January 2013

NOA 3rd Party Newsletter

Nebraska Optometric Association Volume 13, Issue 1

Please remember to forward NOA Newsletters To all of your doctors and staff !!

From the AOA:

Can I Sell Post-Op Glasses to a Medicare Recipient Without Being a Medicare Supplier?

AOA: Medicare fee for service covers post-op eyeglasses for cataract patients only if the glasses are provided by a DMEPOS supplier who is enrolled in Medicare. If the optometrist is not enrolled in Medicare for DMEPOS, then the glasses are not covered. Neither the doctor nor the patient can obtain reimbursement for the glasses from Medicare if the supplier is not enrolled. If a Medicare beneficiary wants to pay out of pocket for eyeglasses from a supplier who is not enrolled in Medicare, she/he may do so **but the doctor should be sure to explain to the patient that the glasses would be covered if they were obtained by another supplier who is enrolled in Medicare, and the doctor should be certain to have an ABN form signed by the patient** acknowledging that although she/he could have these glasses covered elsewhere she/he agrees to pay the doctor out of pocket (and that he/she cannot get reimbursement from Medicare). The CMS 1490S form, for the patient to seek reimbursement, may not be used in this situation. The patient will get a denial because Medicare only pays for covered eyeglasses, and covered eyeglasses only include those supplied by an enrolled supplier. Medicare fee for service will never pay when the DMEPOS supplier is not enrolled, no matter who submits the claim. Also, apparently a Medicare Advantage patient may obtain glasses from an optometrist contracted by the MA plan who is not enrolled as a supplier in Medicare.

If you want to supply Medicare-covered post-op glasses or contact lenses, you must enroll as a

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DMEPOS supplier. You have a choice of being a par- or non-par Medicare provider, but only if you have enrolled in Medicare. Medicare requires the par/non-par choice to be the same for all enrollments, e.g., as a Medicare B provider or as a Medicare Supplier. This means if you are "par" for professional services, you have to be "par" for DMEPOS. If you are not enrolled, then you are not par or non-par; glasses you prescribe are not covered by Medicare no matter who submits the bill.

Medicare EPs must complete attestation for the 2012 program year by February 28, 2013.

Deadlines for Getting Paid for 2012 EHR Incentives

December 31 deadline

The reporting year ends on **December 31, 2012** for eligible professionals (EPs) participating in the Medicare and Medicaid EHR Incentive Programs in 2012. For participating EPs, this means they must have completed their 90 or 365-day reporting period (within the calendar year) by the end of 2012 in order to receive an incentive payment.

When do I attest?

Medicare EPs must complete attestation for the 2012 program year by February 28, 2013, but can attest as soon as their reporting period is complete. CMS encourages EPs to register and attest sooner rather than later to resolve any potential issues that may delay their payment.

Resources from CMS

CMS has several resources located on the EHR Incentive Programs website to help EPs properly meet meaningful use and attest, including:

- A Registration & Attestation page on the CMS EHR Incentive Programs website that houses information on registration and attestation, and includes links to additional resources. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html
- The Meaningful Use Attestation Calculator allows EPs to determine if they have met the Stage 1 meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary. http://www.cms.gov/apps/ehr/
- The Attestation User Guide for Medicare Eligible Professionals provides step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the attestation system. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP_Attestation_User_Guide.pdf
- The Attestation Worksheet for EPs allows users to enter their meaningful use measure values, creating a quick reference tool to use while attesting.
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP-Attestation-Worksheet.pdf
- **Want more information about the EHR Incentive Programs?**

Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms

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- BEST to contact via Email at: SchneiderEd@msn.com
- Fax number is 402-464-1214. Call Ed before faxing.

NOA 3rd Party Newsletter

Verify Your Registration with PECOS, the MAC, and the EHR Registration System

CMS recommends you take important steps in order to successfully register for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CMS recommends you take the following step in order to successfully register for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

Enroll in the Provider Enrollment, Chain and Ownership System (PECOS). See http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Your registration status with the EHR Incentive Programs will remain in "issue pending" until you have an active enrollment record in PECOS. You will need the following information to successfully enroll with PECOS:

- An active NPI
- NPPES User ID and password. Internet-based PECOS can be accessed with the same User ID and password that a physician or non-physician practitioner uses for NPPES
- Personal identifying information (legal name, Social Security number, and date of birth)
- School information (name of school and graduation year)
- Professional license/certification information
- Practice location information
- Information about any final adverse action(s), if applicable
- Drug Enforcement Agency (DEA) number

If you are already enrolled, confirm your information is correct.

