October 2013

NOA 3rd Party Newsletter

Nebraska Optometric Association Volume 13, Issue 10

Please forward to all of your doctors and staff

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From the AOA: Breaking News

HHS announces that significant choice and lower-than-expected premiums will be available in the new Health Insurance Marketplaces

Quack note: If the HHS predictions contained in this article prove to be true, it could have a significant impact on the number of children covered by the Pediatric Vision Benefit in Nebraska. Which, in turn, makes it even more important to carefully evaluate Pediatric Vision Benefit 3rd party plans prior to signing on as a provider. See the Quack Webinar on evaluating 3rd party plans at https://noaonline.webex.com/cmp0307l/webcomponents/docshow/docshow.do?siteurl=noaonline&setupStatus=1 (The first 90 seconds of this Webinar has technical difficulties that are quickly rectified.)

From the AOA: A new report released on September 25 by the Department of Health and Human Services (HHS) states that consumers will see increased competition in the Health Insurance Marketplace, including many new and affordable choices in the 36 states where HHS will fully or partly run the Marketplace. According to the report, consumers will be able to choose from an average of 53 health plans in the Marketplace, and the vast majority of consumers will have a choice of at least two different health insurance companies. Premiums nationwide will also be approximately 16 percent below earlier projections from the Congressional Budget Office, with about 95 percent of eligible uninsured lives in states having lower than expected premiums (before taking into account financial assistance).

Starting on October 1, the new Marketplace will be open for business where millions of Americans can shop for and purchase health insurance coverage online in one place. Consumers will be able to compare plans side-by-side based on pricing, quality and benefits and find out whether they qualify for premium assistance. No one can be denied coverage because of a preexisting condition. A six-month open enrollment period will run through March 2014. Coverage from participating health plans begins as early as January 1, 2014. To view the report online, click here. http://www.piersystem.com/go/doc/2430/1914497/

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

EVERY Provider Is Expected to Subscribe to WPS Medicare eNews

WPS Medicare is pleased to offer the convenient services of our WPS Medicare eNews to all providers in our jurisdiction. WPS Medicare eNews is an electronic newsletter (Listserv) sent to you via email. When you subscribe, WPS Medicare eNews will bring the latest Medicare news directly to your email box, free of charge! You may unsubscribe at any time and, as with all aspects of the WPS Medicare publications, we value your privacy and will never disclose, give, sell, or transfer any personally identifiable information to third parties. WPS Medicare eNews announces the posting of the following:

- Time-sensitive national and local Medicare news
- Medicare program changes
- Policy updates, including new, retired, and revised policies
- Training events (including seminars, teleconferences, webinars, and on demand trainings!)
- *Communiqué* newsletters
- Specialty- and service-specific educational articles
- Much, much more!

CMS has instructed that every Medicare provider (including physicians, nurses, and billing staff) should be subscribed to eNews. It is a common misconception that only one provider in an office can be subscribed to WPS Medicare eNews; **CMS and WPS encourage and expect ALL Medicare providers to subscribe to eNews**.

WPS Retires More LCD Policies Affecting Optometry/Ophthalmology

WPS has recently retired the LCD policies found in the table below. Unfortunately, this leaves the provider unknowledgeable about limitations of coverage for these services. How can you decide whether your service will be covered by Medicare? Although there is no guarantee that the information remains applicable, Dr. Quack suggests you refer to the retired LCDs whenever there is a question about coverage. To search for a particular retired LCD, use the Medicare MCD Archive web site at http://coverage.cms.fu.com/mcd_archive/search.asp?clickon=search&

Our WPS LCDs are Disappearing!

