Nebraska Optometric Association

Volume 9, Issue 8

NOA 3rd Party Newsletter

Special points of interest:

- False Claims Act: Overpayments must be returned. P.3.
- Rules for the new ABN. P.4.
- CMS HIT Web Site. P.5.
- Barriers to OD EMR. P.8.
- Entities that can demand your records. P.5.

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Medicaid Cancels New Managed Care Program

The Nebraska Department of Health and Human Services (DHHS) has rejected all bids to award contracts to implement changes to the administration of the Nebraska Medicaid Managed Care Program for Physical Health. The Primary Care Plus and Share Advantage plans will continue to manage physical health services to clients in Douglas, Lancaster, and Sarpy counties through August 31, 2009.

The expansion of physical health managed care will not be implemented September 1, 2009. Clients residing in Cass, Dodge, Gage, Otoe, Sarpy, (Continued on page 3)
cards as a form of payment does not, by itself, make an entity a creditor. “Financial institutions” include entities that offer accounts that enable consumers to write checks or make payments to third parties through other means, such as other negotiable instruments or telephone transfers.

The FTC’s Red Flags Web site, www.ftc.gov/redflagsrule, offers resources to help entities determine if they are covered and, if they are, how to comply with the Rule. It includes an online compliance template that enables companies to design their own Identity Theft Prevention Program through an easy-to-do form, as well as articles directed to specific businesses and industries, guidance manuals, and Frequently Asked Questions to help companies navigate the Rule.

Although many covered entities have already developed and implemented appropriate, risk-based programs, some – particularly small businesses and entities with a low risk of identity theft – remain uncertain about their obligations. The additional compliance guidance that the Commission will make available shortly is designed to help them. Among other things,

- Commission staff will create a special link for small and low-risk entities on the Red Flags Rule Web site with materials that provide guidance and direction regarding the Rule.
- The Commission has already posted FAQs that address how the FTC intends to enforce the Rule and other topics — www.ftc.gov/bcp/edu/microsites/redflagsrule/faq.shtm.

The enforcement FAQ states that Commission staff would be unlikely to recommend bringing a law enforcement action if entities know their customers or clients individually, or if they perform services in or around their customers’ homes, or if they operate in sectors where identity theft is rare and they have not themselves been the target of identity theft.

The three-month extension, coupled with this new guidance, should enable businesses to gain a better understanding of the Rule and any obligations that they may have under it. These steps are consistent with the House Appropriations Committee’s recent request that the Commission defer enforcement in conjunction with additional efforts to minimize the burdens of the Rule on health care providers and small businesses with a low risk of identity theft problems. Today’s announcement that the Commission will delay enforcement of the Rule until November 1, 2009, does not affect other federal agencies’ enforcement of the original November 1, 2008, compliance deadline for institutions subject to their oversight.

The Federal Trade Commission works for consumers. To file a complaint, visit the FTC’s online Complaint Assistant or call 1-877-FTC-HELP (1-877-382-4357). The FTC enters complaints into Consumer Sentinel, a secure, online database available to more than 1,500 civil and criminal law enforcement agencies in the U.S. and abroad. The FTC’s Web site provides free information on a variety of consumer topics.
Medicaid Managed Care….

(Continued from page 1)

Saunders, Seward and Washington counties will remain fee for service at this time.

Providers will receive additional information regarding the expansion of and enrolling in managed care plans as it becomes available.

Further information on the Nebraska Medicaid Managed Care Program will be posted as new information becomes available and can be viewed at the Nebraska Medicaid’s website at:

http://www.dhhs.ne.gov/med/provhome.htm

From the AOA News:
Revised False Claims Act tightens overpayment rules

Federal efforts to crack down on the financial industry could impact health care practitioners who file claims for reimbursement under federal health plans such as Medicare and Medicaid, the AOA Advocacy Group warns.

Under recently enacted revisions to the federal False Claim Act, knowingly and improperly retaining an overpayment from a federal health plan could be considered a false claim, the AOA Advocacy Group notes. The revised law also effectively places responsibility on health care practitioners to determine if they have received an overpayment.

Those who receive an overpayment but do not detect it may be at risk for penalty under the revised law. Health care practitioners who discover an overpayment should consult with an attorney regarding their obligations under the law, the AOA Advocacy Group advises.