- Ensure your information with your Medicare Administrative Contractors (MAC) is up-to-date and matches your information in the CMS EHR Registration & Attestation System. The MAC processes your claims. Use this list to find your MAC and confirm your information is correct.

- Register early for the EHR Incentive Programs. This helps to more easily resolve any issues that may affect your incentive payment.

Participation Resources: CMS developed registration user guides for Medicare eligible professionals (EPs), Medicaid EPs, and Medicare and Medicaid eligible hospitals. You can also read the CMS Registration, Attestation, and PECOS Checklist for more information.

Want more information about the EHR Incentive Programs? Make sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs. (see page 2).

Learn the Basics of enrolling in Internet-based PECOS: Take a look at The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners, a helpful fact sheet series that provides education to physicians and non-physician practitioners on how to use Internet-based PECOS and includes a list of Frequently Asked Questions (FAQs).

From CMS: Sign up for the CMS Medicare Fee-For-Service Provider e-Newsletter to Stay Informed

The Medicare Learning Network® (MLN) now offers a weekly electronic newsletter, the CMS Medicare FFS Provider e-News at:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html

Subscribe to CMS Medicare FFS Provider e-News today to receive:

- Information on upcoming calls, meetings, and events;
- Announcements on items such as the EHR Incentive Programs, ICD-10, Medicare enrollment, the Medicare Shared Savings Program, and new regulations;
- Claims, pricing, and code updates; and
- Updates on MLN products and MLN Matters® articles.

The newsletter includes a clickable table of contents, allowing you to move directly to items of interest to you.

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Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs at

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms

From WPS: New, Improved eNews is Here!

WPS Medicare is pleased to announce our successful transition to Constant Contact. To ensure all of our customers continue to receive important Medicare news on a timely basis, we ask that you go out to your account and verify your subscription information, as well as update your account to provide some general information. Please use the following instructions to access and update your WPS Medicare eNews account.

Go to http://www.wpsmedicare.com

Select the eNews link in the top right corner of the webpage

Enter your email address and select Continue. You will receive the following message:

WPS Medicare eNews

Please enter your email address below to sign up for our mailing list.

Your email address: _____

WPS Medicare is pleased to announce our successful transition to Constant Contact.

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm

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Information Regarding the 2013 Medicare Physician Fee Schedule

The negative update of 27% under current law for the 2013 Medicare Physician Fee Schedule is scheduled to take effect on January 1, 2013.

Medicare Physician Fee Schedule claims for services rendered on or before December 31, 2012, are unaffected by the 2013 payment cut and will be processed and paid under normal procedures and time frames.

The Administration is disappointed that Congress has failed to pass a solution to eliminate the sustainable growth rate (SGR) formula-driven cuts, and has put payments for health care for Medicare beneficiaries at risk. We continue to urge Congress to take action to ensure these cuts do not take effect. Given the current progress with the legislation, CMS must take steps to implement the negative update.

Under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt. CMS will notify you on or before January 11, 2013, with more information about the status of Congressional action to avert the negative update and next steps.

2013 Medicare Provider Enrollment Application Fee

Federal Register Notice, CMS-6044-N, published on November 30, 2012, announced that the new Medicare provider application fee for CY 2013 is $532.00. Effective January 1, 2013, the new application fee will be imposed on institutional providers that are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information. This fee is required with any enrollment application submitted on or after January 1, 2013 and on or before December 31, 2013.

For more information on the Federal Register notice please refer to CMS-6044-N, entitled "Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2013."

Medicare: Appropriate Use of Modifiers

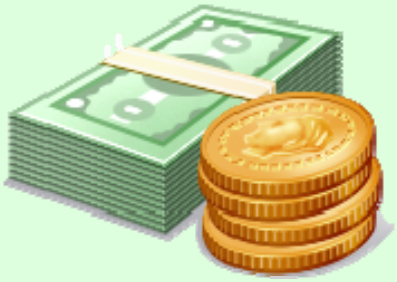
Are you having trouble determining the appropriate use of a modifier? Would you like to learn more about various modifiers? If so, the following web resources could provide the help you are looking for:

Modifier On Demand Training at http://www.wpsmedicare.com/j5macpartb/training/on_demand/modifiers.shtml

Modifier Fact Sheets at http://www.wpsmedicare.com/j5macpartb/resources/modifiers/

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm

Health Professional Shortage Area Bonus Payment Reminder



Physicians furnishing services to Medicare beneficiaries in areas designated as of December 31, 2012 by the Health Resources and Services Administration (HRSA) as primary care geographic Health Professional Shortage Areas (HPSAs) are eligible for a ten percent bonus payment for services furnished from January 1, 2013, to December 31, 2013. If an area does not have a geographic primary care HPSA designation, but does have a geographic mental health HPSA designation, then only psychiatrists furnishing services to Medicare beneficiaries in the designated area are eligible for the ten percent bonus.

