**PQRS More Complex for 2014**

2014 Bonus Requirements Differ from Future Penalty Requirements

Correct PQRS reporting will continue to garner an annual bonus through December of 2014. The PQRS bonus will disappear in 2015, and an annual payment adjustment (penalty) will replace it. The 2015 and 2016 penalties will be based on 2013 and 2014 PQRS reporting, respectively. To make the matter even more complex, the reporting requirements for the 2013 and 2014 bonus differ from the 2013 and 2014 reporting requirements to prevent their respective 2015 and 2016 penalties. To summarize...

2013 Payment Bonus: 0.5%  
PQRS bonus reporting required 3 PQRS measures on 50% of applicable patients. [Use of the 2013 NOA PQRS traffic sheet should have met this requirement.]
- To avoid the 2015 penalty, only one measure needed to be reported during 2013.

2014 Payment Bonus: 0.5%  
The 2014 PQRS rules were released by CMS shortly before our press time, and the AOA is currently clarifying with CMS these more complex 2014 PQRS requirements. As released, the 2014 bonus rules require 9 (instead of the previous 3) PQRS measures across 3 (instead of 1) National Quality Strategy domains, for 50% of applicable Medicare patients. Dr. Quack continues to be in contact with CMS and the AOA regarding their ongoing dialogue, and will keep NOA members abreast of any new developments or clarification. Dr. Quack has not created his usual PQRS traffic sheet for 2014 due to the increased complexity of these new requirements, including questions on the PQRS use of ICD-10 codes beginning in October.
- To avoid the 2016 penalty, 2014 PQRS reporting requires 3 PQRS measures on 50% of applicable patients. [Perhaps continued use of the 2013 NOA PQRS traffic sheet will meet this requirement?]
(Continued from page 1)

**2015 Penalty 1.5%** The 2015 *penalty* is avoided if, during 2013, your PQRS reporting included one valid measure via claims, via participating registry, or via EHR.

**2016 Penalty 2.0%** The 2016 *penalty* can be avoided if, during 2014, PQRS reporting includes 3 measures on 50% of applicable patients.

### AOA Statement on the New 2014 PQRS Requirements

The following is from ongoing correspondence between Dr. Quack and the AOA:

In December, CMS officials held a conference call regarding PQRS changes for 2014. During the call, CMS strongly encouraged providers of all types to report on measures related to services that they believe all health care professionals should be providing. CMS specifically mentioned the tobacco cessation measure, the medication documentation measure and the hypertension measure. However, while this may be what CMS is encouraging, we [the AOA] want to be able to tell our members exactly what is needed to avoid the PQRS payment penalty and to obtain the incentive bonus.

For those doctors who are just interested in avoiding the 2016 *penalty*, they will need to report on 3 measures for 50% of applicable Medicare patients. Doctors who choose this option will not need to worry about reporting measures with varying National Quality Strategy (NQS) domains.

To obtain the 2014 *bonus*, doctors will have to put in a lot more work. Generally, 9 measures across 3 National Quality Strategy domains for 50% of applicable Medicare patients is the requirement to receive an incentive bonus; however, it may be possible for optometrists to report fewer measures and still obtain the incentive.

AOA is meeting with CMS in January to ascertain the minimum requirements for ODs to earn the bonus, and will hold a PQRS webinar for members in January to review the options for optometrists.


Preparing for ICD-10

Is your office ready for ICD-10? Do you feel you need additional education and training? What resources are available to help you prepare for the October 1st transition from ICD-9 to ICD-10?

As Dr. Quack sees it, ICD-10 is not rocket science, but definitely requires action....

1. Your office should already have in your possession the 2014 ICD-10-CM code book (Available from Amazon and other sources).

