rapid) eye movement, brings the eye back onto the fixation target (Fig. 1). Unlike acquired forms of nystagmus due to neurologic illness, the waveform of infantile nystagmus is often complex, commonly being punctuated by brief periods where the eyes remain still, with the line of sight directed towards the fixation target, called ***foveation periods*** (Fig. 1). When foveation periods are present, visual acuity is frequently normal or near normal, as it is during these periods that the patient is able to clearly see the fixation target. Surprisingly, patients with well-developed foveation periods often do not complain of ***oscillopsia*** (the perception that the visual world is in motion), despite almost continuous movement of their eyes.

The nystagmus of INS is predominantly horizontal, but often has torsional (rotational) and smaller vertical components that can be difficult to detect clinically. Usually the nystagmus is conjugate (the eyes move synchronously in the same direction), although it can sometimes be dysconjugate, as in the see-saw variant, where one eye moves up while the other eye moves down. The nystagmus is often more prominent when attempting to fixate a distant target or if the patient is anxious, whereas it is usually less prominent when the patient converges to look at a near target or with eye closure. In many cases, the nystagmus is minimized when the eyes are positioned at a particular gaze angle that is known as the ***"null" position*** or zone. Patients may unconsciously adopt a head turn in order to keep their eyes in this position, to minimize the nystagmus and maximize their visual acuity.

INS most commonly occurs in isolation, but it can be associated with abnormalities of the retina, optic nerves, or optic chiasm, such as oculocutaneous albinism, achromatopisa ("color blindness"), optic atrophy, optic nerve hypoplasia, achiasma (absence of the optic chiasm), and a variety of retinal abnormalities including Leber's congenital amaurosis and congenital stationary night blindness. Infantile nystagmus is often a feature of septo-optic dysplasia, a distinctive syndrome characterized by optic nerve hypoplasia and hypoplasia or absence of certain midline brain structures, such as the septum pellucidum and corpus callosum, and pituitary gland (Fig. 2). Patients with septo-optic dysplasia often have visual field defects, such as bitemporal hemianopia (Fig. 2), and endocrine deficiencies. Up to a third of patients with infantile nystagmus have coexisting strabismus. INS can occasionally be familial, with autosomal-recessive, autosomal-dominant, and x-linked modes of inheritance reported.

Investigations
The first step in the investigation of a patient with suspected INS is a neuro-ophthalmologic assessment, including assessment of visual acuity, visual fields, color vision, fundi, and eye movements. Ideally, the patient should be assessed by a neuro-ophthalmologist or a pediatric ophthalmologist. Adequate assessment of the patient's visual system is important, as response to treatment partly depends on the severity of associated afferent visual system abnormalities.

An extremely important part of the assessment is to record the patient's eye movements, in order to determine the waveform and components of the nystagmus. This is particularly important when there is uncertainty about the diagnosis, as in an adult who is incidentally noted to have nystagmus. Eye movements can be recorded using a variety of non-invasive techniques, such as with infrared electro-oculography or the magnetic search coil technique. Identification of a characteristic INS waveform confirms the diagnosis.

Most patients with INS do not require further investigations unless other visual, neurologic, or systemic abnormalities are identified or suspected. Structural abnormalities of the anterior visual system, brain, and pituitary gland are best detected using magnetic resonance imaging (MRI). Electrophysiologic tests, such as electroretinography, may be necessary to detect abnormalities of retinal

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Infantile Nystagmus Syndrome

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function. Endocrinologic evaluation is required in those patients with pituitary abnormalities.

Treatment

A number of effective treatments for INS have recently been identified, including surgical and medical treatments. A surgical treatment was proposed by our colleague, Dr. Lou Dell'Osso, after he serendipitously discovered that strabismus surgery had a beneficial effect on INS. In the currently recommended surgical treatment, ***tenotomy,*** selected extra-ocular muscles are severed from the eye at their tendinous attachments and then reattached at their original positions. Tenotomy can be combined with conventional strabismus surgery if there is coexisting strabismus. Tenotomy has been shown to damp nystagmus, prolong foveation periods, and increase the range of the "null" zone of the nystagmus. The means by which it works is unclear, although it is thought to be due to modulation of proprioceptive feedback from the extra-ocular muscles.

Medical therapy using gabapentin and memantine has recently been shown to reduce the intensity of the nystagmus, prolong foveation periods, and improve visual acuity in patients with INS. Patients with afferent visual system abnormalities are less likely to improve than those who have normal visual systems. Tenotomy and medical therapies act by different mechanisms and can therefore be combined in selected cases.

In summary, infantile nystagmus is a common and usually isolated finding that is often detected in infancy, but may remain undetected until later in life. Less often, it can be associated with disorders of the afferent visual system, brain, and pituitary gland. Eye movement recordings are the single most important test used to confirm the diagnosis. Depending on the patient's symptoms and degree of visual deficit, surgical treatment with tenotomy and/or medical treatment with gabapentin or memantine may be beneficial.

Editor's note: *The AMCNO welcomes article submissions from our members. The* Northern Ohio Physician *does not obtain medical reviews on articles submitted for publication.*

AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Debbie Blonski at the AMCNO offices at (216) 520-1000, ext. 102. ■

Figure 1: Typical nystagmus waveforms seen in infantile nystagmus syndrome. The jerk waveform (top) is characterized by a slow phase (thin arrow), which typically increases in velocity with time, and a corrective quick phase (thick arrow) that brings the eye back onto the fixation target. The pendular waveform (middle) is sinusoidal without quick phases. More complex waveforms (bottom) are also commonly seen, such as a pendular waveform that has superimposed foveation periods (arrowheads).