It is the responsibility of the physician to determine if a service is furnished in a geographic HPSA. Eligibility is determined annually based on the status of the designation as of December 31 of the prior year.

- A physician or provider that was eligible for the ten percent bonus in 2012 may not be eligible for the bonus in 2013.
- A physician or provider that was not eligible for the ten percent bonus in 2011 may be eligible for the bonus in 2012. Information on designated areas is available from HRSA.

The following websites may be helpful in determining if an area is a geographic primary care or mental health HPSA:
HRSA website (shows if an area is eligible) http://bhpr.hrsa.gov/shortage/shortageareas/index.html
HRSA website (identifies designations within a state), http://bhpr.hrsa.gov/shortage/shortageareas/index.html
FFIEC website (identifies census tracts by entering an address) http://www.ffiec.gov/Geocode/default.aspx

CMS publishes annually a list of ZIP codes for which the ten percent bonus is paid automatically. Only areas where the entire ZIP code falls within the designated area at the time the list is developed are listed.
Physicians and providers furnishing services in eligible areas that are not on the CMS list of ZIP codes for automatic payment of the bonus must use the AQ modifier to receive the bonus. Only physicians furnishing services in areas designated as of December 31, 2012 as a geographic primary care HPSA whose ZIP code is not on the list should use the modifier. Only psychiatrists furnishing services in areas that are not designated as a primary care HPSA as of December 31, 2012 but are designated as a geographic mental health HPSA should use the modifier if the ZIP code is not on the list for automatic payment.

Information on the Medicare Physician bonus program, including the list of ZIP codes eligible for automatic payment of the bonus, can be found on the Physician Bonuses website.

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Retention of Patient Records

[Quack Note:We continue to receive questions regarding retention of patient records. This topic was covered thoroughly in an article written by AOA's Elizabeth Ortmann-Vincenzo, J.D., published in the AOA Journal *Optometry*, Volume 78, Issue 6, Pages 314-318 (June 2007). A small portion of her article is in italics below, followed by information specific to Nebraska.]

How long are optometrists required to keep their patient records? "Forever" would be the answer under ideal circumstances. Once a practitioner has established the doctor–patient relationship, there is at least the potential for legal liability at virtually any time in the patient's life thereafter.

However, although keeping records forever would be ideal, it is not required, nor is it feasible for most practitioners. Many practitioners have so many records that they are running out of space in their offices and perhaps even have records in their basements at home. Practitioners today have a variety of options for reducing their office record storage space requirement, from off-site storage to electronic records. However, from time to time, many practitioners probably still ask themselves if there is anything that they can actually throw out. Patient records are just one aspect of the records issue. Optometric practices are businesses that must, for a variety of reasons, maintain a number of business records.

As a rule, patient records should be kept for a minimum of 10 years after the date of the patient's last visit. However, practitioners should carefully check the law in their respective states and review several other considerations before determining what policy on patient record retention may be appropriate for a practice.

In Nebraska it is suggested that all patient records be retained for at least 10 years from the last patient encounter.

NOA attorney Larry Albers informed us that although there is a two year Statute of Limitations on malpractice action in Nebraska, the legislature has extended that to a total of 10 years through the Statute of Repose. This allows a patient to bring action on conditions that do not immediately become apparent.

The record of a minor should be kept for 10 years beyond when that minor reaches the age of majority (able to sign contract and make legal decisions for him/herself). In other words, if you last treated a child when s/he was 10 years old, you must keep the records until s/he is age 19 (age of majority) plus 10 more years (Statute of Repose), or until s/he is 29 years old.

Medicaid recently reminded providers that patient records must not only be retained, but must also thoroughly document all services and materials for which claims were filed, and must be available for Medicaid to review when requested.

Medicare recently published (in part) the following: Under 42 CFR 424.516(f)(1), a provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to (1) maintain documentation (see next paragraph) for 7 years from the date of service, and (2) provide access to that documentation upon the request of CMS or a Medicare contractor. The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services. If a provider fails to respond to a letter request for documentation within 30 days of the Medicare contractor's request, the contractor may revoke the provider's Medicare billing privileges and impose a 1-year re-enrollment bar.