2. Using the 20 most frequent diagnoses in your office setting, prepare a crosswalk table from ICD-9 to ICD-10 for each of those diagnoses (e.g., for diabetes, put the ICD-9 diabetic diagnoses codes on one side of the page, and ICD-10 diagnoses codes on the flip side). Have staff use both sides of these forms when choosing the correct diagnosis code for each patient encounter. This allows the doctors and staff to become familiar with the ICD-10 coding. You can copy the information off of your ICD-9 and ICD-10 code books, or find it online at http://www.icd10data.com. This should be done NOW.

3. Contact your software representative and make sure your software will handle ICD-10, whether using EHR software, non-EHR optometric software, or simply software your computer uses to print claims on the new CMS-1500 that is required in April 2014.

4. Contact and make sure your billing clearinghouse will accept ICD 10 codes from your software.

5. TEST TEST TEST with Medicare, Medicare DME, BCBS, Medicaid, etc. etc. CMS announced a national testing week for current direct submitters (providers and clearinghouses) from March 3 through 7, 2014. More information is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MMB465.pdf.

- Noridian: Registration information will be posted later. Please watch for further communication at https://www.noridianmedicare.com/dme/news/docs/2013/12_dec/icd_10_testing_week_march_3_7_2014.html
- BCBS: See https://www.nebraskablue.com/providers/icd-10/
- Nebraska Medicaid plans to begin ICD-10 electronic transaction testing with trading partners in the second calendar quarter of 2014. More details will be published as known at http://dhhs.ne.gov/medicaid/Pages/ICD-10.aspx

The NOA 3rd Party Newsletter has published numerous articles on preparation for ICD-10

- Quack ICD-10 video (top-right column) http://nebraska.aoa.org/prebuilt/NOA/
- CMS resources: http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm
CMS ICD-10 Training Webinar Video: Navigating ICD-10, the Provider Perspective

CMS has released a new recording of an ICD-10 training webinar conducted for the National Association of Community Health Centers. The video is available on the ICD-10 Provider Resources page at http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html.

This webinar includes information on:

- Changes in ICD code structure, code definitions, and the recurring patterns that help providers to understand the organization and content of ICD-10 codes.
- The importance of clinical documentation in order to accurately and thoroughly capture medical concepts to inform ICD-10 coding.

Approaches to assess ICD-10 readiness, identify gaps, prioritize tasks, and monitor progress through continuous quality improvement.

Keep Up To Date on ICD-10


Nebraska Medicaid and ICD-10

This bulletin provides information regarding the Nebraska Medicaid ICD-10 Implementation Project.

Use of Unspecified ICD-10 Codes

In preparation for the transition from ICD-9 to ICD-10, the following information should be considered regarding the use of unspecified codes:

- Each healthcare encounter should be coded to the highest level of specificity known for that encounter.
- Due to the greater number of code choices in ICD-10-CM, the need for unspecified codes should be reduced.
- Unspecified codes should be reported when they most accurately reflect what is known about the patient’s condition at the time of that particular encounter.
- When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code.
- It is inappropriate to select a specific code that is not supported by the medical record documentation, or to conduct diagnostic testing solely to determine a more specific code.

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm
Medicaid and the New CMS-1500 Requirements

On November 14, 2013, Provider Bulletin #13-75 was published indicating that Nebraska Medicaid will be following the same timeline adopted by the Centers for Medicare & Medicaid (CMS) for the transition of the CMS 1500 health insurance paper claim form. The transition timeline for moving from the current 08/05 version to the 02/12 version is as follows:

- **Effective January 6, 2014**, Nebraska Medicaid will begin receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).
- **Effective January 6 through March 31, 2014**, Nebraska Medicaid will have a dual use and processing period during which we will continue to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).
- **Effective April 1, 2014**, Nebraska Medicaid will receive and process paper claims submitted only on the revised CMS 1500 claim form (version 02/12).