In addition to requiring health care practitioners to return overpayments, the revised law makes it easier for government investigators to take action against health care providers who file fraudulently bill the government indirectly through an entity that contracts with the government, the AOA Advocacy Group notes.

As a result claims submitted through Medicare private insurers or state Medicaid programs may soon come under greater scrutiny by federal officials.

Under the newly revised law, government officials have power to scrutinize any information, submitted by a health care practitioner, which may influence a government health plan’s decision to provide reimbursement.

For that reason, practitioners should take care to make sure that any supporting documentation for claims - such as responses to claim inquiries - provide accurate information, the AOA Advocacy Group advises.

The new False Claims Act revisions eliminate constraints on government investigators that were imposed under a pair of U.S. Supreme Court rulings in 2004 and 2008.

Source: AOA News
http://www.aoanews.org/x9460.xml?AOMember

Improperly retaining an overpayment from a federal health plan could be considered a false claim.
The new Advance Beneficiary Notice of Noncoverage (ABN) can fulfill both the mandatory and voluntary notice function.

**Mandatory Function:**
Providers should provide an ABN to their patients whenever they believe Medicare will deny the service based on medical necessity. Providers use the GA modifier to indicate they expect Medicare will deny a service as not reasonable and necessary and they provided the patient with an ABN. Appending the GA modifier to the procedure code establishes the beneficiary’s financial liability should Medicare deny the services based on medical necessity guidelines.

Medicare instructs providers not use general statements on the ABN. A general statement does not provide enough information to allow the beneficiary to make an informed decision about whether or not to proceed with the service. The statement "Medicare may not pay" is too general. Please do not use this statement.

Here are examples of statements that are acceptable along with specific information about the service in question:

- Medicare Part B usually does not pay for this many visits or treatments.
- Medicare Part B usually does not pay for this service.
- Medicare Part B usually does not pay for such an extensive procedure.
- Medicare Part B usually does not pay for this equipment.
- Medicare Part B usually does not pay for this lab test.
- [Quack addition: Medicare B usually does not pay for this service for patients with your condition (diagnosis).]

Be sure the ABN is specific to the date of service and procedure billed. There is no need to provide individual ABNs for a series of services; however, you must list the dates of service individually.

**Voluntary Function:**
Noncovered services are those which cannot be paid by Medicare and are statutorily excluded from being a Medicare covered benefit. Providers can bill a beneficiary for noncovered services. In most cases the beneficiary will be liable for the cost of the service. Providers are not required to bill Medicare unless a beneficiary requests a denial from Medicare.

The ABN is not required for services statutorily excluded from coverage under Medicare. However, the ABN can be issued voluntarily, in place of the Notice of Exclusion from Medicare Benefits (NEMB) form, for services that are noncovered.

[Quack note: the NEMB form may be an easier choice, however.] If the beneficiary requests a denial from Medicare, the provider may bill the services to Medicare using the GY modifier. The GY modifier defines the service as statutorily excluded or as a service that does not meet the definition of any Medicare benefit. The GY modifier must be appended to a procedure code when the provider wants to indicate that the service is statutorily noncovered or is not a Medicare benefit. The GY modifier is the most appropriate modifier in this situation.

Information regarding the use of the ABN is available on the Centers for Medicare & Medicaid Services (CMS) Website at the following addresses:

http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage


The NEMB form can be found at


Information regarding the use of the GA and GY modifiers is available on the Wisconsin Physicians Service (WPS) Medicare Website.
CMS Creates Website on HIT

A new website is now available from the Centers for Medicare & Medicaid Services (CMS) concerning Health Information Technology as provided for in the American Recovery and Reinvestment Act of 2009. On this website, you can find information pertaining to the Medicare and Medicaid incentives for electronic health records adoption and important links to related websites at the Department of Health and Human Services.