2013 Claims Based PQRSTraffic Sheet

Directions: For ***each patient visit*** which includes a service ***and*** diagnosis that qualifies for PQRI (the "denominator"), circle the appropriate diagnosis code and procedure code, then check the box next to the appropriate CPT II code (the "numerator"), which your staff will then file on that same Medicare claim. *Note that there are three disease categories for optometry: primary open angle glaucoma, macular degeneration, and diabetes.*

PRIMARY OPEN ANGLE GLC

MEASURE #12 POAG: OPTIC NERVE EVALUATION WITHIN THE LAST 12 MONTHS ON ALL PATIENTS AGED 18 YEARS AND OLDER WITH A DIAGNOSIS OF PRIMARY OPEN-ANGLE GLAUCOMA

TO QUALIFY:
BOTH
⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 365.10, 365.11, 365.12, 365.15
AND
⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

TO CODE:
- 2027F: OPTIC NERVE HEAD EVALUATION PERFORMED
- 2027F 1P: DOCUMENTED *MEDICAL* REASON(S) FOR NOT PERFORMING AN OPTIC NERVE HEAD EVALUATION (Example: already accomplished w/i last 12 months)
- 2027F 8P: OPTIC NERVE HEAD EVALUATION WAS NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED

MEASURE #141 POAG: REDUCTION OF IOP BY 15%, OR DOCUMENTATION OF A PLAN OF CARE: POAG PATIENTS 18 YEARS AND OLDER WHOSE GLC TX HAS NOT FAILED (THE MOST RECENT IOP WAS REDUCED BY AT LEAST 15% FROM THE PRE-INTERVENTION LEVEL) —- OR IF THE MOST RECENT IOP WAS NOT REDUCED BY AT LEAST 15% FROM THE PRE-INTERVENTION LEVEL, A PLAN OF CARE WAS DOCUMENTED WITHIN 12 MONTHS.

TO QUALIFY:
BOTH
⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 365.10, 365.11, 365.12, 365.15
AND
⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

TO CODE:
- 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level
- IOP Reduced Less than 15% Pre-intervention Level but with GLC Plan of Care *CODE BOTH OF THE FOLLOWING*
  - 0517F: Glaucoma plan of care documented
  - 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level
- IOP Reduced Less than 15% Pre-intervention Level with no documented GLC Plan of Care , Reason not Specified *CODE BOTH OF THE FOLLOWING*
  - 0517F 8P: Glaucoma plan of care not documented, reason not otherwise specified
  - 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level
- IOP Measurement not Documented, Reason not Specified
  - 3284F 8P: IOP measurement not documented, reason not otherwise specified

MACULAR DEGENERATION

MEASURE #14 AMD: DILATED MACULAR EXAMINATION. PATIENTS AGED 50 & OLDER WITH AMD WHO HAD A DILATED MACULAR EXAMINATION PERFORMED WHICH INCLUDED DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE *AND* THE LEVEL OF MACULAR DEGENERATION SEVERITY IN 12 MONTH PERIOD. DEFINITIONS: MACULAR THICKENING – ACCEPTABLE SYNONYMS FOR "MACULAR THICKENING" INCLUDE: INTRARETINAL THICKENING, SEROUS DETACHMENT OF THE RETINA, PIGMENT EPITHELIAL DETACHMENT. SEVERITY OF MACULAR DEGENERATION – Mild, moderate, or severe.

TO QUALIFY:
BOTH
⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 362.50. 362.51, 362.52
AND
⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014; 99201, 99202, 99203, 99204, 99205; 99212, 99213, 99214, 99215; 99304,99305, 99306, 99307, 99308, 99309, 99310; 99324, 99325, 99326, 99327, 99328; 99334, 99335, 99336, 99337

TO CODE:
- 2019F: DILATED MACULAR EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE *AND* THE LEVEL OF MACULAR DEGENERATION SEVERITY
- 2019F 1P: DOCUMENTED *MEDICAL* REASON(S) FOR NOT PERFORMING A DILATED MACULAR EXAMINATION (e.g.: already accomplished w/i last 12 mos.)
- 2019F 2P: DOCUMENTED *PATIENT* REASON(S) FOR NOT PERFORMING A DILATED MACULAR EXAMINATION
- 2019F 8P: DILATED MACULAR EXAM WAS NOT PERFORMED, OR DID NOT INCLUDE DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE PLUS THE LEVEL OF MACULAR DEGENERATION SEVERITY, REASON NOT OTHERWISE SPECIFIED

MEASURE #140 AMD: COUNSELED REGARDING THE AGE-RELATED EYE DISEASE STUDY (AREDS); BENEFITS AND/OR RISKS OF THE AREDS FORMULATION FOR PREVENTING PROGRESSION OF AMD PROVIDED TO PATIENT AND/OR CAREGIVER(S) ; PATIENTS 50 YEARS OLD OR OLDER.