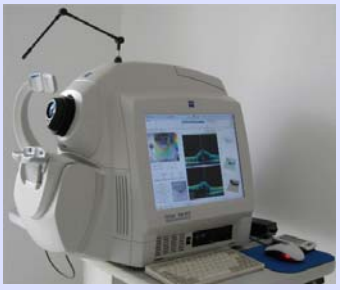
LCD Policies Retired Effective August 1st, 2013

Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Computerized Corneal Topography	L31064	OPHTH-014	08/01/2013
This LCD and attached Billing and Coding Guidelines document are retired.			
Corneal Pachymetry	L30485	OPHTH-025	08/01/2013
This LCD and attached Billing and Coding Guidelines document are retired.			
Ophthalmic Biometry	L31624	OPHTH-006	08/01/2013
This LCD and attached Billing and Coding Guidelines document are retired.			
Optical Coherence Tomography (OCT)	L29971	OPHTH-015	08/01/2013

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

Retired OCT LCD Soon to be Replaced by SCODI LCD

A Scanning Computer Ophthalmic Diagnostic Imaging (SCODI) Local Coverage Determination is soon to replace the Retired Wisconsin Physician Service OCT LCD. The full SCODI LCD has yet to be approved; however, the following information has been gleaned from the proposed LCD.



SCODI includes the following tests:

- Confocal Laser Scanning Ophthalmoscopy (topography)
- Scanning Laser Polarimetry, nerve fiber analyzer
- Optical Coherence Tomography (OCT)

Indications included:

- Glaucoma
- Retinal Disorders
- Anterior Segment Disorders
- Long Term Use of Chlorquine (CQ) and or Hydroxychloroquine (HCQ)

  Coding note:

  * Use V71.89 when testing is necessary prior to chloroquine (CQ) and hydroxychloroquine (HCQ) therapy.
  * Use V58.69 and V67.51 to report testing due to the use of chloroquine (CQ) and/or hydroxychloroquine (HCQ).

Specific coding guidelines for this proposed policy:

The following codes would generally not be necessary with SCODI. When needed the same day, documentation must justify the procedures.

- 92250 Fundus photography with interpretation and report
- 92225 Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial
- 92226 Subsequent ophthalmoscopy
- 76512 B scan (with or without superimposed non-quantitative A-scan).

It should be noted that there are National Correct Coding Initiative (NCCI) mutually exclusive edits for CPT codes 92133, 92134 and 92250. The NCCI edits state that code 92132 can't be billed the same day as either 92133 or 92134.

A modifier is allowed if performed on separate eyes. However, CPT code 92250 has a bilateral indicator of "2" on the Medicare Physician Fee Schedule Database. Therefore, the fee schedule amount represents photography of both eyes. Modifier -52 and the appropriate anatomic modifier (-LT or -RT) should be appended if only one eye is photographed.

The CPT codes 92132, 92133 and 92134 have a bilateral indicator of "2" on the Medicare Physician Fee Schedule Database. Therefore, the fee schedule amount represents payment for both eyes. Do not submit modifier -50. If only one eye is examined, submit the appropriate anatomic modifier (-LT or -RT) and modifier -52.

Stay tuned for the announcement of the posting of this LCD on the WPS website, following its final approval.

Nebraska Optometric Association

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The NOA Third Party Newsletter is published monthly by the Nebraska Optometric Association with the assistance of Ed Schneider, O.D., Third Party Consultant. To reach Ed (aka Dr. Quack):

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

CMS-1500 Revised Claim Form Updates: Medicare to Accept New Form Starting January 2014 ; Required April 2014

The CMS-1500 Claim Form has been recently revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set. The revised CMS-1500 form (version 02/12) will replace version 08/05. The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes, which is important as the October 1, 2014, transition approaches. ICD-9 codes must be used for services provided before October 1, 2014, while ICD-10 codes should be used for services provided on or after October 1, 2014. The revised form also allows for additional diagnosis codes, expanding from 4 possible codes to 12.

Only providers who qualify for **exemptions from electronic submission** (see http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html?utm_medium=email&utm_source=govdelivery) may submit the CMS-1500 Claim Form to Medicare. For those providers who use service vendors, CMS encourages them to check with their service vendors to determine when they will switch to the new form.

Medicare will begin accepting the revised form on January 6, 2014. Starting April 1, 2014, Medicare will accept only the revised version of the form.

"Medicare Enrollment and Claim Submission Guidelines" Booklet Has Been Revised

The "***Medicare Enrollment and Claim Submission Guidelines***" Booklet (ICN 906764) was revised and is now available in downloadable format. This booklet is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Noncoverage; and billing requirements. See

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf?utm_medium=email&utm_source=govdelivery

MAC Operations Continue During Shutdown

During the time that the partial government shutdown is in effect, Medicare Administrative Contractors will continue to perform all functions related to Medicare fee-for-service claims processing and payment.