Posted now are:

- A CMS fact sheet and questions/answers pertaining to the incentive programs
- Link to press release pertaining to the process of defining meaningful use (Comments are due June 26, 2009.)
- Resources on Health IT and privacy & security (HIPAA)

Find information at:
http://www.cms.hhs.gov/Recovery/11_HealthIT.asp

Medical Records Documentation Alert

Providers can receive documentation requests from the following:

- Medicare Carriers
- Fiscal Intermediaries (FI)
- Medicare Administrative Contractors (MAC)
- Comprehensive Error Rate Testing (CERT) Contractors
- Recovery Audit Contractors (RAC)
- Program Safeguard Contractors (PSC)

The CERT contractor recently identified two errors:

1. Evaluation and Management (E/M) services
   - Failure to document medical records
   - Failure to provide sufficient documentation
   - Over- and under-coding

2. Provider Signature
   - Unsigned physician note
   - Physician notes without a legible identifier

E/M information is available on the WPS Medicare Website:
http://www.wpsmedicare.com/finapropek/training/resources/provider_types/evalandmgmnt.shtml

Information on the signature requirement for medical records documentation is located in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Pub. 100-08, Program Integrity Manual, Chapter 3, Section 3.4.1.1.B at

Annual Update of ICD-9-CM

CMS reminds providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage

or at the National Center for Health Statistics (NCHS) Web site in June of each year at

PC-ACE PRO32 UPGRADE 2.14 NOW AVAILABLE ONLINE

If you are currently using the PC-Ace Pro32 billing software, you can now download the latest upgrade online. You can download this information from the WPS EDI Website:
http://www.wpsic.com/edi/pcapecpro32.shtml

Now available online are:

- The upgrade to the latest version of PC-Ace, version 2.14
- Instructions related to the upgrade
- User Guides/Manuals

If you are not using the version listed above, it is very important that you update your software immediately.
EMR/EHR Stimulus Incentive Plan

The information in this article was provided by First Insight, developers of MaximEyes EMR/Practice Management Software, www.first-insight.com. Dr. Quack felt this article to be very informative, and appreciates First Insight’s permission to print it in our NOA 3rd Party Newsletter. [Since neither Dr. Quack nor the NOA recommend or endorse any particular EMR or Practice Management software, some specific references to First Insight are not found below.]

What is the EMR/EHR stimulus incentive plan?

On February 17, 2009, President Barack Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009. The $19.2 billion HITECH ACT, more commonly referred to as the Health Information Technology for Economic and Clinical Health Care Act, allocates $17.2 billion in Medicare and Medicaid incentives to doctors who adopt certified electronic health/medical records.

How will the Federal government distribute incentive payments?

Medicare Incentives: Beginning in 2011 physicians who are “meaningful users” of “certified EMR/EHR technology” will be eligible to receive up to $44,000 paid out over a five-year period in the form of incentive payments through Medicare reimbursements. Medicare incentives are based on “meaningful use” and are not tied to the actual cost of acquiring or maintaining an EHR.

According to the Centers for Medicare and Medicaid Services (CMS), the incentive payment is equal to 75 percent of Medicare allowable charges for covered services furnished by the eligible provider in a year, subject to a maximum payment in years 1-5.

An additional 10% incentive bonus payment is available to physicians operating in a designated Health Professional Shortage Area (HPSA); for more information visit www.hpsafind.hrsa.gov. The maximum payment for the first year is $18,000 (2011 and 2012) and bonus payments decline each subsequent year within the five-year period. Incentives will be paid out on a per provider basis. Bonus payments will phase out in 2016. See the table below for details.

Medicaid Incentives: Non-hospital based physicians whose Medicaid patient caseload is at least 30% may be eligible for up to $65,000 in Medicaid incentive payments over a five-year period. Physicians must demonstrate “meaningful use” of a certified EMR/EHR product. However, physicians must decide to receive either Medicare or Medicaid incentives, not both. Hospitals will be eligible for both incentives.

Why should you purchase and implement EMR/EHR now?

While the federal government has only released EHR incentive objectives as to what qualifies an eligible provider as a meaningful user, it’s imperative that you are several steps ahead of the federal mandates and not wait until the last minute to get started. As an early adopter of EHR, it will be much easier for you to capitalize on incentive dollars — 70% of the funding comes in the first two years. And although incentives are not effective until 2011, you must install EMR/EHR and collect data by 2010 before you can qualify for maximum incentive payments.

Don’t wait to purchase and implement EHR, as this will increase the risk that your practice may not be eligible to receive maximum incentive payments.

