2016 NOA 3rd Party Update

What you need to know going forward into 2017

- Major 2017 Changes in ICD-10 Diagnosis Coding
- MIPS: 2017 Changes in Computing Your Reimbursement
- Coding & Office Procedures
- HIPAA
  - Your Patients' Rights
  - Cybersecurity Concerns
- Enrollment/Revalidation
  - Questions to Ask Before Enrolling
  - Keeping Your Enrollment Current

Dr. Quentin Quack

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2017 Changes in ICD-10 Diagnosis Coding

- Changes begin October 1st, 2016
  - 2,305 new codes
  - 553 revised codes
  - 212 deleted codes
- Hundreds of new codes affecting ODs and OMDs
  - 232 New codes just for Diabetic Retinopathy
  - Now 130 codes for glaucoma
  - 32 New codes for ARMD
ICD-10 for 2017

Family matters, but only through Sept. 30
• Currently, Medicare & other 3rd Parties are not denying claims if the diagnosis code is from the appropriate “family” of codes.
• This “family coding” grace period ends on Sept. 30, 2016;
  • Codes must be specific, and
  • Use of the 2305 new ICD-10 codes is required

ICD-10 for 2017: NOA 3rd Party Resource

How to Use...
• If you have EHR, use it to confirm EHR codes, especially if you have problems filing claims
• If you don’t have EHR, use to determine the correct 2017 ICD-10 codes.
MEDICARE’S MIPS Replaces PQRS in 2017
Merit-Based Incentive Payment System

The MIPS is a new program that combines parts of
• PQRS Physician Quality Reporting System
• VM Value Modifier aka Value-based Payment Modifier
• EHR Medicare Electronic Health Record

Professionals (EPs) will be measured on:
• Quality: As with PQRS reporting
• Resource use: What does it cost CMS for you to provide care
• Clinical practice improvement: Public Health using EHR
• Meaningful use of certified EHR technology: Meaningful Use of EHR
Doctors of Optometry need to report 6 QUALITY measures, including 4 or more of the following.

**BASIC EYE RELATED QUALITY MEASURES:**
Pick 4 or more of these measures

- **POAG**: optic nerve evaluation
- **AMD**: dilated macular exam
- **AREDS**: Council for vitamins
- **Diabetes**: Dilated Eye Exam
- **Diabetic Retinopathy**: Communicate with PCPs

**QUALITY**

• ODs must report 6 quality measures.
  • Must include
    • One Cross-cutting Measure
    • One Outcomes Measure
  • There are opportunities for Bonus points
    • Reporting more than one outcome measure
    • Communicating with PCP

**PICK 4**
Doctors of Optometry need to report 6 QUALITY measures. You must include one cross-cutting measure as shown below:

**CROSS CUTTING MEASURES**
Pick 1 or more of these measures
- Document Meds: dose, frequency, route
- BMI measure: height and weight
- Close the referral loop: referral reports
- Tobacco Screening/Cessation

Extra Credit: You can report more than 6 measures and CMS will give you credit for your top scoring measures (but you must include 1 cross-cutting and 1 outcomes measure)

Outcome Measures
Pick 1 or more of these measures
- Glaucoma 15% reduction in IOP
- BP control: measure and advise plan if high

Extra Credit: Reporting 1 Outcome Measure is mandatory. Reporting a 2nd earns you 2 BONUS points.