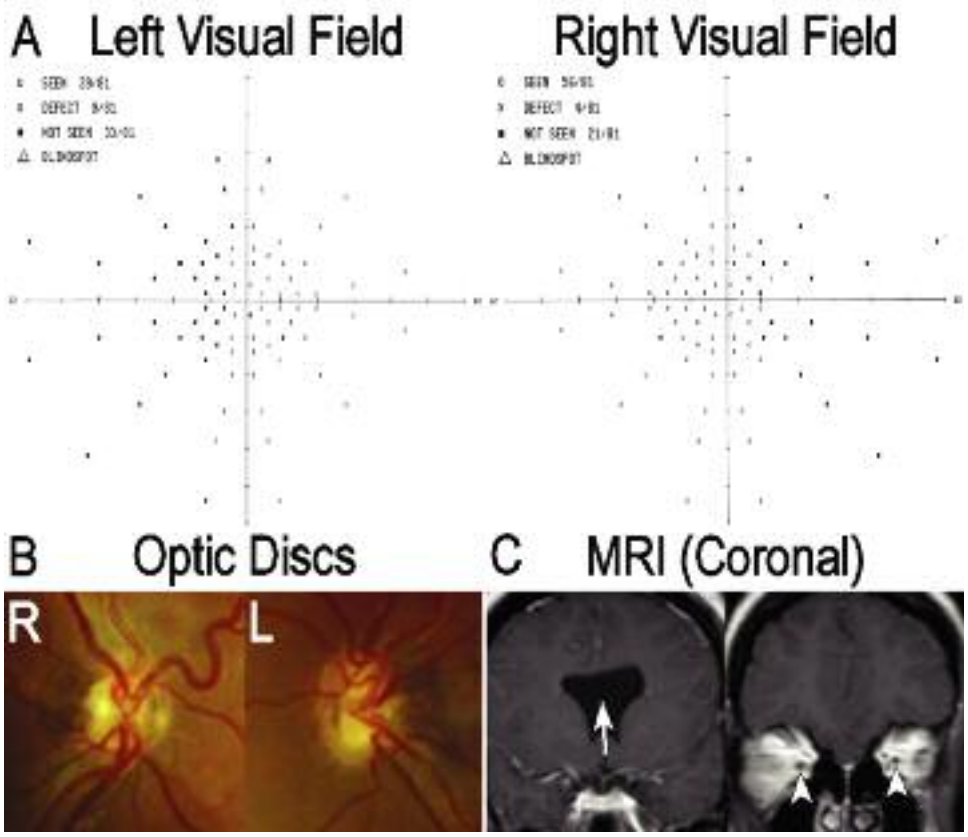

Figure 2: Visual fields, optic disc photographs, and magnetic resonance imaging (MRI) from a patient with INS and septo-optic dysplasia. (A) A bitemporal hemianopia was detected on Humphrey automated perimetry. (B) Optic disc photographs demonstrate bilateral optic disc hypoplasia (R, right optic disc; L, left optic disc). (C) Coronal T1-weighted MRI reveals an absent septum pellucidum (arrow) with bilateral optic nerve hypoplasia (arrowheads). The optic chiasm could not be identified.

Academy of Medicine Education Foundation 2009 Scholarships

Scholarship applications can be obtained from the registrar or financial aid offices of eligible schools. **The filing deadline is January 31, 2009** for medical students meeting AMEF scholarship eligibility criteria:

1. AMEF awards scholarships each year to Third and Fourth year medical students (MD/DO) who are or were residents of Cuyahoga, Summit, Lake, Geauga, Ashtabula, Lorain or Portage counties, and who demonstrate an interest in organized medicine, leadership skills, community involvement and academic achievement.
2. AMEF scholarships will be awarded to Third and Fourth year medical students attending the following institutions: Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine, Northeastern Ohio Universities College of Medicine and Ohio University College of Medicine. ■

Include AMEF in Your Charitable Giving Plans

AMEF uses funds to provide medical scholarships to assure that our medical schools continue training physicians to meet the need of patients in the future. In addition, your donation may assist with other worthwhile foundation activities that support public health and education initiatives. Look for AMEF's annual newsletter, *Foundation Facts,* in your mail soon and remember your profession in your giving plans.

Call for 2009 AMCNO Honorees

The AMCNO invites you to nominate an individual who **is a member of the AMCNO** that you believe is deserving of special recognition by the AMCNO. Any physician who wishes to nominate an individual for one or more of these awards should complete the form below and mail it to Elayne Biddlestone at the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000, ext. 100 to provide your honoree nominations over the phone. Deadline for submission:12/31/08.

- **JOHN H. BUDD, M.D. DISTINGUISHED MEMBERSHIP** – This award is bestowed upon a member of the AMCNO who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.
- **CHARLES L. HUDSON, M.D. DISTINGUISHED SERVICE** – Awarded to a physician whom the AMCNO deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.
- **CLINICIAN OF THE YEAR** – Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.
- Your Name: _____
- Your Nomination: _____
- Nominated for the following award:

_____

Please include an explanation as to why you are nominating this individual

_____

_____

Are you Interested in Running for the AMCNO Board of Directors in 2009

Directors are elected to represent their district, which is determined by primary hospital affiliation or at large for a two-year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the board of directors please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/08.

Yes, I am interested in running as a candidate for the AMCNO board of directors _____

Name and Contact information:

_____

The 2007-2008 Legislative Session

By: Michael Wise, AMCNO Lobbyist

At the State Level

After almost two years of furious activity, the 127th Ohio General Assembly is about to close. Over 600 House Bills and 350 Senate Bills have been introduced. Of those Bills, 118 passed the House and 111 made the initial pass in the Senate. Of the 118 House Bills that passed the House, 74 of those Bills then went on to pass the Senate and the Governor then signed 73. Of the 111 Senate Bills that passed the Senate, 55 of those Bills passed the House and the Governor then signed 54 of those Bills.

This General Assembly actually had less Bill introductions than prior years. We also saw over 10% of the introduced legislation become law — previous years had a lower percentage. While there still remains over two months in this legislative session, the actual number of session days could be less than ten days. Elections and politics are now the priority in Columbus. That said, a number of Bills that impact physicians have become law. Those Bills and issues include:

Insurance Contracts – Doctors and insurers clashed over coverage and contract issues during the debate over HB 125. This legislation did ultimately pass and an ad hoc group was formed to develop recommendations for communications standards for physicians and insurance entities. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been appointed to that group and a report will be issued to the General Assembly by January 1, 2009. The Director of the Ohio Department of Insurance stated that "these standards will enable a medical provider to send and receive from insurance entities and other payors sufficient information to enable that provider to determine at the time of the enrollee's visit the enrollee's eligibility for services. Standardized real time adjudication of provider claims for services will also be handled at this time." (see related story on page 1).