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

Erroneous Denials of Medicare Ophthalmology Codes

The latest package of National Correct Coding Initiative (NCCI) edits, Version 19.2, effective July 1, 2013, was updated appropriately to include the ophthalmology Evaluation and Management (E&M) procedure codes 92012 and 92014 based on the policy outlined in the Internet Only Manual (IOM) 100-04, Chapter 12, Section 40.3.B. However, CMS has been made aware that the Multi-Carrier System inadvertently omitted procedure codes 92012 and 92014 from the E&M range of 99201-99499 and is not allowing the use of separately billed modifiers 25, 24, and 57. This is causing claims to deny inappropriately when the modifiers are appended to these procedure codes.

CMS is correcting this issue and A/B Medicare Administrative Contractors (MACs) will reprocess all inappropriately denied claims by November 15, 2013. Providers do not need to take any action in having their claims corrected.

ACA Incentive Programs

Stage 2 Guide for the EHR Incentive Programs Now Available

CMS has released a new resource, **An Eligible Professional's Guide to Stage 2 of the EHR Incentive Programs** http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_EPs_9_23_13.pdf?utm_medium=email&utm_source=govdelivery, which provides a comprehensive overview of Stage 2 of the EHR Incentive Programs to eligible professionals. The guide outlines criteria for Stage 2 meaningful use, 2014 clinical quality measure reporting, and 2014 EHR certification. The guide's table of contents makes it easy for you to navigate through Stage 2 topics. Interactive tabs included at the bottom of each page allow you to transition between different chapters. Chapters include:

- What is Stage 2 of the EHR Incentive Programs?
- What are the requirements under Stage 2 of Meaningful Use?
- How will clinical quality measures (CQMs) change?
- Resources

The guide can be found on the **Educational Resources** page of the **EHR website** at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=%2Fehrincentiveprograms%2F&utm_medium=email&utm_source=govdelivery

Want more information about the EHR Incentive Programs?

Visit the **EHR Incentive Programs** website https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?utm_medium=email&utm_source=govdelivery for the latest news and updates on the EHR Incentive Programs.

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

Submitting Quality Data for the 2013 EHR Incentive Programs

Providers must report clinical quality measures (CQMs) to CMS to demonstrate meaningful use under the EHR Incentive Programs.

For the 2013 reporting year, there are two options for reporting CQMs for the Medicare EHR Incentive Program: through the **CMS Attestation System** or **through electronic reporting pilots**. See http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CQM_Through_2013.html?utm_medium=email&utm_source=govdelivery

Attestation

When you are ready to submit CQM data through the Attestation System, you should:

1. Log in to the CMS Registration and Attestation system. See https://ehrincentives.cms.gov/hitech/login.action
2. Enter your data for the meaningful use core and menu objectives
3. Report your CQM data directly from your certified EHR technology into the Attestation System:
    - Eligible professionals must report a total of six CQMs
        - Three core or alternate core measures (only report an alternate core measure if one of the core denominators is zero)
        - Three additional measures from a list of 38
        - If you are attesting to CQM data for the EHR Incentive Programs you may submit a zero result for a CQM if the zero is the accurate calculation from your EHR

Electronic Reporting Pilots

Eligible professionals and eligible hospitals also have the option to submit CQMs through electronic reporting, or eReporting pilots *[Quack Note: make sure your EHR software is capable this prior to depending upon it]*:

- For eligible professionals: Through **the PQRS-Medicare EHR Incentive Pilot** at http://cms.gov/eHealth/downloads/CMS_PQRS_ParticipationDocument.pdf?utm_medium=email&utm_source=govdelivery

Exclusions

Some CQMs cannot be met during the reporting period chosen by the provider and so exclusions are available for those CQMs. For example, many CQMs for EPs require a minimum of two visits for a patient to meet the denominator criteria. Exclusions do not count against a provider's attestation requirements.