Resource use is an attempt to measure how much you cost CMS to provide your care to patients.
- There is nothing for doctors of optometry to submit when the Resource Use score is analyzed.
- This score is derived from calculations based on per capita expenditures based on claims data.
- Certain conditions, i.e., diabetes, are emphasized when calculating Resource Use scores.
Clinical Practice Improvement Activities (CPIAs) are new to Medicare. CPIAs are designed for doctors of optometry to demonstrate their role in overall public health initiatives. Registry reporting (including AOA MORE) is emphasized in the scoring of CPIAs.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

- Use AOA MORE to show practice patterns (20 points)
  - Use your data to learn how you treat and manage patients
- Use AOA MORE to compare specific outcomes (10 points)
  - Compare your data vs aggregate of all data in AOA MORE for glaucoma and more
- Use AOA MORE to show standards of practice care (10 points)
  - Compare your data vs aggregate of all data in AOA MORE
- Use AOA MORE to promote adherence to treatment plans (10 points)
- Allow 24/7 access to clinicians (20 points)
- Collect Patient experience and satisfaction data (10 points)
- Provide Medication Reconciliation with Transition of Care (10 points)
- Close referral loop: reports to referred physicians (10 points)

Advancing Care Information (Formerly EHR Meaningful Use Technology)

ACI SCORE: The ACI score is based on a Base Score, Performance Score and a Bonus Score. (This information will cover the “primary” pathway and assumes your EHR vendor is up to present day certification)

ACI SCORING FORMULA

Base Score: 30 points, required to obtain full credit
Performance Score: up to 50 points. The better you perform, the better your score.
Bonus Points: Participating in the Year 2 Transition of Care program

Total ACI Score: Based on full credit. If you achieve 90% you will get full credit for ACI.

Advancing Care Information
(Formerly EHR Meaningful Use Technology)

ACI BASE SCORE Objectives listed by category:

Protect Health Information (PHI)
• Perform Security Risk Analysis

Patient Electronic Access
• Provide access to portal
• Provide patient specific education

Coordination of Care
• View, download, transmit
• Secure messaging
• Patient generated health data

Health Information Exchange
• Exchange info with physicians
• Exchange info with patients
• Clinical info reconciliation

Clinical Data Registry [AOA MORE]
• Immunization
• Clinical Data (optional)
• Syndromic Surveillance (optional)
• Public Health Reporting (optional)

eRx

Health Information Exchange
• Exchange info with physicians
• Exchange info with patients
• Clinical info reconciliation

Clinical Data Registry [AOA MORE]
• Immunization
• Clinical Data (optional)
• Syndromic Surveillance (optional)
• Public Health Reporting (optional)

MIPS Reporting Options for 2017

Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019. These options, and other supporting details, will be described fully in the final rule.

• First Option: Test the Quality Payment Program
• Second Option: Participate for part of the calendar year
• Third Option: Participate for the full calendar year
• Fourth Option: Participate in an Advanced Alternative Payment Model in 2017 (via ACOs*, etc.)

*EyeAssure IPA may well provide access to ACOs

PROPOSED RULE
MIPS Timeline

2017 2018 2019 2020

Performance Period (Jan-Dec)
1st Feedback Report (July)
Reporting and Data Collection
2nd Feedback Report (July)
Targeted Review Based on 2017 MIPS Performance
MIPS Adjustments in Effect

Analysis and Scoring
AOA MORE: Your Tool to Simplify MIPS

- AOA MORE can be used to report all of your QUALITY measures, ACI measures and your CPIAs.
- Reporting QUALITY measures with AOA MORE earns you bonus points.
- In the future, CMS proposes that AOA MORE will be able to define/create our own CPIAs and quality measures for doctors of optometry to be used in the MIPS program!
- AOA Additional Notes/Disclaimers: There are other potential quality measures and CPIAs that a doctor of optometry could report to meet the program objectives. This is simply an overview of one way a doctor of optometry may engage with the program if the proposed requirements are finalized.

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A Medicaid Patient with Primary Vision Coverage:
Billing Medicaid and Collecting Co-pay

• When billing Medicaid as secondary, the total amount you will be reimbursed from the Primary Coverage plus from Medicaid will not exceed the maximum Medicaid would have paid if it had been billed as primary.

Co-pay example #1:
• Your total fee: $100;
• EyeMed allowable: $80;
• EyeMed co-pay: $20;
• Medicaid or Medicaid MCO allowable: $60.