Prescription Drug Offenses – HB 195 narrowed somewhat the prescription related exemption from the drug possession offenses by requiring that the controlled substance be obtained pursuant to lawful prescription. The Bill also ended up incorporating Senate Bill 310. That Bill requires public officials to immediately forfeit their public office upon entering a guilty plea for a drug possession offense.

Newborn Care Facilities – Under HB 331, operation of a maternity unit, newborn care nursery or maternity home would be prohibited unless licensed by the Department of Health. The legislation also creates a Maternity and Newborn Advisory Council within the Department of Health that would advise and consult with the department director on rules, implementation and enforcement of the legislation, development of inspection criteria, procedures, and guidelines to enforce the provisions of the Bill and make recommendations to the Public Health Council on improving maternity and newborn care in the state.

Hospital Staffing – This legislation (HB 346) would give direct patient care nurses a voice in adopting a staffing plan for the hospital in which they work. Some hospitals may have a nursing care committee but may not include any or too few nurses to represent all the types of care in the institution. The Bill is a far cry from legislation favored by the nurses union that would mandate aggressive nurse to patient ratios.

Cancer Trials – The Senate took action in Senate Bill 186 to requires insurance companies to cover routine care expenses for patients involved in cancer-related clinical trials.

Radiological Assistants – This legislation from the Senate transfers regulation of radiologist assistants from the Ohio Department of Health to the State Medical Board and allows the board six months to adopt rules and implement the program. SB 229 also requires applicants to hold credentials from the National Registry of Radiologic Technologists and permits assistants to perform procedures not listed in the Bill if they are authorized in the Board's rules. Finally, the Bill limits assistants' authority to administer drugs to those that are directly related to the radiological procedure being performed. The Bill also creates a distinction between on-site supervision at the same location and direct supervision within actual sight of the physician. The former would apply in most cases, while the latter would be required for procedures performed when the patient is under high levels of sedation or analgesia.

Physician Ranking – While this legislation has not passed the General Assembly, AMCNO has been working with Senator Bob Spada on this issue for most of 2008 and SB 355 has been introduced. In addition, Rep. Tom Patton has introduced a companion bill in the Ohio House – HB 622. The purpose of this legislation is to provide the patient with accurate information when selecting a physician. This legislation would prevent the health insurance company from ranking a physician solely based on one specific criteria to persuade a consumer to choose one physician over another. The designations would be made based on cost efficiency, quality of care or clinical experience. The legislation also allows physicians the right to review and appeal their ratings prior to the ratings being released to the public. Senator Spada is term limited but was eager to assist AMCNO with this initiative. Representative Tom Patton is running for this Senate seat and he has offered to pick up this effort if he is elected to the Ohio Senate. In the House, Representative Carol Ann Schindel has agreed to become the Sponsor of this legislation in the House in the next General Assembly if she is re-elected, and Rep. Schindel is also a co-sponsor of HB 622. The AMCNO through our PAC is supporting both candidates in the upcoming election.

At the Federal Level

Mental Health Parity – More than one-third of all Americans will soon receive better insurance coverage for mental health treatments because of a new law that, for the first time, requires equal coverage of mental and physical illnesses. The requirement was included in the economic bailout bill that President Bush signed last week. Most employers and group health plans provide less coverage for mental health care than for the treatment of physical conditions like cancer, heart disease or broken bones. They will need to adjust their benefits to comply with the new law, which requires equivalence, or parity, in the coverage. For many years, insurers have set higher co-payments and deductibles and stricter limits on treatment for addiction and mental illnesses. The new law will make it easier for people to obtain treatment for a wide range of conditions, including depression, autism, schizophrenia, eating disorders and alcohol and drug abuse. Federal officials said the law would improve coverage for 113 million people, including 82 million in employer-sponsored plans that are not subject to state regulation. The effective date, for most health plans, will be Jan. 1, 2010. The Congressional

(Continued on page 9)

CHARITY CARE SURVEY

The Academy of Medicine of Cleveland & Northern Ohio Physician Charity Care Survey

This survey is commissioned by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) to gain a better understanding of the level of uncompensated care (i.e., charity care) by physicians to patients in this region.

In addition, The AMCNO wants to know more about physicians' perceptions of activities related to quality of care and public reporting. Please take a few moments to complete and return this questionnaire. All responses will be anonymous and will be reported in aggregate so that no given individual is identifiable. If you identify yourself to the AMCNO as willing to provide charity care on the last page of this questionnaire, any identifying information will be removed to ensure the confidentiality of your survey responses.

Please complete and return this survey by November 21, 2008. You may return the completed survey by regular mail to The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) 6100 Oak Tree Blvd., Ste. 440, Independence, Ohio 44131, or by fax to (216) 520-0999 or scan the survey and return by email to lhale@amcnoma.org. Please be sure to return all completed pages of the survey.

You may also complete the survey electronically — the link for the online survey will be sent out via email from the AMCNO offices.

Questions about You and Your Practice

First we would like to ask you about yourself and your practice to establish the context of your responses to the questions on charity care and quality of care measurement and reporting.

1. How many years have you been practicing medicine? (Please check all that apply.)
   - ☐ Less than 10 years
   - ☐ 10-19 years
   - ☐ 20-29 years
   - ☐ 30 years or more
   - ☐ I am retired

2. What is the zip code of your primary practice? _____

3. Including yourself, how many physicians are in your practice?
   - ☐ Under 5
   - ☐ 5-15
   - ☐ 16-50
   - ☐ Over 50

4. What is your primary practice setting type?
   - ☐ Public health clinic or community health center
   - ☐ Private practice
   - ☐ Multi-practice system
   - ☐ Other (Please specify _____)

(Continued on next page)

CHARITY CARE SURVEY

5. What is your specialty?
   - ☐ Family Medicine
   - ☐ Internal Medicine
   - ☐ Pediatrics
   - ☐ Other (Please specify _____)

6. What patient income level would you say your practice serves mostly? (Please check only one.)
   - ☐ Low income
   - ☐ Middle income
   - ☐ High income
   - ☐ Mixed income

7. Please estimate to the best of your knowledge, what percentage of your patients have each of the following types of medical coverage.
   - ☐ _____% Have insurance through Medicare
   - ☐ _____% Have insurance through Medicaid
   - ☐ _____% Have insurance coverage through private health plans
   - ☐ _____% Have no insurance

8. Which of the following types of new patients are you accepting? (Please check all that apply.)
   - ☐ Medicare
   - ☐ Medicaid
   - ☐ Private insurance
   - ☐ Self-pay

Provision of Charity Care

Communities across the U.S. are establishing a more organized program of charity care for the uninsured. The AMCNO and its partners are interested in your feedback on design characteristics of such a program in our community, and in better understanding uncompensated care already provided by area physicians.