TO QUALIFY:
BOTH
⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 362.50. 362.51, 362.52
AND
⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*circle one*): 92002, 92004, 92012, 92014; 99201, 99202, 99203, 99204, 99205; 99212, 99213, 99214, 99215; 99307, 99308, 99309, 99310; 99324, 99325, 99326, 99327, 99328; 99334, 99335, 99336, 99337

TO CODE:
- 4177F: Age-Related Eye Disease Study (AREDS) formulation counseling provided to patient or caregiver.
- 4177F 8P: Age-Related Eye Disease Study (AREDS) formulation was not counseled, reason not otherwise specified

2013 Claims Based PQRS Traffic Sheet

DIABETES

MEASURE #18: DIABETIC RETINOPATHY: DILATED FUNDUS EXAM OF DIABETIC W/ DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA *AND* LEVEL OF SEVERITY OF RETINOPATHY WITHIN THE LAST 12 MONTHS IN PATIENT 18 YEARS AND OLDER

TO QUALIFY:
BOTH

⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014; 99201, 99202, 99203, 99204, 99205; 99212, 99213, 99214, 99215; 99304,99305, 99306, 99307, 99308, 99309, 99310; 99324, 99325, 99326, 99327, 99328; 99334, 99335, 99336, 99337

TO CODE:

- 2021F: DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY (E.G., BACKGROUND DIABETIC RETINOPATHY, PROLIFERATIVE DIABETIC RETINOPATHY, NONPROLIFERATIVE DIABETIC RETINOPATHY).
- 2021F 1P: DOCUMENTED *MEDICAL* REASON(S) FOR NOT PERFORMING A DILATED MACULAR OR FUNDUS EXAMINATION
- 2021F 2P: DOCUMENTED *PATIENT* REASON(S) FOR NOT PERFORMING A DILATED MACULAR OR FUNDUS EXAMINATION
- 2021F 8P: DILATED MACULAR OR FUNDUS EXAM WAS NOT PERFORMED, OR DIDI NOT INCLUDE DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY, REASON NOT OTHERWISE SPECIFIED

MEASURE #19: DIABETIC RETINOPATHY: DILATED FUNDS EXAM; AND COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE, WITH DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY WITHIN THE LAST 12 MONTHS IN PATIENT 18 YEARS AND OLDER

TO QUALIFY:
BOTH

⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014; 99201, 99202, 99203, 99204, 99205; 99212, 99213, 99214, 99215; 99304,99305, 99306, 99307, 99308, 99309, 99310; 99324, 99325, 99326, 99327, 99328; 99334, 99335, 99336, 99337

TO CODE:

- PERFORMED AND COMMUNICATED; *CODE BOTH OF THE FOLLOWING:*
  - G8397: DILATED MACULAR OR FUNDUS EXAM PERFORMED
  - 5010F: DILATED MACULAR OR FUNDUS FINDINGS COMMUNICATED
- PERFORMED BUT NOT COMMUNICATED DUE TO *MEDICAL* REASONS; *CODE BOTH OF THE FOLLOWING:*
  - G8397: DILATED MACULAR OR FUNDUS EXAM PERFORMED
  - 5010F 1P: DILATED MACULAR OR FUNDUS FINDINGS NOT COMMUNICATED DUE TO *MEDICAL* REASON(S)
- PERFORMED BUT NOT COMMUNICATED DUE TO *PATIENT* REASONS; *CODE BOTH OF THE FOLLOWING:*
  - G8397: DILATED MACULAR OR FUNDUS EXAM PERFORMED
  - 5010F 2P: DILATED MACULAR OR FUNDUS FINDINGS NOT COMMUNICATED DUE TO *PATIENT* REASON(S)
- PERFORMED BUT NOT COMMUNICATED DUE TO REASONS NOT SPECIFIED; *CODE BOTH OF THE FOLLOWING:*
  - G8397: DILATED MACULAR OR FUNDUS EXAM PERFORMED
  - 5010F 8P: DILATED MACULAR OR FUNDUS FINDINGS NOT COMMUNICATED DUE TO REASON(S) NOT SPECIFIED
- NOT PERFORMED
  - G8398: DILATED MACULAR OR FUNDUS EXAM NOT PERFORMED

….continued next column…..