• EyeMed would pay you $80 less the $20 co-pay, or $60.
• You cannot collect the EyeMed co-pay.
• Since the Medicaid allowable is $60, when you bill Medicaid, you will receive $0 from Medicaid.

Co-pay example #2:
• Your total fee: $100;
• EyeMed allowable: $70;
• EyeMed co-pay: $20;
• Medicaid or Medicaid MCO allowable: $60.

• EyeMed would pay you $70 less $20 co-pay, or $50.
• You cannot collect the EyeMed co-pay.
• Since the Medicaid allowable is $60, when you bill Medicaid as secondary, you will receive a total of $10 from Medicaid and the patient, giving you a total of $60, which is the Medicaid allowable.
A Medicaid Patient with Primary Vision Coverage:
Billing Medicaid and Collecting Co-pay

- The only co-pay you would collect from the patient is the very small Medicaid co-pay for the exam and the glasses.
- Many patients are exempt from Medicaid co-pay (examples: age 18 and under, or pregnant, or hospitalized, or in nursing home, or disabled, etc.)
- Standard Medicaid co-pay for “Vision Care”
  - $2 per exam
  - $2 for complete glasses, or for pair of lenses only, or for frame only
- You cannot decline to provide services or materials if the patient declines to pay their Medicaid co-pay.

Medicaid regulations on billing can be found at:

Medicaid co-pay information can be found at
http://dhhs.ne.gov/medicaid/Pages/med_medcopay.aspx

FTC: Release of a Contact Lens Rx

Prescribers must:
- Give a copy of the contact lens prescription to the patient at the end of the contact lens fitting – even if the patient doesn’t ask for it.
- Provide or verify the contact lens prescription to anyone who is designated to act on behalf of the patient, including contact lens sellers.
- In any response to a verification request, prescribers must
  - correct any inaccuracy in the prescription,
  - inform the seller if it’s expired and
  - specify the reason if it’s invalid.

FTC 2004 Contact Lens Rule
FTC: Release of a Contact Lens Rx

- A prescriber may require payment of fees for an eye examination, fitting, and evaluation before the release of a contact lens prescription, but only if the prescriber requires immediate payment in the case of an examination that reveals no requirement for ophthalmic goods.
- For purposes of the preceding sentence, presentation of proof of insurance coverage for that service shall be deemed to be a payment.

FTC 2004 Contact Lens Rule

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HIPAA: New Rules on Releasing Patient Records

Under the HIPAA Privacy Rule, covered entities are required to:
- Establish a process to accept either written or electronic requests by patients for their health information.
- Take reasonable steps to verify the identity of an individual making a request.
- Provide the information in a form or format requested (i.e., paper or electronic), if at all possible. If the preferred form or format is not available, the covered entity and individual must agree on a readable alternative.
HIPAA: New Rules on Releasing Patient Records

- Provide access to the information within 30 calendar days of the request. That time frame may be extended an additional 30 days if the information is not readily available; the requester must be notified of the extension.
- Provide access to most information in the "designated record set," including medical records, billing and payments records, insurance information, clinical laboratory results, medical images, wellness and disease management program files, clinical notes and other information used to make medical decisions about patients.
- Transmit the patient's information to another person or entity if the patient requests it.

New HIPAA Rules

HIPAA: New Rules on Releasing Patient Records

- Copies must be provided despite any outstanding balance being due to the provider.
- Deny access only in limited circumstances. For instance, an entity is not required to create new information or provide information in the designated record set that is not used in making decisions about a patient's care. That includes patient safety activity records or quality assessment or improvement records.

New HIPAA Rules

HIPAA: New Rules on Releasing Patient Records

A reasonable, cost-based fee for providing the information fee may include only the cost of:
- LABOR for copying the PHI requested by the individual, whether in paper or electronic form;
- SUPPLIES for creating the paper copy or electronic media (e.g., CD or USB drive) if the individual requests that the electronic copy be provided on portable media;
- POSTAGE, when the individual requests that the copy, or the summary or explanation, be mailed; and
- PREPARATION of an explanation or summary of the PHI, if agreed to by the individual.

