Quality health care for Medicare recipients is a high priority for the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). In November 2001, HHS announced the Quality Initiative to assure quality health care for all Americans through accountability and public disclosure. The Quality Initiative was launched nationally in 2002 with the Nursing Home Quality Initiative (NHQI), expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HFI). These initiatives resulted in the “grading” of these institutions across the nation. [You can see an example of the hospital grading system at HTTP://WWW.HOSPITALCOMPARE.HHS.GOV/]

In 2004, the Physician Focused Quality Initiative was developed, which includes the Doctor’s Office Quality (DOQ) Project. [Remember, Medicare classifies optometrists as physicians.] CMS then announced the launch, in 2006, of the Physician Voluntary Reporting Program (PVRP). Its purpose is to better analyze the quality of care provided to Medicare beneficiaries by using a set of quality G-codes established by Medicare. These non-specialty specific G-codes will be voluntarily reportable by using the existing system for physician claims. The G-codes can be found at HTTP://WWW.CMS.HHS.GOV/PHYSICIANFOCUSEDQUALINITS/

The Core Starter Set of 16 priority measures can be seen at HTTP://WWW.CMS.HHS.GOV/PHYSICIANFOCUSEDQUALINITS/

The G-codes currently listed by PVRP do not appear to directly affect the care provided by optometrists, unless they practice in close conjunction with an ophthalmologist or in a hospital setting. However, Dr. Quack feels PVRP is just in its infancy. Eventually there may be G-codes that directly relate to optometric care. It is essential for us, as a profession, to monitor the PVRP system closely, and to participate when appropriate. It seems likely that Medicare physicians will eventually be graded much as hospitals and nursing homes are currently graded. As optometrists we must continue to provide quality services, and when it becomes appropriate, participate by using proper G-codes. This should help assure that we, both as individuals and as a profession, are graded fairly and favorably.

Learn more from the web site where the information for this article was gleaned: HTTP://WWW.CMS.HHS.GOV/PHYSICIANFOCUSEDQUALINITS/.

NEW 3rd PARTY CONTACT INFORMATION FOR 2006

Email is best: SchneiderEd@msn.com

If you cannot use email, Ed’s cell phone is 402-310-2367. Voicemail is available.

Need to fax? To assure HIPAA privacy, it’s best to call Ed before faxing.
Editor’s Note: As Dr. Quack dreamt up the following scenario, it seemed to take on a life of its own. Please excuse its length.

Shirley Clueless, a local do-it-yourselfer auto mechanic, came into Dr. Quack’s office complaining of a foreign body sensation in her right eye. She stated that she had recently crawled under her rusty pickup (without eye protection) to repair a muffler, and since then had suffered right eye discomfort.

Visit #1—Day One:

History: As a matter of standard office protocol, Shirley reviewed and initialed her previously completed standard history forms, including review of all systems (ROS), and past, family, and social history (PFSH). Her chief complaint (CC) was recorded as “I think I have something in my right eye”, and History of present illness (HPI) was: FB sensation OD, for 5 days, accompanied by tearing and photophobia, associated with repairing a muffler. When asked Shirley stated she had not been hammering metal against metal.

Examination: VA was 20/20. Slit lamp examination revealed two large and one small superficial metallic foreign bodies in the right cornea. The larger FBs had a significant rust rings. All other findings were normal. Close inspection showed no sign of a penetrating injury. There was general conjunctival injection, especially adjacent to the cornea, but the anterior chamber was clear.

Treatment: All three FBs were removed with a golf-club spud. The rust beneath the larger FBs was not currently amenable to removal using either a spud or Alger brush.

Dr. Quack instilled generic erythromycin ophthalmic ointment, and gave the tube to the patient to use b.i.d. over the next few days.

[Why did Dr. Quack give away the antibiotic? The cost of generic erythromycin is minimal, and it is illegal in Nebraska to sell Rx medication without a pharmacy registration. Writing an Rx for a prophylactic antibiotic would certainly be acceptable; however, this patient’s name was Clueless, and since she may not have filled a written Rx, Dr. Quack wanted to assure compliance by giving her the tube of e-mycin.]

A return appointment was set for the next day to check patient comfort, corneal re-epithelialization, rust, and look for development of iritis.

Coding: Billing for an E&M visit plus a surgical procedure would result in the visit being denied. Therefore, only procedure 65222 (removal of superficial corneal FB) was used. The first FB removal was listed on the first line, the subsequent FB removals on the second line with a 51 (multiple procedure) modifier and units of two. (see below).

(Continued on page 3)
(Continued from page 2)

Visit #2—Day Two:
History: When Shirley returned she reported her eye felt better than it had the day before. Her CC was listed as followup of FBs OD. HPI was “OD feels better and less red; vision has not changed.” No ROS or PFSH.