9. Are you currently providing charity care for the uninsured?
   - ☐ Yes ☐ No

10. If a low-income patient who has insurance cannot afford a co-payment for care, do you generally see the patient anyway?
    - ☐ Yes ☐ No

11. How many additional charity care patients would you be willing to serve?
    - ☐ None ☐ 1-5 ☐ 6 or more

(Continued on next page)

CHARITY CARE SURVEY

The Academy of Medicine of Cleveland & Northern Ohio Physician Charity Care Survey *(Continued)*

12. For whom would you be willing to provide additional uncompensated care? (Please check all that apply.)
    - ☐ Anyone who in uninsured
    - ☐ Only the working uninsured
    - ☐ Children
    - ☐ Adults

13. Where would you be willing to see additional uncompensated care patients? (Please check all that apply.)
    - ☐ In my office/practice
    - ☐ In a community clinic setting
    - ☐ In a hospital clinic setting

14. If you are currently seeing or are willing to see uncompensated care patients in a clinic setting, which features matter the most to you? Please check the top 3 features that would be most supportive of your volunteer work. (Please check only 3 responses.)
    - ☐ The clinic would take care of scheduling and reminders to avoid no-shows
    - ☐ The clinic would take care of all paperwork
    - ☐ The clinic would provide nursing and other support staff
    - ☐ The clinic would adjust hours to meet my schedule
    - ☐ I would be covered by the clinic's malpractice insurance as a volunteer under state law

15. If you are a specialist, which of the following services do you currently provide or are willing to provide?

Currently	Would be willing	
☐	☐	Diagnostic services
☐	☐	Treatment services
☐	☐	Other (Please specify _____)

16. When providing uncompensated care to uninsured patients, it is helpful to have standardized processes and resources in place. Please check the top 3 features most important to you when providing charity care. (Please check only 3 responses.)
    - ☐ A standard sliding scale fee
    - ☐ Prescription benefit for the uninsured patient
    - ☐ Access to free or low-cost medical testing
    - ☐ Low-cost inpatient and outpatient hospital services
    - ☐ Case management services
    - ☐ Prior screening and verification of eligibility of services
    - ☐ Access to low-cost specialist care
    - ☐ A standard co-pay (What amount would you recommend? $_____

(Continued on next page)

CHARITY CARE SURVEY

17. Do you currently participate in an organized program of uncompensated care?

☐ Yes ☐ No

If yes, please describe in the space provided below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

OPTIONAL

Charity Care Referral Listing

The AMCNO is interested in compiling contact information of physicians interested in providing charity care and those who are already doing so. By filling out and signing the information below you are indicating that your contact information can be compiled for these purposes. This section will be detached from your questionnaire upon receipt to ensure anonymity of your responses above.

Are you interested in receiving information about an organized program of charity care in our region?

☐ Yes ☐ No

☐ I am currently providing charity care. (Please describe _____)

☐ I am interested in providing charity care.

Name_____

Specialty_____

Mailing Address_____

Phone_____

Fax _____

Email_____

Signature_____

THANK YOU FOR COMPLETING THE AMCNO PHYSICIAN CHARITY CARE SURVEY!

Legislative Update

(Continued from page 8)

Budget Office estimates that the new requirement will increase premiums by an average of about two-tenths of 1 percent. Businesses with 50 or fewer employees are exempt.

2008 Elections

The AMCNO Voter Guide has been sent out to all members and it includes information on local races, as well as local judicial races, the Ohio Supreme Court and all the other northern Ohio legislative races. This Guide is a major undertaking and special mention should be made to thank the staff at the AMCNO for their work on the guide in addition to Ms. Bernadette Barnes at McDonald Hopkins for her effort to make the guide a reality.

Alternative Dispute Resolution (ADR)

The AMCNO legislative committee and board of directors agree that the AMCNO should continue to pursue alternatives to the civil justice system in Ohio. The arbitration legislation spearheaded by the AMCNO will not pass in this General Assembly and the AMCNO is considering alternatives. The AMCNO has set up a meeting with Ohio Supreme Court Chief Justice Moyer to discuss another alternative — the concept of specialty and medical courts. To date, the Ohio Supreme Court has already developed pilot programs around the state of Ohio to set up business courts. This type of court results in expedited cases, judges that are trained in the specifics of the cases, and less cancelled dockets. The AMCNO plans to continue to review alternatives to the current tort reform system.

Executive Branch Issues

Tobacco Legislation – A firestorm erupted during the Spring of 2008 as the Governor moved to abolish the Ohio Tobacco Prevention Foundation (OTPF). This was an effort to balance the state budget redirect most of the $270 million endowment to job creation. HB 544 abolished the Fund. Under that legislative action, the Department of Health is expected to administer a much smaller anti-tobacco initiative.

As a follow up to the issues with OTPF, the General Assembly passed and the Governor signed legislation to abolish the Foundation. The legislation effectively eliminates funding tobacco prevention and cessation programs. As of July 1, 2008, the Ohio Department of Health spent about $3 to $5 million per year on tobacco prevention compared to OTPF spending of $46 million per year. The Ohio Department of Health did just pay out $2.5 million in bills from various vendors hired by OTPF prior to its elimination. Legislation enacted earlier this year transferred duties of the former OTPF to the department and immediately shifted its $270 million endowment mostly into an economic stimulus package. After payments were made to the vendors about $6 million remains for anti-smoking programs; and of that amount, $2 million has been earmarked for community intervention programs, $2 million for operation of the Tobacco Quit Line, $800,000 for enforcement of the statewide ban on smoking in public places, and $900,000 for related purposes.