2014 CQM Reporting Changes

Beginning in 2014, all providers must report CQMs based on new requirements outlined in the Stage 2 final rule, regardless of what stage they are in. For more information on these requirements, such as the number of CQMs and how to select which ones to report, visit the **2014 CQMs webpage** at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html?utm_medium=email&utm_source=govdelivery.

Want more information about the EHR Incentive Programs?

Make sure to visit the **CMS EHR Incentive Programs website** at http://www.cms.gov/EHRIncentivePrograms for the latest news and updates on the EHR Incentive Programs.

2012 eRx Incentive Payments Now Being Issued

On September 5, 2013, WPS Medicare began issuing the 2012 eRx incentive payments. The Electronic Remittance Advice (ERA) will carry the "LE" and RX12 indicators in the PLB-03-1 and PLB-03-2 segments and the Standard Paper Remittance (SPR) will carry the message "This is an eRx incentive payment."

WPS Medicare would like to remind providers that although code "LE" is defined as a Levy in the X12 Implementation Guide, CMS uses code "LE" to indicate a federally mandated incentive payment.

New Interactive Tool To Determine Potential Upcoming Payment "Adjustments" [Penalties]

Payment adjustments affect certain eligible professionals who do not satisfy mandatory criteria for one or more of the eHealth programs.

You can determine if you will incur a future eHealth program payment adjustment with this easy-to-use, interactive eHealth Payment Adjustment Tool CMS developed. The tool shows what payment adjustments to expect based on your past, current, and expected future participation in eHealth programs.

eHealth Programs with Upcoming Payment Adjustments

Navigate through the tool by answering a series of questions about your participation and eligibility status for the following programs:

- **eRx Incentive Program** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html?redirect=%2Ferxincentive&utm_medium=email&utm_source=govdelivery
- **Medicare EHR Incentive Program** http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=%2Fehrincentiveprograms%2F&utm_medium=email&utm_source=govdelivery
- **Physician Quality Reporting System** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=%2Fpqri&utm_medium=email&utm_source=govdelivery

Each program has its own interactive decision tree that provides results based on the EP's answers. CMS encourages you to use the tool to become more informed about potential payment adjustments.

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

Win or Lose, Antitrust Litigation will *break your bank*.

It is the responsibility of each employee, volunteer, or other individual acting on behalf of the AOA or the NOA to understand and comply with the antitrust compliance policy.

From the AOA

Antitrust Dos and Don'ts

*Quack Note: the following is from the American Optometric Association. The information it contains is equally applicable to the NOA and its members. So, when reading below, please think "**AOA and NOA**" wherever you see the term "**AOA**" .*

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It is the responsibility of each employee, volunteer, or other individual acting on behalf of the AOA to understand and comply with the antitrust compliance policy. If situations arise in which an individual has concerns about the antitrust implications of certain conduct, he or she should contact legal counsel for guidance.

Antitrust Dos and Don'ts

Impermissible Actions under the Antitrust Laws

1. Coordinate with competitors to engage in joint negotiations with third party payers on the reimbursement policies.
2. Facilitating concerted action with competitors to increase fees or reimbursement rates. Such concerted action would include:
    - A recommendation by AOA that its members withdraw from contracting with a third party payer (group boycott);
    - An AOA resolution that its members should not participate in a third party payer's plan or prohibiting members' participation in the plan;
    - An AOA recommendation that its members not disclose certain patient medical information requested by a third party payer;
    - The AOA members pledging that they will not submit patient information requested by a third party payer;
    - An AOA recommendation that its members protest or challenge every reimbursement made by a third party payer; or
    - The AOA coordinating the mass resignation of members if the third party payer's policies are not acceptable.

Permissible Actions under the Antitrust Laws

1. Provide educational information to third party payers regarding the procedures performed by ODs and explain—where appropriate—that such procedures are identical to the procedures of ophthalmologists.
2. Educate third party payers on the costs to ODs for providing various procedures.
3. Obtain information from third party payers regarding the justification for the disparities in reimbursement rates.
4. Educate third party payers on the scope of an ODs practice as authorized by various states.
5. Educate third party payers as to the reasons that AOA believes having full participation by ODs adds value to the plan.
6. Explain to third party payers the reasons that ODs and ophthalmologists should be provided with the same opportunities within networks and plans.
7. Obtain information from third party payers on whether the rates for identical procedures within individualized plans for ODs and ophthalmologists are different; and if there is a difference, seek an explanation for that difference.