New HIPAA Rules
The fee may NOT include costs associated with:

- verification;
- documentation;
- searching for and retrieving the PHI;
- maintaining systems;
- recouping capital for data access, storage, or infrastructure; or
- other costs not listed above even if such costs are authorized by State law.

**HIPAA** New Rules on Releasing Patient Records

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**HIPAA: Cyber Security**

To protect patient data and your practice from cyberattacks, follow these recommendations:

- Ensure electronic patient information is encrypted. Basic passwords won’t cut it when it comes to hi-tech hackers, so activate the encryption program that most electronic health record (EHR) systems already offer.
- Perform a risk analysis to evaluate potential for cyberattack. Not all software is created equal—as doctors investigating EHR vendors can attest—and older model computer operating systems (OS) might not be HIPAA compliant any longer due to end of support.
To protect patient data and your practice from cyberattacks, follow these recommendations:

- **Add peace of mind with cyber liability insurance.** Protect business functions online, including operating the practice website and storing confidential patient records with cyberliability insurance available from AOAExcel.
- **Review the HIPAA Privacy and Security Rules.** Optometrists who transmit information in an electronic format, such as a claim to Medicare or other payers, are considered covered entities under HIPAA and should be aware of the HIPAA Privacy and Security Rules. Click here to learn more ways to circumvent risks to your patients and practice.

Currently hackers can crack most passwords within 60 minutes, 90% of the time, including 15 character number letter passwords.

- A team of hackers has managed to crack more than 14,800 supposedly random passwords - from a list of 16,449 - as part of a hacking experiment for a technology website.
- The success rate for each hacker ranged from 62% to 90%, and the hacker who cracked 90% of hashed passwords did so in less than an hour using a computer cluster.

**Passwords should NOT include:**
- Names
- Addresses
- Initials
- Birthdates
- Phone numbers
- Acronyms
- Dictionary words
- Common abbreviations

**Passwords should include ALL of the following, intermixed:**
- Lower & Upper case letters
- Numbers
- Special characters
- Use a password only on one site
- Change Frequently (60 days)
HIPAA and Cyber Security: **Passwords**

http://www.passwordmeter.com/

https://howsecureismypassword.net/

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<th>Score</th>
<th>Complexity</th>
<th>Length</th>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I would take a computer about 3 milliseconds to crack your password. Why not try to create and remember a stronger password? It's free!
HIPAA and Cyber Security: **Passwords**

http://www.passwordmeter.com/

The following forms and information are designed to help practitioners comply with the requirements of HIPAA.

**Forms**
- Sample Business Associate Agreement
- Sample Notice of Privacy Practices

**Manual**
- HIPAA Security Regulation Compliance Manual

HIPAA and Cyber Security: **AOA Resources**

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2016 NOA 3rd Party Update
Questions to Ask Before Signing a 3rd Party Plan

1. Does this contract fit into your Practice Business Plan?
   - Do you have a practice business plan?
   - Is this contract a vision, med/surgical plan or does it cover both services?
   - Is your practice equipped and trained to handle this type of contract?
   - If this plan is a medical plan, are you required to participate in the MCO’s less than desirable vision plan?

2. Does this contract allow you to practice full scope optometry?
   - How does this contract define an optometrist vs. other provider types?
   - If this plan is a medical contract, are you allowed to participate to the full scope of licensure in your state?
   - Are you as a provider under this contract given the flexibility to determine and provide what is “medically necessary” care?

3. What is the economic impact of this contract on your practice?
   - What does this contract mean to your practice in terms of revenue and expenses?
   - Will this contract displace other patients that are more or less desirable economically?
   - What are your alternatives to this contract?