Two bills are currently in the General Assembly that could have an additional impact on the tobacco issue. They are:

Senate Bill 346 would create smoking ban exemptions involving family-owned businesses, outdoor patios and private clubs. This bill is strongly opposed by the tobacco coalitions in the state, inclusive of the Investing in Tobacco Free Youth Coalition, which the AMCNO is an active participant. The bill would allow exemptions to the smoking ban currently in place throughout Ohio. The AMCNO strongly opposes this bill.

House Bill 572 would create the Center for Tobacco Use Prevention in the Department of Health to exercise duties of the former Tobacco Use Prevention and Control Foundation that were transferred to the Department, and to fund the Center's operations with an increased rate of tax on non-cigarette tobacco products (other tobacco products). The AMCNO has been an active supporter of an increase in the OTP tax. The AMCNO strongly supports this bill and has written to Governor Strickland voicing our strong support. If the bill does not pass in this General Assembly, which is highly unlikely, the AMCNO and the Coalition will work to re-introduce the legislation in the next General Assembly and support its' passage.

We are now almost through with this two-year legislative cycle. AMCNO has a comprehensive tracking system of all health care related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000. ■

HB 125's new credentialing provisions – effective September 25

On September 25, 2008, the new credentialing provisions of HB 125 went into effect for health care providers in Ohio. Under the law, all physicians and other health care providers will be subject to only one credentialing process for insurance credentialing purposes. Therefore, all insurers must use the Council for Affordable Healthcare (CAQH) form developed for credentialing purposes. Insurers will not be allowed to add additional questions. Physicians will only have to fill out one credentialing form with CAQH and then provide access to insurers. The form can be accessed electronically through the Ohio Department of Insurance (ODI) Web site at www.ohioinsurance.gov or directly through CAQH at www.caqh.org/credapp. Paper credentialing is also available.

The new law imposes time limits on insurers in their credentialing process, and if the time limits are not met the insurers will face penalties. A brief outline of the process is as follows:

- Physicians can submit their credentials to CAQH when requested by an insurer and do not need to wait until their employment has started.
- If there is a question or problem with the physician's credentials, the insurance company must notify the physician within 21 days from the date the credentials were submitted.
- The insurance company must either accept or deny the physician's credentials within 90 days.
- If the insurance company takes more than 90 days to credential a physician, the insurance company must either 1) pay the physician $500/day for every day over 90 days, including weekends; or 2) reimburse the physician under the terms of the contract for any services provided after 90 days until the insurance company finishes the credentialing process. These penalties accrue whether or not the physician's credentials are accepted by the insurer. It is up to the insurer which penalty the insurer will pay.

This new insurer credentialing process does not apply to hospitals that credential physicians so physicians must continue to work directly with any hospital when asked for credential information. In addition, for Medicaid managed care programs the credentialing time lines do not begin to run until the National Provider Identification Number (NPI) is submitted along with the credentialing form.

NEO RHIO – Bringing Connected Healthcare to Northeast Ohio

Update to AMCNO Members

Brian F. Keaton, MD, FACEP – President & CEO, NEO RHIO

NEO RHIO, the Northeast Ohio Regional Health Information Organization, is an inclusive, multi-stakeholder collaborative dedicated to improving the quality, safety and efficiency of healthcare in Northeast Ohio. Using shared information technology and the secure exchange of health information, we are working to change the way healthcare is provided in our region. What began two years ago as a hospital-centric effort to link the emergency departments in Cuyahoga, Summit, and Stark Counties has grown into a much more ambitious project. At its core, NEO RHIO is being built to assure that all necessary healthcare information is available to patients and providers where it is needed, when it is needed.

Since its inception, NEO RHIO's mission and vision have remained constant, but its scope has expanded considerably. NEO RHIO has incorporated as a nonprofit Ohio corporation, and its first Board of Directors and senior management are hard at work turning a good idea into a functional community resource. Our initial business plan focused primarily on information exchange among health care systems, hospitals and a limited number of group practices. The initial users were to be emergency department professionals with data products oriented toward improving emergency care. We have moved beyond this approach to include a more comprehensive service offering that will be made available to a greater number of care providers from a larger geographic area. NEO RHIO and OneCommunity have successfully partnered on a project called HealthNet which was funded for $11.3 million under the FCC Rural Healthcare Pilot Program. HealthNet will provide the infrastructure to enable broadband connectivity to rural healthcare providers in 22 counties of NEO. It is anticipated that those 22 counties will become the footprint for NEO RHIO once build-out is complete. We have selected the technology and our vendor partner, and start-up funding and early adopters are actively being sought.

We have also taken on significantly more responsibility for health information exchange (HIE) services and support. Participants (i.e., hospitals, providers, etc.) will connect once to the RHIO after which NEO RHIO will be responsible for developing and maintaining interfaces, training, Help Desk, and other services associated with the HIE. In most cases, NEO RHIO will assume responsibility for delivering results to clinicians (including paper, fax, and electronic), and clinicians will begin to receive results from all data sources in a consolidated data stream sorted by ordering physician and patient. With the exception of EMR-Lite, NEO RHIO will not be assuming responsibility for supporting EMR functionality beyond data connectivity.

The suite of services offered will enable Web-based sharing of patient-centric information among hospitals, physicians, other RHIO's and healthcare organization, insurance companies, and other stakeholders.

This data set can include any item that is available electronically including:

- Demographics
- Lab/Pathology
- Radiology reports (with embedded links to images)
- Other transcribed reports
- ADT, including visits, discharges, admits
- Scanned reports such as EKGs, Consent, Advance Directives, etc.
- Meds history
- Problems and encounters
- Clinical notes
- Allergies
- Immunizations

Data sources can include:

- Hospitals and clinics
- Physician practices
- Pharmacy data sources such as SureScripts / RxHub
- Insurers
- Medicaid / Medicare
- Public Health

Data exchange will be used to facilitate activities such as:

- Clinical messaging (i.e., electronic results delivery to physician EMR)
- Direct patient care
- ePrescribing*
- Disease management*
- Quality assessment*
- Patient referrals including direct transfer of patient records between physician practices
- Research*
- Public Health reporting*
- Other activities as approved by the patient, data sources, and the RHIO

NEO RHIO will make information available to caregivers in a variety of ways. All authorized users will be able to access information about their patients via a Web-based Virtual Health Record (VHR) which will provide a consolidated view of patient information from all sources. They will also be able to direct queries through the VHR. Physicians who use a third party EMR will have results for their patients delivered directly to their EMR "in box." An important addition to the NEO RHIO suite of services is EMR-Lite, a Web-base, ASP EMR solution that is hosted and managed by the RHIO. EMR-Lite offers clinicians much of the functionality of a third party EMR, including many important collaboration tools, at a very affordable price. It does not provide billing, scheduling, financial management, or other practice management functionality that is usually found in "full" EMR packages.