<table>
<thead>
<tr>
<th>MEDICARE INCENTIVES BY YEAR SCHEDULE</th>
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<tbody>
<tr>
<td><strong>Pay-Out Year</strong></td>
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<tr>
<td><strong>Starting Year</strong></td>
</tr>
<tr>
<td>2011</td>
</tr>
<tr>
<td>2012</td>
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<tr>
<td>2013</td>
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<tr>
<td>2014</td>
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<tr>
<td>2015</td>
</tr>
<tr>
<td><strong>2011</strong></td>
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<td><strong>2012</strong></td>
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<td><strong>2013</strong></td>
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<tr>
<td><strong>2014</strong></td>
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<tr>
<td><strong>2015</strong></td>
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<tr>
<td><strong>Total bonus payment</strong></td>
</tr>
<tr>
<td><strong>2011</strong></td>
</tr>
<tr>
<td><strong>2012</strong></td>
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<tr>
<td><strong>2013</strong></td>
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<td><strong>2015</strong></td>
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<td><strong>$44,000</strong></td>
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<tr>
<td><strong>$44,000</strong></td>
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<tr>
<td><strong>$39,000</strong></td>
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<tr>
<td><strong>$24,000</strong></td>
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<td><strong>$0</strong></td>
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</tbody>
</table>

Source: American Recovery and Reinvestment Act of 2009. Because federal statutes, regulations and rulings change frequently, information in this table is subject to change.
Are there penalties for not using EMR/EHR?

Starting in 2015, physicians who are not “meaningful” EHR users will see a 1% reduction in Medicare payments. The reduction increases to 2% in 2016 and 3% in each subsequent year. If the United States Department of Health and Human Services (HHS) Secretary finds that by the end of 2017 the proportion of physicians who are meaningful EHR users is less than 75%, HHS may continue to ratchet down payments by 1% a year (not more than 5 percent overall). Hardship exceptions may be issued on a case-by-case basis, such as exceptions for physicians who practice in rural areas without adequate Internet access.

What is a certified EMR/EHR technology?

Uniform rules and criteria for how the government will administer the incentives are still under development. The Secretary of HHS is expected to adopt an initial set of standards, implementation specifications, and certification criteria by December 31, 2009, but that date is subject to change. …

What is a meaningful user?

According to HHS, to qualify for the EHR incentives, doctors must meet all of the following three criteria:

- Demonstrate use of a “certified EHR technology” in a meaningful manner, including electronic prescribing.
- Demonstrate that the certified EHR technology is connected in a manner that provides for the electronic exchange of medical records.
- Submit information on clinical quality measures (PQRI) specified by the Secretary of HHS.

CMS/HHS is expected to publish a proposed rule in late 2009 to define “meaningful use” of certified EMR/EHR technology and establish criteria for incentive programs. For more information, visit the CMS/HHS website.

What is CCHIT?

The Certification Commission for Healthcare Information Technology (CCHIT) is a private, nonprofit organization and is the officially recognized certification agency in the U.S.” that applies standards, tests products, and awards a “seal of compliance” to EHR software. CCHIT’s mission is to accelerate the adoption of health information technology (HIT) by creating an efficient, credible and sustainable certification and inspection program. CCHIT was founded by AHIMA, HIMSS and NAHIT. For more information about CCHIT, visit [www.CCHIT.org](http://www.CCHIT.org) or [www.ehrdecisions.com](http://www.ehrdecisions.com).

Are ... software products CCHIT certified?

… Currently, CCHIT testing criteria is not yet available for eye care specialty EMR/EHR software and is only available for ambulatory specialties. However, the CCHIT Certification Commission has committed to providing eye care specialty testing criteria for optometry and ophthalmology before 2011. This timeline may change to an earlier date due to the emerging requirements of the American Recovery and Reinvestment Act EHR Stimulus Bill. …

What incentives are available now for PQRI?

Eye care providers who successfully report PQRI quality information in 2009 may earn a bonus payment of 2 percent of their total allowed charges for covered Medicare Physician fee schedule services (up to a maximum of $5,000). Allowable charges are that portion of the submitted charges that is approved for Medicare payment (including the deductible and coinsurance). …

What incentives are available now for ePrescribing?