4. What plan products are you required to participate in?
   - Does this contract allow you to select which products you participate in?
   - Are you required to participate in “all products”?
   - Does the contract allow you to terminate one product or does this automatically terminate your participation in all products?

5. What is your reimbursement under this plan?
   - Does this contract provide enough information to determine what you will be paid for the services you provide?
   - Does it include a comprehensive fee schedule for routine vision visits as well as medical services?
   - Are fees equal for all provider types?

6. Is reimbursement sufficient?
   - What are your costs to provide the services required under this contract?
   - Have you calculated your “chair time” costs? If not, do it now!
   - If optical services are required, does the plan provide sufficient margins on optical goods?
Questions to Ask Before Signing a 3rd Party Plan

• 7. Does this contract have an obligation to pay you promptly?
  • Does the contract provide a specific payment time period?
  • Are there separate payment time periods for electronic or paper claims?
  • Does the MCO agree to pay interest if there are delays in payment?
  • Does your state have a prompt pay law or fair business practice act?

• 8. Can reimbursement terms be change unilaterally?
  • Does the contract require the MCO to provide notice of any reimbursement changes?
  • Can you terminate the contract if you object to the changed reimbursement terms

• 9. How does this plan provide patient eligibility?
  • Does the MCO have a quick and efficient mechanism to obtain patient eligibility?
  • Is the method of attaining benefits accessed by telephone, fax or is it web based?
  • Does the MCO stand by this information or can it reverse itself?

• 10. Does this contract clearly define covered services?
  • Does this clearly define in the contract or policy manual the covered routine vision and medical eye services?
  • How are patients made aware of the covered services (benefits) available to them?
  • How are you listed as a provider?

• 11. Are services requiring prior authorization clearly defined?
  • Does the contract clearly designate any and all services and procedures subject to prior authorization?
  • Does the MCO provide for an efficient and reliable method for obtaining prior authorization?
  • Is this method by phone, fax or is it web based? What is the turn around time for authorization?

• 12. What are your rights to appeal a reimbursement decision?
  • Are specific procedures provided to appeal a reimbursement decision?
  • Is the appeals process fair or is it weighted heavily in favor of the MCO?
  • Is there any independent review permitted as part of the internal appeals procedure?
Questions to Ask Before Signing a 3rd Party Plan

• 13. Does this plan require compliance with a formulary?
  • For medical services:
    • Is a drug formulary published?
    • Are there Rx tier pricing schedules?
  • For optical plans:
    • Are you required to use a specified frame selection or optical laboratory?
    • Are contact lens benefits tied to a specific supplier or mail order plan?

• 14. Does this contract allow for “panel rental” to other entities?
  • Can the MCO “sell” or “rent” its network to a third party or a third party administrator?
  • Are you allowed to “opt in” or “opt out” of “rented” panels?
  • Will your fees be further discounted or does the reimbursement schedule remain the same?

Questions to Ask Before Signing a 3rd Party Plan

• 15. How can you terminate this contract?
  • Can you terminate if the MCO breaches the contract?
  • Is the termination time clearly stated?
  • Does the contract require annual renewal or is this an “evergreen” contract that renews automatically?
  • Do you pay an annual fee for renewal or annual credentialing?

Questions to Ask Before Signing a 3rd Party Plan

• Could an IPA like EyeAssure help at all in evaluating 3rd parties?
  • The Chiropractic IPA “SecureCare” does provide some plan information for its members...
Medicare Revalidation Requirements

Are you due to revalidate?

- Revalidation is the process of resubmitting and recertifying the accuracy of a provider’s enrollment information.
- Sixty to 90 days before doctors are due to revalidate, notices will be sent by their Medicare administrative contractors via email (Watch Junk or Spam folders.) or through regular mail.
- There is an online tool to look up providers' revalidation due dates. Doctors can find their due dates on a new CMS revalidation lookup tool.