Clinicians usually have three questions:

1. What will I experience?
2. What will this cost me?
3. When can I expect to see these changes?

The answer to all three is, "It depends." It depends on the EMR system you currently have in place (if any), the healthcare system you currently are associated with (if any), and the strategy that your hospital or healthcare system is employing to connect to clinical care providers. It also depends on the number of data sources you interact with on a regular basis.

If you are an employed or closely affiliated physician with a major health system that has a stable patient population and has made a significant commitment to health information technology, you may not notice a lot of difference. You will notice, however, that your patient records contain test results, reports, and images from data sources that you have never seen before. You'll also appreciate the fact that the

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* enabled through NEO RHIO HIE but not included in proposed initial application

NEO RHIO – Bringing Connected Healthcare to Northeast Ohio

(Continued from page 11)

Interoperability Hub (I-Hub) will enable you to collaborate directly with your colleagues in the community who use a different EMR than the one you use. This applies to physicians who are affiliated with your healthcare system and those that are not. Imagine how this will streamline consults, referrals, handoffs, etc.

If you are a physician from a small to medium sized group that practices at several hospitals and outpatient labs and imaging centers, you will appreciate the fact that your results will now come to you via one source — a single interface to your EMR if you have one or a single fax or print source if you do not. You will also appreciate being able to bring up the Virtual Health Record (VHR) using a standard Internet connection to view consolidated information about your patient. In most cases, you will also be able to query the database that was the source of the information to dig deeper if clinically indicated. You will also realize the benefits of I-Hub.

If you don't have an EMR, NEO RHIO will make EMR-Lite available to you at a very low monthly charge. EMR-Lite can serve as a bridge between paper records and a full EMR implementation or it can be combined with separate practice management and financial applications to serve as a practices EMR solution.

Cost is always a serious consideration. Again, the answer to the question, "What will this cost me?" is, "It depends." Most hospital systems are committed to providing connectivity and EMR assistance to the physicians that they work with most closely. Many hospitals and systems are budgeting to absorb the majority of the cost associated with connecting their physicians to NEO RHIO. For those physicians that do not enjoy such support, the costs are very reasonable. Nonaffiliated physicians will pay an annual NEO RHIO membership charge of $500/year. Access to the NEO RHIO network, consolidated results delivery, interface from your EMR to NEO RHIO, and access to consolidated patient data through the VHR will cost $204/year or $17/month. Adding EMR Lite to the base VHR product costs only an additional $10/ physician/month. It is important to note that NEO RHIO charges are based on licensed physicians only. There will be no additional charge for providing access to the system for your staff.

Timing is the final question, and again, the answer is, "It depends." The build-out of NEO RHIO throughout all of Northeast Ohio is anticipated to take 3-5 years. We are actively seeking hospitals and hospital systems that are willing to commit to connection and data exchange in 2009. We plan to stage physician connections to coincide with bringing live the major data sources that are used by those physicians.

AMCNO is an active participant in NEO RHIO. As we increase our activity and begin to tackle the thorny issues of privacy, confidentiality, data use agreements, deployment schedule, service offerings, etc., we will need the input of clinicians in all of the communities that we serve. Please stay in contact with the AMCNO staff and leadership for developments. If you wish to serve on a NEO RHIO committee or work group, please let us know. ■

How to File a Prompt Payment Complaint with the Ohio Department of Insurance

By: Mary Jo Hudson, Director of the Ohio Department of Insurance

Medical providers dissatisfied with the time it takes to be reimbursed or due to improper reimbursements made by an insurance company can lodge a complaint with the Ohio Department of Insurance.

Since its launch in 2003, the Department's Ohio Complaint Handling and Monitoring Program — called OCHAMP — offers providers a secure, Web-based appeal process to resolve prompt payment disputes in a timely fashion.

The system — the first of its kind to be implemented in the country — has fielded a total of 10,160 complaints since its inception. There were 2,174 provider prompt payment complaints last year. The majority of the complaints have been about slow reimbursement and denied or partially paid claims. Self-funded entities, Medicare and federal employee benefits plans, all are outside the scope of Ohio's prompt payment law due to federal preemption.

To access OCHAMP, providers need to visit the Department's Web site at www.ohioinsurance.gov and click the "File a Complaint with ODI" link, located under the "Quick Links" section of the home page. Next, click the "Provider Complaint Information Page" to submit a complaint and to review information on the prompt payment law, frequently asked questions, and other information especially tailored to providers. A hard copy complaint form can also be obtained in this area to be mailed or faxed to the Department.

Providers should note that they are to first follow all contract grievances and appeal procedures with an insurer before filing a complaint with the Department.

After these steps are completed, OCHAMP electronically forwards the complaint to the insurer for a response. The insurer will be directed to resolve the complaint directly with the provider and notify the Department and the provider of the resolution of the complaint.

Meetings were recently held at the Department with providers, insurers and businesses to ensure that the Department is effectively addressing needs of stakeholders involved in this process. The discussions were informative, productive and insightful. The Department is currently reviewing the prompt payment complaint processes and procedures in light of the feedback provided.

A sampling of the topics discussed were: different ways to file a complaint and collect and share prompt payment complaint data, retaliation issues, and the Department's enforcement authority of prompt payment violations. For a complete summary of the topics discussed and responses provided by the Department, please visit the "Prompt Pay-IRO Meetings" link, located in the "Quick Links" section on the Department's Web site.