In 2009, CMS removed PQRI Measure 125 (ePrescribing) and will use the Medicare Improvements for Patients and Providers Act (MIPAA) incentive program instead. In 2009 and 2010, physicians who successfully ePrescribe may receive a bonus payment of 2 percent of their overall Medicare Part-B reimbursement (up to a maximum of $5,000 annually). Amounts will vary depending on the annual allowable Medicare Part-B billings. In 2011-2012, the reward for ePrescribing will be 1 percent, while the penalty for not ePrescribing begins in 2012.

…”

Source for this article:


Note: the source article contains a number of links and resources that you might find of value. They were not included due to technical reasons.

See Also: Barriers to EHR

Next page
As the debate over national health care reform intensifies on Capitol Hill, a growing consensus has emerged among Washington, D.C., analysts and policymakers that health information technology (HIT) will serve an important role in improving the quality and efficiency of health care in America, according to the AOA Advocacy Group.

The central component of HIT, the electronic health record (EHR), can enable providers to better organize patient data, help deliver coordinated care among a patient’s team of providers, prevent errors and cut overall costs. However, many barriers to greater adoption and use of HIT remain, an AOA spokesperson told a key congressional subcommittee.

"EHR programs hold an amazing potential to improve patient care and lower costs, but the systems and programs are extremely expensive and many small health care practices - including many optometrist’s offices - will not be able to implement the technology without support from the federal government," said Charles Stuckey, O.D., executive director of the Pennsylvania Optometric Association.

Dr. Stuckey highlighted optometry’s concerns in June 24 testimony before the U.S. House of Representatives Committee on Small Business, Subcommittee on Health, Regulations and Trade as hundreds of ODs and optometry students stormed Capitol Hill as part of the AOA’s largest federal grassroots lobbying campaign ever - the 2009 AOA Congressional Advocacy Conference.

He thanked Congress for working with the AOA to ensure that optometrists are eligible for HIT incentives created through the American Recovery and Reinvestment Act (ARRA), the economic stimulus package approved by Congress earlier this year. But, he warned that a failure to make federally certified eye care EHRs available and provide guidance on exactly how they expect EHRs to be used. In turn, that could slow development of a planned Nationwide Health Information Network (NHIN).

The meaningful use provision was included in the stimulus legislation to ensure that health care practitioners not only purchase EHR systems but use them meaningfully. Once an EHR system is installed in a health care practice, it will take a practitioner and staff several months to learn how to use the system and incorporate it into the practice workflow, Dr. Stuckey noted.

As a result, Dr. Stuckey said, many eye care practices might not qualify for the badly needed financial incentives during the first year of the program unless government administrators promptly act to make certified eye care EHRs available and provide guidance on exactly how they expect EHRs to be used. In turn, that could mean eye care providers will be slower than necessary in joining the nation’s EHR network, thereby impeding efforts to establish the system over the projected time frame, Dr. Stuckey said.

"If you purchase a system, it will take some time to get ready (to use it). We're talking about 2011, which is not that far away," Dr. Stuckey said.

Source: AOA

http://www.aoanews.org/x9453.xml?AOAMember
### Table of Modifiers for Medicare Durable Medical Equipment (Post-op Rx’s)