NOTE: THE FOLLOWING MEASURE IS MOST LIKELY MEANT FOR THE PATIENT'S PCP. HOWEVER, SINCE IT DESCRIBES OUR SERVICES, IT COULD BE CODED. As with all codes, once you start coding this measure, you must code EVERY INSTANCE OF THIS MEASURE.

MEASURE #117: DIABETIC DILATED EYE EXAM PERFORMED BY AN EYE CARE PROFESSIONAL ON ALL PATIENTS AGED 18 THROUGH 75 YEARS WITH A DIAGNOSIS OF DIABETES

TO QUALIFY:
BOTH

⇒ ONE OF THE FOLLOWING ICD-9 DIAGNOSIS CODES *(CIRCLE ONE):* 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

⇒ ONE OF THE FOLLOWING CPT PROCEDURE CODES (*CIRCLE ONE*): 92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402

TO CODE:

- 2022F: DILATED RETINAL EYE EXAM WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED
- 2024F: SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED
- 2026F: EYE IMAGING VALIDATED TO MATCH DIAGNOSIS FROM SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS RESULTS DOCUMENTED AND REVIEWED
- 3072F: LOW RISK FOR RETINOPATHY (NO EVIDENCE OF RETINOPATHY IN THE PRIOR YEAR)
- *2022F or 2024F or 2026F *with* 8P: DILATED EYE EXAM WAS NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED.

Be sure to check the 2013 PQRS measure specifications at the CMS link below to assure Dr. Quack has not made an error when creating these two pages:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
The specifications manual is accessible at the bottom of the page under "related links."

From the AOA: Medicare Expanding Multiple Procedure Payment Reductions

AOA: Effective Jan. 1, 2013, Medicare will expand its Multiple Procedure Payment Reduction (MPPR) policy to the technical component (TC) of selected eye care procedures. The new payment reduction policy will apply largely to ophthalmic imaging services. The multiple payment reductions are applied when multiple services are furnished to the same patient on the same day.

The reductions apply to TC-only services and the technical component of global services. The reductions do not apply to professional component (PC) services. When multiple ophthalmic imaging services subject to this policy are provided by a physician or group practice to the same patient on the same day, the most expensive service will be paid at the normal Medicare physician fee schedule rate, while the TC of the other services will be paid at 80 percent of the fee schedule.

The AOA argued against expanding the MPPR policy to ophthalmic imaging and succeeded in reducing the discount from 25 percent to 20 percent," said AOA Federal Relations Committee Chair Roger Jordan, O.D. "Although there is no scientific basis for these reductions, the CMS has slowly subjected more and more procedures and services to these reductions based on the theory that services performed together can be provided more efficiently."

For a full explanation, and a list of codes affected, see the full article on page three of the December issue of the AOA News found at http://www.omagdigital.com/publication/?i=137726

From the AOA: More Dilemma on the S-Codes

By Stephen Montaquila, O.D., Third Party Center

Some health plans are now beginning to include comprehensive annual eye examinations in their benefit offerings. While this is something that we have long championed, it is not without reservation that we endorse these changes. In the absence of a Current Procedural Terminology (CPT© American Medical Association) code specific to a "wellness" eye examination, health plans in some cases are now using the S code to define this service. As a reminder, the S code is defined in the Healthcare Common Procedure Coding System (HCPCS) as "routine ophthalmological service, includes refraction" though it has no definition under CPT. The service that CPT does define, a comprehensive eye examination and its content, is often also regulated by state law. Optometrists in some states may be precluded by state laws and regulations from providing a lesser examination.

There is no "well visit," or "asymptomatic," or "nonmedical" service defined in CPT for eye care. By contrast, in medicine, CPT has defined well visit codes from birth to death. This allows the primary care physician a more specific code set to define the level of service provided and also allows the health plan the ability to provide very specific services to their enrollees.

For eye care professionals, S codes represent both a problem and an opportunity. We must report service in a clearly understandable and accountable way. We also recognize that both the eye care professional and, more importantly, our patients benefit from a system wherein all covered services are provided under the health plan in an integrated way. We understand why health plans sometimes struggle with how preventive and well eye care services are integrated into their plan offerings, as well as how those services should be billed and how they should be reimbursed.