Examination: VA was 20/20, patient appeared more comfortable. PERRLA. A slit lamp exam indicated less injection, no iritis, almost complete re-epithelialization of all three FB sites, and the rust deposit starting to become more diffuse, but still appearing attached in the central area of the two previous large FBs. Mild, chronic belpharitis was again noted.

Treatment: The patient was asked to continue the erythromycin ointment b.i.d., and return in one week. Advised to call immediately if symptoms increased. It was explained that the corneal rust may dissipate on its own, but even if it did not, it would be much easier to remove in a week or so.

Coding: History was problem focused, exam could have been problem focused (less than 6 eye elements), or expanded problem focused (6 elements, such as acuity, conjunctiva, adnexa, pupil/iris, cornea, A/C.). Decision making would be straightforward. Result: 99212.

Visit #3: One Week
History: CC: Patient reported that the eye has continued to be slightly red, and that there continued to be a twinge of discomfort OD. HPI recorded as: F/U FB OD.

Examination: VA 20/20. Very mild injection; slit lamp revealed rust that was significantly more dissipated into the epithelium than before at both of the larger FB sites. It was obvious, however, that the epithelium would not adhere normally unless the rust was removed from those sites. Rust had completely dissipated at the site of the smaller FB.

Treatment: The rust was removed from both areas with an Alger brush. At one site the rust was easily removed; at the second site more aggressive use of the Alger brush was required. The patient was asked to continue the erythromycin ointment b.i.d., and to return in 24 hours to check the area of the cornea where the more aggressive Alger brushing had been necessary.

Coding: Since use of the Alger brush was to remove the metal oxide superficial FB material, 65222 was used for the first site, and 65222-51 the second site.

Visit #4: One Week + One Day
History: Patient was essentially symptom-free. CC and HPI were recorded as F/U FB OD.


Treatment: Erythromycin ointment was discontinued, and use of 2% hypertonic saline ointment h.s. OD was instituted, and continued for the next two weeks, then could be discontinued.

Coding: History and Exam were problem focused, and decision making straightforward. Result: 99212.

Suggestions for Quack?
There is more that one way to pluck a duck...

The previous article was written from Dr. Quack’s perspective. Perhaps you may have handled this patient somewhat differently. If so, and if you would like to comment, please email Dr. Quack at SchneiderEd@msn.com.

Dr. Quack will insert your thoughts in next month’s newsletter as space permits, and give you credit, unless you prefer to remain anonymous. Please see the article below regarding contributions to our newsletter.

Would You Contribute a Comment, Case, or Coding Example?

Dr. Quack thinks it might be fun and informative if our members would take a few moments from their busy day to contribute to our Third Party newsletter. Such contributions might include:
♦ Suggested alternatives to Dr. Quack’s coding.
♦ Suggested alternatives to Dr. Quack’s patient care.
♦ Coding or clinical examples of your own.
♦ Coding challenges you or your staff have met and conquered.
♦ Coding challenges that remain challenges.
♦ Case studies. That is, present a case, and request input from your peers on alternative management options.

Your contribution doesn’t need to be in finished form. Dr. Quack can modify your contribution for publication.

If you have a pearl of coding or clinical information you would like to share, email your thoughts to Dr. Quack at SchneiderEd@msn.com.

Quack Thought: Computers are like air conditioners. They work fine until you start opening windows.
The FTC Contact Lens Rule, published in 2004, requires the release of a patient’s contact lens prescription after each contact lens “fitting”. A fitting, however, is broadly defined, and includes a yearly contact lens examination that found no change in the contact lens prescription. Dr. Quack thought it prudent to remind our members what this federal law requires regarding the repeated release of a contact lens prescription. The following is excerpted/condensed directly from the FTC rule as published in the Federal Register. You can find the entire rule in a previous 3rd Party Newsletter at HTTP://NOAONLINE.ORG/MEMBERS/THIRDPARTY/2004_09_NEWSLETTER.PDF.

WHEN A PRESCRIBER COMPLETES A CONTACT LENS FITTING (FTC DEFINITION: CONTACT LENS FITTING MEANS THE PROCESS THAT BEGINS AFTER AN INITIAL EYE EXAMINATION FOR CONTACT LENSES AND ENDS WHEN A SUCCESSFUL FIT HAS BEEN ACHIEVED OR, IN THE CASE OF A RENEWAL PRESCRIPTION, ENDS WHEN THE PRESCRIBER DETERMINES THAT NO CHANGE IN THE EXISTING PRESCRIPTION IS REQUIRED), THE PRESCRIBER:

1. WHETHER OR NOT REQUESTED BY THE PATIENT, SHALL PROVIDE TO THE PATIENT A COPY OF THE CONTACT LENS PRESCRIPTION; AND
2. SHALL, AS DIRECTED BY ANY PERSON DESIGNATED TO ACT ON BEHALF OF THE PATIENT, PROVIDE OR VERIFY THE CONTACT LENS PRESCRIPTION BY ELECTRONIC OR OTHER MEANS.