BCBS Fall "Update" Available; Contains Important Information for ODs

The Blue Cross and Blue Shield of Nebraska Fall 2013 issue of Update is currently available online at https://www.nebraskablue.com/~/media/pdf/Provider/Update%20Newsletters/Provider%20Update%20Fall%202013.pdf. It has some important articles relevant to some Nebraska ODs, including:

New Contact Information for Medicaid Patients & Applicants

Quack Note: ***The information below is for Medicaid patients and applicants, not providers****. Up until now Medicaid clients and potential clients have been suffering long delays when attempting to contact the department. In an effort to remediate those problems, Medicaid has significantly altered the method used by clients to reach the department. The information below can be given to Medicaid patients as a courtesy if they are unaware of these changes in contact information.*

# # #

Clients who currently receive benefits do not need to call or reapply, unless you have received a letter telling you to call or reapply. In addition, current clients must continue to report changes.

NEW PHONE NUMBERS STARTING 9/30/2013

MEDICAID Questions about Medicaid programs call: 1-855-632-7633

* Calls from Lincoln local numbers call: 402-473-7000
* Calls from Omaha local numbers call: 402-595-1178
* TTY: 402-471-7256
* Fax: 402-471-9209

Customer service hours for Medicaid:

* 8:00 am to 5:00 pm Monday - Friday
* Closed weekends & federal and state holidays

Economic Assistance (SNAP, Energy, Child Care, ADC)

* Questions about EA programs call: 1-800-383-4278
* Calls from Lincoln local numbers call: 402-323-3900
* Calls from Omaha local numbers call: 402-595-1258
* TTY: 402-471-7256
* Fax: 402-595-1901

Customer service hours for Economic Assistance:

* 8:00 am to 5:00 pm Monday - Friday
* Closed weekends & federal and state holidays

AOA: New HIPAA rules took effect Sept. 23

From the AOA:

The compliance date for the new, updated Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule was Sept. 23. The AOA is providing resources to help you with every step.

The new HIPAA Compliance section of the AOA website http://www.aoa.org/optometrists/tools-and-resources/hipaa-compliance (member login required to view) includes:

- Updated **AOA HIPAA Security Regulation Compliance Manual** (available free of charge to AOA members);
- A sample **HIPAA Business Associate Agreement**; and
- A sample **HIPAA Notice of Privacy Practices**, developed by the **AOA Office of Counsel** for use in optometric practices, which are available in bulk from AOA Marketplace.

The AOAExcel® HIPAA page http://www.excelod.com/login (member login required to view) includes:

- AOA White Paper: **Updated HIPAA Regulations-What Optometrists Need to Know**, with questions and answers about the privacy regulations

In addition, the **U.S. Department of Health & Human Services** (HHS) http://www.hhs.gov/news/press/2013pres/01/20130117b.html offers resources for HIPAA-covered entities and their business associates.

HIPAA Question: What is a Business Associate?

Dr. Quack has received questions on what comprises a "Business Associate". The following is a portion of the Business Associate definition provided by the U.S. Department of Health & Human Services' ***Office of Civil Rights*** *(OCR). Be sure to go to the OCR site for greater detail.* **http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/businessassociates.html**

What Is a "Business Associate?" A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate. A covered health care provider, health plan, or health care clearinghouse can be a business associate of another covered entity. The Privacy Rule lists some of the functions or activities, as well as the particular services, that make a person or entity a business associate, if the activity or service involves the use or disclosure of protected health information. The types of functions or activities that may make a person or entity a business associate include payment or health care operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules.

Business associate functions and activities include: claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing. Business associate services are: legal; actuarial; accounting; consulting; data aggregation; management; administrative; accreditation; and financial. See the definition of "business associate" at 45 CFR 160.103.

(Continued on page 11)

(Continued from page 10)

Examples of Business Associates.