<table>
<thead>
<tr>
<th>EXAMPLE ITEMS (All are per lens charges)</th>
<th>V-Code</th>
<th>MODIFIER(S)</th>
<th>DOCUMENTATION</th>
<th>CLAIM REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deluxe frame extra charge</td>
<td>V2025</td>
<td>GY</td>
<td>ABN for courtesy only (none-covered item)</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
<tr>
<td>UV lens coating, medically necessary (non-polycarb only)</td>
<td>V2755</td>
<td>KX</td>
<td>Reason for medical necessity documented</td>
<td>File on claim containing only medically necessary items</td>
</tr>
<tr>
<td>UV lens coating, NOT medically necessary</td>
<td>V2755</td>
<td>EY &amp; GA</td>
<td>ABN Required</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
<tr>
<td>Photochromic tint, medically necessary</td>
<td>V2744</td>
<td>KX</td>
<td>Reason for medical necessity documented</td>
<td>File on claim containing only medically necessary items</td>
</tr>
<tr>
<td>Photochromic tint, NOT medically necessary</td>
<td>V2744</td>
<td>EY &amp; GA</td>
<td>ABN Required</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
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<tr>
<td>#1 or #2 rose tint, medically necessary</td>
<td>V2745</td>
<td>KX</td>
<td>Reason for medical necessity documented</td>
<td>File on claim containing only medically necessary items</td>
</tr>
<tr>
<td>#1 or #2 rose tint, NOT medically necessary</td>
<td>V2745</td>
<td>EY &amp; GA</td>
<td>ABN Required</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
<tr>
<td>AR coating, medically necessary</td>
<td>V2750</td>
<td>KX</td>
<td>Reason for medical necessity documented</td>
<td>File on claim containing only medically necessary items</td>
</tr>
<tr>
<td>AR coating, NOT medically necessary</td>
<td>V2750</td>
<td>EY &amp; GA</td>
<td>ABN Required</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
<tr>
<td>Anti-scratch coating</td>
<td>V2760</td>
<td>GY</td>
<td>ABN for courtesy only (none-covered item)</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
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<tr>
<td>Oversize, required by RX</td>
<td>V2780</td>
<td>KX</td>
<td>Reason for medical necessity documented</td>
<td>File on claim containing only medically necessary items</td>
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<tr>
<td>Oversize, patient preference</td>
<td>V2780</td>
<td>EY &amp; GA</td>
<td>ABN Required</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
<tr>
<td>Progressive add extra charges</td>
<td>V2781</td>
<td>GY</td>
<td>ABN for courtesy only (none-covered item)</td>
<td>Must file on claim separate from claim containing medically necessary items</td>
</tr>
</tbody>
</table>
CMS recommends that each health care provider,

- Secure and maintain their own NPPES account information (i.e., User ID, Password, and Secret Question/Answer) for safety and accessibility purposes.
- Reset their NPPES passwords at least once a year. See the NPPES Application Help page at [https://nppes.cms.hhs.gov/NPPES/Help.do](https://nppes.cms.hhs.gov/NPPES/Help.do) and select the ‘Reset Password Page’ for applicable rules.
- Review their NPPES records in order to ensure that the information reflects current and correct information within 30 days of the effective date of the change.

View NPPES Information in one of two ways:

1. By accessing the NPPES record at [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created.

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**Dr. Quentin Quack's Quacked Humor**

**Dispatcher:** 911 What is your emergency?

**Caller:** I heard what sounded like gunshots coming from the brown house on the corner.

**Dispatcher:** Do you have an address?

**Caller:** No, I have on a blouse and slacks, why?

**Dispatcher:** 911 What is your emergency?

**Caller:** Someone broke into my house and took a bite out of my ham and cheese sandwich.

**Dispatcher:** Excuse me?

**Caller:** I made a ham and cheese sandwich and left it on the kitchen table and when I came back from the bathroom, someone had taken a bite out of it.

**Dispatcher:** Was anything else taken?

**Caller:** No, but this has happened to me before and I'm sick and tired of it!

![X]

**Dispatcher:** 911

**Caller:** Yeah, I'm having trouble breathing. I'm all out of breath. Dam....I think I'm going to pass out.

**Dispatcher:** Sir, where are you calling from?

**Caller:** I'm at a pay phone. North and Foster.

**Dispatcher:** ! Sir, an ambulance is on the way. Are you an asthmatic?

**Caller:** No

**Dispatcher:** What were you doing before you started having trouble breathing?

**Caller:** Running away from the Police.

![X]

**Dispatcher:** 911 What is the nature of your emergency?

**Caller:** My wife is pregnant and her contractions are only two minutes apart

**Dispatcher:** Is this her first child?

**Caller:** No, you idiot! This is her husband!

**Dispatcher:** I thought you just said it was nine-one-one

**Caller:** Honey, I may be old, but I'm not stupid.

![X]

**Dispatcher:** 911 What's the nature of your emergency?

**Caller:** My wife is pregnant and her contractions are only two minutes apart

**Dispatcher:** Is this her first child?

**Caller:** No, you idiot! This is her husband!

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**To access the new NOA 3rd Party web page directly:**

2. Enter your User Name (AOA member #) and Password (DOB MMDDYY) when requested.
Dear Dr. Quack,

We recently were denied a BCBS claim for 99213 E&M code along with 920 70, the fitting of a bandage contact lens. The denial code was M1S - Expenses not covered under the program. The patient says the reason it was denied is because our doctor is an OD, not an ophthalmologist. What gives...we’ve always been paid for this type of claim in the past.