A PRESCRIBER MAY NOT:

1. REQUIRE THE PURCHASE OF CONTACT LENSES FROM THE PRESCRIBER OR FROM ANOTHER PERSON AS A CONDITION OF PROVIDING A COPY OF A PRESCRIPTION OR AS A CONDITION OF VERIFICATION OF A PRESCRIPTION;
2. REQUIRE PAYMENT IN ADDITION TO, OR AS PART OF, THE FEE FOR AN EYE EXAMINATION, FITTING, AND EVALUATION AS A CONDITION OF PROVIDING A COPY OF A PRESCRIPTION OR AS A CONDITION OF VERIFICATION OF A PRESCRIPTION; OR
3. REQUIRE THE PATIENT TO SIGN A WAIVER OR RELEASE AS A CONDITION OF RELEASING OR VERIFYING A PRESCRIPTION.

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.

Providers are required to release a patient’s contact lens Rx, without the patient requesting it, after the original contact lens fitting, and after a yearly examination that found no change in the contact lens Rx.

Promoting Coverage of Optometric Services

Do you have a company in your area whose employees would benefit from insurance coverage of optometric services? If so, please contact Dr. Quack or the NOA, for a couple of reasons.

♦ The AOA has a newsletter, Optometry the Primary Eye Care Profession, that it will send to such corporate human resources departments regarding the importance of covering routine eye care for employees.

♦ The NOA and the AOA may be able to help you in approaching this company regarding the covering of optometric care for their employees.

You can reach Dr. Quack at SCHNEIDERED@MSN.COM, or the NOA office at NOA@ASSOCOFFICE.NET.
NPI Implementation

**Dear Dr. Quack,**
When do we need to start using the National Provider Identifier?

**Dr. Quack’s Quote:**
The following is directly from the most recent DMERC Dialogue. It applies to Medicare B as well. Other insurers may request you use the NPI sooner than Medicare and DMERC.

**January 3, 2006 – October 1, 2006:**
Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

**October 2, 2006 – May 22, 2007:**
CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

**May 23, 2007 – Forward:**
CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

And remember, as we mentioned last month, you will need a separate identifier for each doctor, and one NPI for each office as well. If you have two doctors and three offices, you will need an identifier for each doctor (2), and one for each office (3).

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Checking DMERC Claim Status

**Dear Dr. Quack:**
How can I check status of a DMERC claim?

**Dr. Quack’s Quote:**
DMERC’s toll-free number to check claim status is 877.320.0390.

This number will be answered by an Interactive Voice Response (IVR) system that is ostensibly capable of responding to a variety of supplier inquiries and requests including claim status inquiries.

There are two other electronic claim status options available for suppliers or submitters:

1) Claim Status Inquiry Direct Data Entry (DDE) - this option allows a supplier to dial in and manually key in a beneficiary’s Health Insurance Claim number (HIC#) and other key personal information and receive a response within seconds.

2) Real Time Option – with this option the supplier sends a batch of one beneficiary inquiry into our system through the stratus bulletin board system and then receives a response.

Both options require completion of the DMERC Customer Profile. Contact the Region D Electronic Data Interchange (EDI) department for more information at 1.866.224.3094, option 1.
A Quick Quack Quiz: Does Your Office Need an Audit?

2. When using the E&M codes, do you actually count your history elements, exam elements, and decision making elements when computing the level of service?
3. Do your staff understand Medicare’s requirements regarding CPT’s 92004 or 92014 comprehensive examination codes (i.e., must provide an additional billable diagnostic service & must initiate a treatment program)? Do you follow them exactly?
4. Do data on your exam forms, billing forms, and claim forms match exactly?
5. Do you have a standard history form that addresses all body systems and all medications taken by the patient?
6. Does your doctor include all diagnoses related to the history, chief complaint, & examination at the end of the exam form?
7. Are the same exam codes used over and over, regardless of diagnosis, circumstance, and exam complexity?
8. Do you bill insurance companies differently than private pay patients?

Questions 1-6 should all have been answered “Yes”; questions 7 and 8 answered “No”. If you answered differently, your office needs to consider an NOA audit of your Medicare records.

Dr. Quentin Quack’s Cracked Quips....

The strong young man at the construction site was bragging that he could outdo anyone in a feat of strength. He made a special case of making fun of one of the older workmen. After several minutes, the older worker had had enough. “Why don’t you put your money where your mouth is,” he said. “I will bet a week’s wages that I can haul something in a wheelbarrow over to that outbuilding that you won’t be able to wheel back.”

“You’re on, old man,” the braggart replied. “Let’s see what you got.”

The old man reached out and grabbed the wheelbarrow by the handles. Then, nodding to the young man, he said, “All right. Get in.”