The S code, however, presents pitfalls for both the eye care provider and the insurer. The lack of detail in the definition of the S code is perhaps its greatest liability. When eye care specialists report services under this code it is impossible

(Continued on page 11)

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for insurers or any other involved parties (ACO, MCO, PCP, PCMH administrators) to know exactly what has been done during the examination. This has far reaching implications not only for us as eye care professionals, but in the changing health care system with its new focus on accountability.

The S code represents a coding conundrum for eye care providers. Proper selection of the most appropriate CPT code is the only way clinicians can accurately describe to insurers and other involved parties the services that are provided to patients. We all recognize the implications of correct or incorrect coding and must continue to work with health plans to ensure that the services we provide to members/patients are reported in a clear and accountable way.

When a health plan covers a "self-referred well eye examination" and incorporates that coverage into the health plan offering, they make strides towards recognizing the importance of the services optometrists provide. The comprehensive eye examination codes (92004, new patient, or 92014, established patient) represent the best way to describe the service and we encourage better understanding of coding as it applies to reporting of eye care services.

The AOA Third Party Center cannot endorse the S code as a way to report a comprehensive eye examination. The definition of the code is simply too ambiguous. However, we applaud any health plan that makes strides to increase access to the services that we provide in an integrated, accountable way.

For more information regarding the integration of the eye care benefit into health plans, please contact the Third Party Center at tpc@aoa.org. For questions specific to coding contact askthecodingexperts@excelod.com.

From the AOA: Important Code Changes in CPT-2013

The following is from "Ask the Codeheads", AOA News, December 2012, page 23.

http://www.omagdigital.com/publication/?i=137726

Several codes had language changes for 2013, though the numbers stayed the same. For your reference, we've put the ***new or additional wording in bold italics*** and have noted deleted language with [*strike "wording"*]:

- 92015, Determination of refractive state ***(For instrument- based ocular screening, use 99174)***

- 92132, Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral. ***For specular microscopy and endothelial cell analysis, use 92286.***

- 92286, Anterior segment *[strike "photography"]* ***imaging,*** with specular microscopy and endothelial cell *[strike "count"]* ***analysis***

- Changes in definitions for 92002, 92012, 92004, 92014 include:

"Interpretation and report by the physician o***r other qualified health care professional*** is an integral part of special ophthalmological services where indicated…" and "***(For distinguishing between new and established patients, see Evaluation and Management guidelines)" Note: those guidelines are found at the front of the CPT manual.***

- In the section "Spectacle Services (Including Prosthesis for Aphakia).... When provided by the physician, fitting of spectacles is separate service when provided by the physician and is reported as indicated by 92340-92371…Presence of ***the*** physician ***or other qualified health care professional*** is not required."

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm

HIPAA Privacy & Security Manuals Available in MS Word Format

The front page article of last month's 3rd Party Newsletter addressed HIPAA Privacy and Security, and included links to the AOA HIPAA Privacy Manual and the AOA HIPAA Security Manual, both in PDF format.

It was brought to Dr. Quack's attention that these manuals would be more easily adapted to one's office if they were available in MS Word format. Please find below links to both manuals in MS Word format, hopefully making them easier for your staff to modify for your own office environment.

- The **AOA HIPAA Privacy Manual** is available in MSWord at http://www.aoa.org/x4764.xml
- The **NOA adaptation of the AOA HIPAA Privacy Manual** in MS Word format is available at http://nebraska.aoa.org/prebuilt/noa/NOA%20HIPAA%20Manual%20Final%20in%20Word%20with%20index.doc
- The **AOA HIPAA Security Manual** in MS word is available at http://www.aoa.org/x4760.xml .

HIPAA Privacy: De-Identifying Protected Health Information

The Office of Civil Rights (OCR) released guidance regarding methods for de-identification of protected health information in accordance with the HIPAA Privacy Rule. This guidance fulfills the American Recovery and Reinvestment Act of 2009 (ARRA) mandate that HHS issue such guidance. In response to this mandate, OCR collected research and views regarding de-identification approaches, best practices for implementation and management of the current de-identification standard and potential changes to address policy concerns. OCR solicited stakeholder input from experts with practical technical and policy experience to inform the creation of guidance materials by organizing an in-person workshop consisting of multiple panel sessions, each addressing a specific topic related to de-identification methodologies and policies. The guidance synthesizes these diverse perspectives. It can be found at

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html.