How to Navigate OCHAMP:

1. OCHAMP can be accessed by visiting the Department's Web site at www.ohioinsurance.gov.
2. Click the "File a Complaint with ODI" link in the "Quick Links" area, located at the bottom right of the home page.
3. Click the "Provider Complaint Information Page" link. The prompt payment Web page can be accessed directly at www.ohioinsurance.gov/Company/insprmpt5.htm.
4. Next, click the "Prompt Payment Complaint Form" link in the first paragraph. Select the option to "Fill this form out Online."
5. Scroll down, then either use your User ID and Password or if you are a new user, select Healthcare Provider in the "New Users" section.
6. You will receive the necessary log-in information via email. Use that information to log-in the "Registered Users" area.
7. Select the company you wish to file a complaint against from the selection list provided.
8. A one page form will appear and you need to populate all fields on the form within a 20-minute timeframe and submit.
9. You will receive a pop-up complaint number assigned automatically and a copy of the email that goes to the company notifying them of the complaint.
10. The company has 21-days to respond and you will be notified by email when a response has been provided. The email will include instructions on how to retrieve the response electronically.

To access detailed instructions for submitting complaints on OCHAMP please visit www.ohioinsurance.gov/Company/INS0505Instructions.pdf.

Anyone with prompt payment questions or providers who can only file a paper complaint can contact the Department's Tate Chaney at (614) 644-3428 or Julie Phillips at (614) 644-3411. Emails can be sent to PromptPayComplaints@ins.state.oh.us. Please fax hard copy complaints to (614) 644-3327. The Department's mailing address is 50 W. Town St., Suite 300; Columbus, OH 43215. ■

The Ohio Department of Insurance (ODI) Launches New Web Site

The ODI has been working for several months with staff from professional organizations, inclusive of the AMCNO, to garner input concerning the materials included on the ODI Web site with regard to ease of lookup of information, most frequently search items, and functionality.

The AMCNO staff participated in a Web Site Focus Group and provided input on the Web site. The site is now easier to navigate and provides clear information on how to file a prompt pay complaint, where to look for Ohio Revised Codes and statutes pertaining to insurance issues, information on medical malpractice closed claim data, as well as detailed consumer information. According to the ODI, there are plans to add other items to the Web site in the future such as additional consumer information outlining how consumers can file health insurance company inquiries and complaints.

The ODI is also considering feedback from stakeholders groups with regard to the ODI prompt pay and independent review process to consider changes to the ODI Web site that would provide specific health insurance company information with regard to complaints filed, the types of complaints filed and the geographic location where complaints are filed. ODI plans to reconvene the stakeholder groups which include the AMCNO in the future to further discuss these issues. To view the new ODI Web site go to www.ohioinsurance.gov.

Feet on the Street… and in Physicians' Offices

By: Giesele R. Greene, MD

Recognizing the complexity of the daily workings in a physician's office, UnitedHealthcare is gearing up to provide some help. Physicians and their staffs are central to the delivery of health care and UnitedHealthcare recognizes the role it must play in supporting physicians and their staffs.

As UnitedHealthcare rolls out the new Provider Advocacy Program, physician offices in Ohio can expect to see a Physician Advocate visiting the office to ask, "What can I do to help?" Physician Advocates will work primarily with the practice manager to assist with reducing administrative burden, but will be available to anyone in the office who needs assistance or training.

United is working to earn and sustain a trusted clinical and business relationship with physicians and their staffs to facilitate optimal health status for our members. Through this relationship we can help with:

- Resolution of outstanding claims issues
- Train staff to utilize United's on-line tools to streamline administrative tasks
- Educating new providers on billing and reimbursement practices
- Conduct periodic training programs

Our goal is to build relationships and drive simplicity in our interactions with physician offices. We ultimately want to be the easiest health care organization to deal with and be sensitive to the financial aspects of a medical practice – promoting timely, accurate and fair payment.

UnitedHealthcare understands the administrative burdens on a physician's practice and is constantly implementing new methods of increasing efficiency and quality. Our Provider Advocates are available to physician offices to help them best utilize our changes and improvements.

UnitedHealthcare is currently piloting this program in several markets including Cincinnati and Rhode Island. Both markets have demonstrated good strides in building better relationships. Our local Provider Advocates proactively visit with physician offices to help them resolve any issues and to help them learn about the technology and tools that can make their office administration more efficient.

For example, in northern Ohio, only a small percentage of physician offices submit claims online. On line claims submission utilizing the provider portal at:

https://www.unitedhealthcareonline.com

eliminates hassle, is more efficient and speeds reimbursement. The Provider Advocate can demonstrate this Web site in the office and immediately increase office productivity.

The northern Ohio market has also been making strides in converting facilities and physicians groups to Electronic Payment and Statements (EPS). Over the month of August there was a strong push in a "GO GREEN" marketing campaign resulting in six new facilities and several physician offices starting to utilize the electronic payment system for the first time.

We are committed to continuously visiting physicians' offices to help them better utilize the tools we offer as well as our policies and procedures. Our goal is to build personal relationships with our physicians and network providers, and make interactions with UnitedHealthcare smoother and more efficient.

A similar program, the Specialized Oncology Service Team, implemented a similar program earlier this year and provider satisfaction has improved from 64.88 % to 92.60%.

Dr. Giesele Robinson Greene is the Health Plan Medical Director for Northern Ohio for UnitedHealthcare. ■

Stark Rule Update

Effective October 1, 2008, if a physician is an owner in a physician organization that has a financial relationship with an entity that bills Medicare for designated health services, the Stark law will now regulate that relationship directly. The principal impact of this change is that hospitals and health systems will need to meet the more rigid formalities of having a written contract for services established in advance and limiting the compensation to fair market value when contracting through a physician organization for physician services.

CMS also finalized three changes that take effect next October so as to provide a long transition period. First, CMS will limit turnkey arrangements between hospitals and physicians whereby the physician group performs essentially all of the services relating to a service for which the hospital turns and bills Medicare. Hospitals can continue to lease equipment or obtain personnel and services from physician groups but the fine lines between the two will be established on a case-by-case basis. Also, leases between hospitals and physicians may need to be restructured before October, 2009. Certain types of rental payments to referring physicians based on a percent of revenue will be prohibited and, likewise, leases between a hospital and its referring physicians cannot have rental payments based on the number of procedures performed. In both cases, flat rate rental amounts will need to be established.