Dr. Quack’s Quote:

That denial is because the patient’s BCBS plan is not a standard Nebraska BCBS plan, and does not cover the services you provided. It may be a plan from another state, but more likely, it is an ERISA plan (employer self-insuring plan) that the employer hired BCBS to administer. Unfortunately, federal law allows ERISA plans to cover whatever they wish, including discrimination against provider types. The AOA has been working diligently to address these misguided plans, and they would like to know any specific information you can provide about this patient’s health care plan.

Below is a copy of an article from the 11/12/2003 BCBS Update that explains the M1S denial code.

BlueCard Denials (from BCBS Update, )

If you’ve ever had BCBSNE deny charges in relation to claims submitted for BlueCard (or “out-of-state”) Blue Cross and Blue Shield patients, please be aware that we do not have membership or coverage information for these patients available to us. Therefore, a contact to BCBSNE will not result in more detail on the denial.

The remittance advice you receive back on your BlueCard patient claim is the outcome dictated by the patient’s Home Plan. Charges displayed as “patient liability” should be billed to the patient at this point. Here are some common denial reasons related to membership and coverage:

P74 - No record of membership
M30 - No dependent coverage
M1S - Expenses not covered under the program
M83 - The annual maximum for these services has been met

When such denial reasons exist, patients will need to contact their Home Plan if they disagree with the outcome. Be aware that patients receive an Explanation of Benefits from their Home Plan that explains the reason for the denial and shows the charges as “patient liability”. Home Plans will initiate an adjustment to the original claim, as needed, through the BlueCard Program if the denial is to be reversed (based on the patient contact). Direct questions about BlueCard to your Regional Consultant.


That denial is because the patient’s BCBS plan is not a standard Nebraska BCBS plan.

It may be a plan from another state, but more likely, it is an ERISA plan (employer self-insuring plan) that the employer hired BCBS to administer.
NOA Third Party Newsletter—ABSTRACTS OF THIS MONTH’S ISSUE

FTC DELAYS RED FLAG RULE AGAIN
To give creditors and financial institutions more time to review Red Flag guidance and develop and implement written Identity Theft Prevention Programs, the FTC will further delay enforcement of the Rule until November 1, 2009. P.1.

MEDICAID CANCELS NEW MANAGED CARE PROGRAM
The Primary Care Plus and Share Advantage plans will continue to manage physical health services to clients in Douglas, Lancaster, and Sarpy counties beyond August 31, 2009. P.1.

AOA: REVISED FALSE CLAIMS ACT
Under recently enacted revisions to the federal False Claim Act, knowingly and improperly retaining an overpayment from a federal health plan could be considered a false claim. P.3.

USE OF THE GA AND GY MODIFIER WITH ABN
The new Advance Beneficiary Notice of Noncoverage (ABN) can fulfill both the mandatory and voluntary notice function. P.4.

CMS CREATES WEBSITE ON HIT
A new website is now available from the Centers for Medicare & Medicaid Services (CMS) concerning Health Information Technology as provided for in the American Recovery and Reinvestment Act of 2009. P.5.

MEDICAL RECORDS DOCUMENTATION - ALERT
Providers must respond to documentation requests from a number of governmental entities. P.5.

ANNUAL UPDATE OF ICD-9-CM
CMS reminds providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009. P.5.

PC-ACE PRO32 UPGRADE 2.14 NOW AVAILABLE ONLINE
Information on update available on P.5.

EMR/EHR STIMULUS INCENTIVE PLAN
A comprehensive article on the stimulus incentive plan is provided via MaximEyes. Pp.6-7.

AOA: BARRIERS TO WIDESPREAD HIT ADOPTION
Failure to make federally certified eye care EHR programs available to practitioners over the next 18 months, when the new federal incentives take effect, could slow development of a planned Nationwide Health Information Network. P.8.

TABLE OF MODIFIERS FOR DME (POST-OP RX’S)
A handy Dr. Quack table is provided. P.9.

NPPES – SECURE, MAINTAIN & UPDATE YOUR NPI DATA
CMS recommends that each healthcare provider closely monitor and update their NPI information on the NPPES web site. P.10.

BCBS DENIAL CODES EXPLAINED
Unusual BCBS denial codes explained P.11.