Noridian ABN Web-Based Workshop - February 12, 2013

Join NAS DME Outreach and Education on February 12, 2013 at 1 p.m. CT to review the Advance Beneficiary Notice of Noncoverage (ABN). The review includes definition and purpose of an ABN, acceptable and unacceptable ABNs, instructions on completing the ABN and more. This workshop is scheduled for 90 minutes. Read the complete update at:

https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi%3fid=EFVypFpVpAYBjLqZci&tmpl=dme_viewnews&style=part_ab_viewnews

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm

Dr. Quentin Quack's Queries and Questionable Quotes

Dr. Quentin Quack

Third Party Questions from NOA Doctors and Staff

You Can Bill Medicaid for Glasses Once They Are Delivered

Dear Dr. Quack:
Got a question. I thought I read yesterday on the DHHS website about not being able to bill NE Medicaid for frames and lens until the patient has picked them up. I can not seem to find it again today when I looked for it online. Do you know anything about that rule? Help please.

Dr. Quack's Quote:
You are exactly right...you must deliver the Rx before you can bill Medicaid (or Medicare, for that matter.) The Nebraska Medicaid **Vision Care Handbook** contains all information regarding Medicaid vision care, and is found at http://dhhs.ne.gov/medicaid/Pages/med_phvis.aspx.

The link to "Vision Care Services" (chapter 24) has the information you are seeking. See item 24A on http://dhhs.ne.gov/medicaid/Documents/471-000-65.pdf

Billing Lens 'Extras' Separately Rather Than Bundling Costs

Dear Dr. Quack:
I have heard of offices that include the cost of scratch coating and UV coating in lenses for ALL eye glasses. It is my impression that insurers, including Medicare, want those costs spilt out.

Dr. Quack's Quote:
It is important that *insurers be billed the same as private pay patients.* And 3rd parties (Medicare, Medicaid, etc.) want 'extras' (e.g., UV and Scratch coatings, etc.) billed separately, using appropriate modifiers. Indeed, billing extras separately to insurers is generally to the provider's advantage—otherwise they can lose the reimbursement for the extras. So, the all-inclusive billing policy you mentioned sounds shaky to Dr. Quack.

Dr. Quentin Quack's Quacked Humor

The Family of Potatoes

One night, the Potato family sat down to dinner--Mother Potato, Father Potato, and their three daughters. Midway through the meal, the eldest daughter spoke up. "Mother Potato?" she said. "I have an announcement to make."

"And what might that be?" said Mother, seeing the obvious excitement in her eldest daughter's eyes.

"Well," replied the daughter, with a proud but sheepish grin, "I'm getting married!"

The other daughters squealed with surprise as Mother Potato exclaimed, "Married! That's wonderful! And who are you marrying, Eldest daughter?"

"I'm marrying a Russet!"

"A Russet!" replied Father Potato with pride.

"Oh, a Russet is a fine tater, a fine tater indeed!"

As the family shared in the eldest daughter's joy, the middle daughter spoke up. "Mother? I, too, have an announcement."

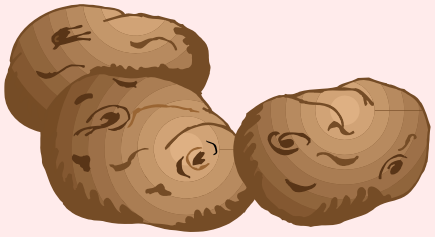
"And what might that be?" encouraged Mother Potato.

Not knowing quite how to begin, the middle daughter paused, then said with conviction, "I, too, am getting married!"

"You, too!" Father Potato said with joy. "That's wonderful! Twice the good news in one evening! And who are you marrying, Middle Daughter?"

"I'm marrying an Idaho!" beamed the middle daughter.

"An Idaho!" said Mother Potato with joy. "Oh, an Idaho is a fine tater, a fine tater indeed!"



Once again, the room came alive with laughter and excited plan for the future, when the youngest Potato daughter interrupted. "Mother? Mother Potato? Um, I, too, have an announcement to make."

"Yes?" said Mother Potato with great anticipation.

"Well," began the youngest Potato daughter with the same sheepish grin as her eldest sister before her, "I hope this doesn't come as a shock to you, but I am getting married, as well!"

"Really?" said Mother Potato with sincere excitement. "All of my lovely daughters married! What wonderful news! And who, pray tell, are you marrying, Youngest Daughter?"

"I'm marrying Peter Jennings!"

"Peter Jennings?!" Father Potato scowled suddenly. "But he's just a common tater!"