Physicians can also expect some additional changes that will go into effect on January 1, 2009, but CMS has not finalized those rules. The proposal would allow certain "gainsharing" arrangements whereby hospitals and physicians can financially align for hospital cost savings and quality improvement measures. We expect a final rule within the next month or two but as of now, the proposed rule has some exciting things to offer in terms of alignment strategies. More soon!

Ohio Department of Job and Family Services (ODJFS) Changes to Fee-For-Service Pharmacy Program

Effective October 1, 2008 ODJFS began full implementation of the federal requirement for tamper-resistant prescription forms. Beginning 10/01/08 a prescription was required to have three tamper-resistant characteristics in order to be reimbursed by Ohio Medicaid. All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy via telephone, fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper resistant on October 1, 2008 a prescription form must contain ALL of the following three characteristics:

- One or more features designed to prevent unauthorized copying of a completed or blank prescription form
- One or more features designed to prevent the erasure or modification of information written on the prescription by the provider
- One of more features designed to prevent the use of counterfeit prescription forms

For printing purposes, you may access the Acrobat version of the pharmacy update from ODJFS Legal/Policy Central at: http://www.odjfs.state.oh.us/lpc/calendar/index.asp.

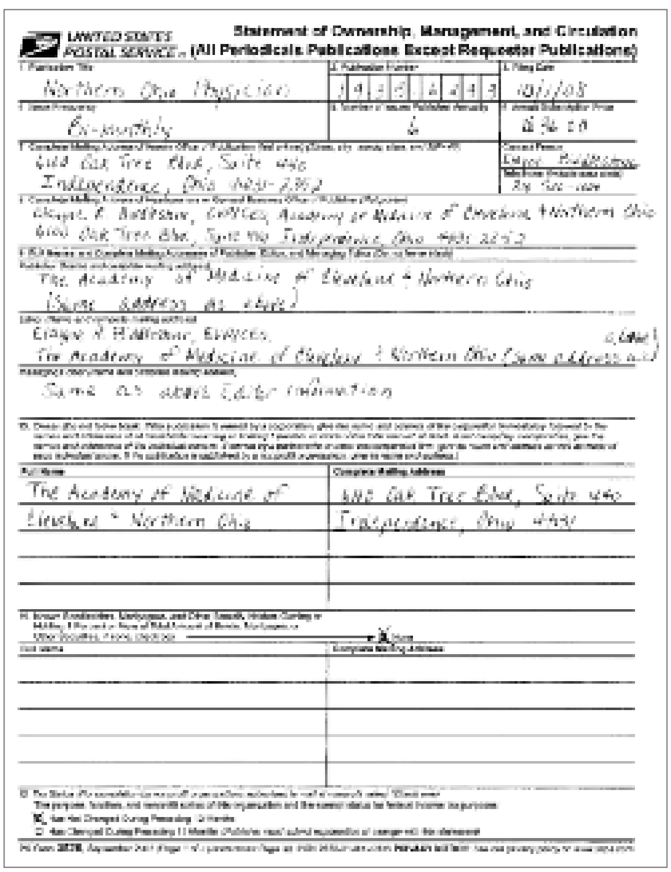
AMCNO MEMBERSHIP ACTIVITIES

Medical Student Picnic

More than 100 students, faculty, friends and family attended this year's medical school picnic of Case and the Lerner College of Medicine October 5. The annual event, held at Squire Valleevue Farm in Hunting Valley, offers students a late summer retreat of food and outdoor fun including volleyball, soccer and tug-o-war games. The AMCNO hosted a raffle awarding prizes of gift certificates to popular local eateries. During the festivities, AMCNO membership staff enrolled 35 new members. Medical school students and residents enjoy the benefits of AMCNO membership at no cost throughout their training. In part, these include weekly medical news updates via email, legislative representation at the state house, a listing in our physician directory and the advantage of AMCNO advocacy for the issues specific to Northeast Ohio physicians. Welcome new members! ■

The winners of the AMCNO raffle prizes line up for a photo op.

Several medical students assist in the picnic preparations.



UNITED STATES POSTAL SERVICE

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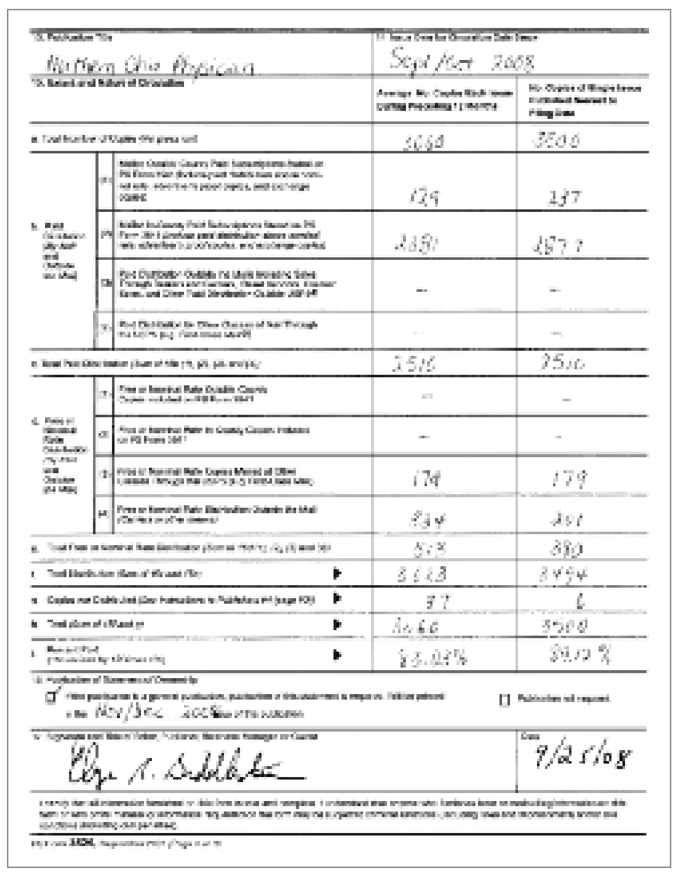

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c.	2516	2510
d. (1)	–	–
d. (2)	–	–
d. (3)	174	179
d. (4)	334	301
e.	513	880
f.	3023	3494
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