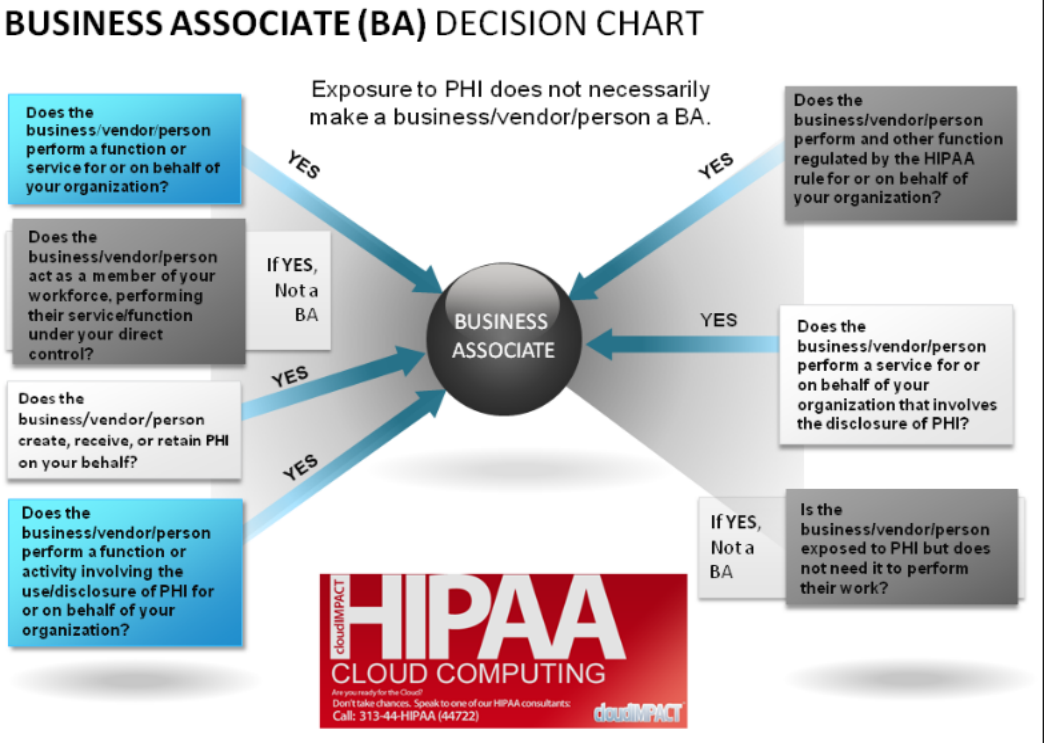
- A third party administrator that assists a health plan with claims processing.
- A CPA firm whose accounting services to a health care provider involve access to protected health information.
- An attorney whose legal services to a health plan involve access to protected health information.
- A consultant that performs utilization reviews for a hospital.
- A health care clearinghouse that translates a claim from a non-standard format into a standard transaction on behalf of a health care provider and forwards the processed transaction to a payer.
- An independent medical transcriptionist that provides transcription services to a physician.
- A pharmacy benefits manager that manages a health plan's pharmacist network.

FAQs regarding Business Associates can be found at http://www.hhs.gov/hipaafaq/providers/business.

- Who Are Business Associates?
- Contracts
- Requirements for Business Associates
- Limited Data Set Usage
- Responsibility of the Covered Entity
- Statutory Authority of HIPAA

Unofficial Business Associate Decision Chart Published by Cloud Impact

The adjacent Decision Chart is an Unofficial Resource that seemed helpful to Dr. Quack. However, use it at your own risk, as it is not published by the HHS Office of Civil Rights.



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

BCBS: Billing a Corneal Abrasion as an Accident?

Dear Dr. Quack, We are getting denials from BCBS on corneal abrasion claims that state "accident related injury" and so there must be a modifier or something else that we are not using appropriately. When I called BCBS they stated that with a corneal abrasion diagnosis you need section 10 filled out, and date of current illness section 14 needs to be filled out. Is this all? Something else I am missing?

Dr. Quack's Quote: I think you have isolated the problems (items 10 and 14)...although this is the first time I have heard of the need to complete these boxes for BCBS or any other 3rd party when a corneal abrasion is the diagnosis.