Revalidation of Medicare Enrollment
Medicare Revalidation Requirements

Doctors have two options for revalidating. They can resubmit their information via:

- **Internet.** Submit your revalidation information to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). You also can upload any supporting documentation there.
- **Regular mail.** Mail paper certification statements (Paper CMS-855) to your Medicare administrative contractor.
- A video slideshow is available on Provider Enrollment Revalidation.
- Our Medicare Contractor's webpage on Revalidation.

Medicare Enrollment: Death of Partner

- If an owner, partner, managing employee, director, officer, authorized/delegated official, etc., has died, a CMS-855B should be submitted as a change request.
- If a replacement for the deceased individual has been made, all pertinent information for the replacement should be included with the change request.
- Organization's billing privileges can be lost if SSA notifies Medicare of death, and organization has not responded to CMS with change request.

Medicare EIDM Recertification

- **What is CMS EIDM?**
  EIDM is the acronym for CMS' Enterprise Identity Management system which includes Identity Verification, Access Management, Authorization Assistance Workflow Tools, and Identity Lifecycle Management functions (i.e., Password Reset, Forgot User ID, etc.).
- **What is a CMS EIDM User account?**
  An EIDM account ensures that only authorized/registered users can access protected information and systems through the CMS Enterprise Portal. (e.g., previous year's PQRS information.)
- **I am new to CMS Enterprise Portal. How should I create my user account?**
  Once you are on the CMS Enterprise portal, select the 'New User Registration' hyperlink.
Medicaid Heritage Health Enrollment

• Heritage Health is the new health care delivery system that combines Nebraska's current physical health, behavioral health, and pharmacy programs into a single coordinated system.
• Beginning January 1, 2017, Heritage Health the three contracted Heritage Health managed care plans are:
  • Nebraska Total Care Vision & Medical: Envolve Benefit Options
  • United Healthcare Community Plan Medical UHC; Vision: Superior Vision
  • Wellcare of Nebraska Vision & Medical: Avesis

TOTAL CARE ENVOLVE CONTACT INFORMATION
• Scott Chandler, RPh
• Director Network Development
• Envolve Vision
• 112 Zebulon Court
• Rocky Mount, NC 27804
• Direct: 252-544-9329
• Fax: 844-698-9702
• Scott.Chandler@envolvehealth.com

WELLCARE AVESTIS CONTACT INFORMATION
Avesis has partnered with WellCare to build their network in Nebraska.
• Avesis
• lroebuck@avesis.com
• 1-800-643-1132 Ext. 11752
Medicaid Heritage Health Enrollment

UNITEDHEALTHCARE COMMUNITY PLAN CONTACT INFORMATION
• UnitedHealthCare has not responded to Dr. Quack’s request for direct contact information for optometrists.
• The link below is from a UHC presentation meant for all types of Heritage Health Medicaid providers for 2017.

Aperture Routine Vision Plan Credentialing

• Doctors due to credential or re-credential with certain routine vision care plans can access guidance that helps them navigate a new, universal credentialing process among 10 managed vision care plans and optical organizations.
• Universal Credentialing Initiative allows doctors to re-credential simultaneously among the plans in which they participate, purportedly streamlining the process and lowering administrative costs.

How to ensure a smooth credentialing process

About 120 days in advance providers due to re-credential with a participating plan via Aperture will receive either
• An email*—the subject line will state, Important Credentialing Information Requested: (Provider Name) (Tracking Number)
• Or a letter from Aperture Credentialing

**Always keep an eye on your spam or junk email folders for an Aperture email with the subject line mentioned above.
Aperture Plans Include...

- AlwaysCare
- Davis Vision
- EyeMed
- eyeQuest
- MESVision®
- National Vision
- UnitedHealthcare/Spectera Eyecare Networks
- Superior Vision
- Vision Benefits of America®
- VSP® Vision Care

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Questions?

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