Incidentally, BCBS of New Mexico has a web site that is helpful when completing the CMS-1500 for BCBS...take a look at it at http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/tost71a_014721.pdf

Please let me know if you have further problems after re-submitting with the items 10 and 14 completed...

Coding a Hospital Visit

Dear Dr. Quack, What are the steps in billing an office visit when one of our doctors went to the hospital and saw a patient? A doctor from the local hospital called and asked if one of our optometrists could come by and see a patient. Do I bill the 99000 code and use the place of service the hospital?

Dr. Quack's Quote: It's a bit complicated if the patient is hospitalized…

If the patient is **Inpatient Hospitalized, and is seen in either the office or hospital:**

- POS hospital (21) [...yep really, even if seen at your office];
- use inpatient (9923x) CPT codes (see CPT for the level of code)

If the patient is **Outpatient Hospitalized, and is seen at the hospital**:

- POS hospital (22);
- use outpatient (9921x) or ER (9928x) CPT codes (see CPT for your specific code)

See more at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2679CP.pdf and

http://nebraska.aoa.org/prebuilt/noa/2012-11_3RD_Party_Newsletter.pdf

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

Dr. Quentin Quack's Quacked Humor

Hit The Floor -- An Urban Legend

Friday, April 13, 2001

A few years back, on a weekend in Atlantic City, a woman won a bucketful of quarters at a slot machine. She took a break from the slots for dinner with her husband in the hotel dining room.

But first she wanted to stash the quarters in her room. 'I'll be right back and we'll go eat,' she told her husband and she carried the coin-laden bucket to the elevator.

As she was about to walk into the elevator she noticed two men already aboard. Both were black. One of them was big... very big... an intimidating figure. The woman froze. Her first thought was: These two are going to rob me. Her next thought was: Don't be a bigot, they look like perfectly nice gentlemen. But racial stereotypes are powerful, and fear immobilized her. She stood and stared at the two men. She felt anxious, flustered, and ashamed. She hoped they didn't read her mind, but knew they surely did; her hesitation about joining them on the elevator was all too obvious. Her face was flushed. She couldn't just stand there, so with a mighty effort of will she picked up one foot and stepped forward and followed with the other foot and was on the elevator.

Avoiding eye contact, she turned around stiffly and faced the elevator doors as they closed. A second passed, and then another second, and then another. Her fear increased. The elevator didn't move. Panic consumed her.

'My God, she thought, I'm trapped and about to be robbed' Her heart plummeted. Perspiration poured from every pore. Then ...one of the men said, "Hit the floor." Instinct told her: Do what they tell you. The bucket of quarters flew upwards as she threw out her arms and collapsed on the elevator carpet. A shower of coins rained down on her. Take my money and spare me, she prayed.

More seconds passed. She heard one of the men say politely, 'Ma'am, if you'll just tell us what floor you're going to, we'll push the button.'

The one who said it had a little trouble getting the words out. He was trying mightily to hold in a belly laugh. She lifted her head and looked up at the two men. They reached down to help her up. Confused, she struggled to her feet. 'When I told my man here to hit the floor,' said the average sized one, 'I meant that he should hit the elevator button for our floor. I didn't mean for you to hit the floor, ma'am.' He spoke genially. He bit his lip. It was obvious he was having a hard time not laughing.

She thought: 'My God, what a spectacle I've made of myself.' She was too humiliated to speak. She wanted to blurt out an apology, but words failed her. How do you apologize to two perfectly respectable gentlemen for behaving as though they were going to rob you? She didn't know what to say.

The three of them gathered up the strewn quarters and refilled her bucket. When the elevator arrived at her floor, they insisted on walking her to her room. She seemed a little unsteady on her feet, and they were afraid she might not make it down the corridor. At her door they bid her a good evening. As she slipped into her room she could hear them roaring with laughter while they walked back to the elevator. The woman brushed herself off. She pulled herself together and went downstairs for dinner with her husband.

The next morning flowers were delivered to her room—a dozen roses. Attached to EACH rose was a crisp one hundred-dollar bill. The card said: 'Thanks for the best laugh we've had in years'

It was signed,

Eddie Murphy & Michael Jordan