The change to the CMS 1500 version 02/12 aligns Nebraska Medicaid with Medicare and other payers. It also supports the submission of the ICD-10 diagnosis code indicator and ICD-10 diagnoses codes for services rendered on or after October 1, 2014. However:

- Do not use ICD-10 diagnosis codes prior to October 1, 2014.
- ICD-10 diagnosis codes can be used effective October 1, 2014, but only for dates of service on or after October 1, 2014.
- If ICD-10 codes are submitted before October 1, 2014, the claims will be denied.

AOA: Remedy to Part D Prescription Denials

AOA: We believe we’ve identified the problem with Part D prescriptions written by optometrists, and we’re working with the Department of Health and Human Services (HHS) to fix the issue. HHS staff is notifying Part D sponsors, some of whom are already aware of the erroneous denials thanks to your phone calls, to correct the automated systems that determine whether prescriptions are valid.

Medicare Part D sponsors have been upgrading their automated systems this month following HHS Office of the Inspector General (OIG) reports last June which identified inappropriately filled prescriptions for Medicare Part D patients. The problems included lack of prescribing authority, and lack of medical necessity. In response, the Centers for Medicare & Medicaid Services (CMS) has focused on the provider taxonomy specialty and subspecialty codes that practitioners self-selected for the National Provider Identifiers (NPIs). It’s AOA’s understanding that some Part D sponsors might not have properly connected all of the optometry taxonomy codes with optometry prescribing authority under state law.

HHS and Part D sponsors are working on retrospective remediation. If you continue to have prescriptions denied next week with messages such as “provider taxonomy ineligible for Part D prescriptions” or “prescriber ID not covered, doctor not eligible to prescribe for this program or patient,” then please contact the Part D sponsor and ask them to correct the mistake immediately.
To access the NOA 3rd Party web page:  http://nebraska.aoa.org/prebuilt/NOA/index.htm

AOA’s Valuable rethink eyecare Resource for Optometrists Addresses Healthcare Changes due to the Patient Protection and Affordable Care Act

Health Care Dynamics are changing dramatically.
Nebraska optometrists must adapt, and do so on a timely basis.

YOU cannot afford to ignore what is occurring in your health care arena.

In the creation of “rethink eyecare”, the AOA has provided an invaluable resource to help you, the practicing OD, understand these changes, communicate with 3rd parties, and adjust your mode of practice accordingly.

The links below are directly from the AOA’s rethink eyecare web site http://www.rethinkeyecare.com/. The material explains to ODs their role in the PPACA. It also provides, for 3rd parties, educational materials about the optometric profession.

Content & White Papers
Eye Health and Accountable Care
- Eye Health and Vision Care should be essential http://www.rethinkeyecare.com/wp-content/pdf/Eye%20Health%20and%20Vision%20Care%20should%20be%20essential.pdf

Optometry’s Role in Accountable Care Organizations
- What Optometrists need to know about ACOs http://www.rethinkeyecare.com/wp-content/pdf/What%20Optometrists%20Need%20to%20Know%20about%20ACOs.pdf
- What Optometrists need to do about ACOs http://www.rethinkeyecare.com/wp-content/pdf/What%20Optometrists%20Need%20to%20Do%20About%20ACOs.pdf
- Medicare ACO List by Start Date http://www.rethinkeyecare.com/wp-content/pdf/Medicare-ACO-StartDate.pdf

Optometry’s Role in Systemic Diseases
- The Role of the Optometrist in Treating Patients with Multiple Chronic Conditions http://www.rethinkeyecare.com/wp-content/pdf/Optometry-Chronic-Conditions.pdf
- The Role of Comprehensive Eye Exams in Early Detection of Disease http://www.rethinkeyecare.com/wp-content/pdf/The%20Role%20of%20Comprehensive%20Eye%20Exams%20in%20Early%20Detection%20of%20Disease.pdf

To access the NOA 3rd Party web page:  http://nebraska.aoa.org/prebuilt/NOA/index.htm
**From the AOA: Patient Protection and Affordable Care Act Recorded Webinar**

Health Care Dynamics are changing dramatically.

Nebraska optometrists must adapt, and do so on a timely basis.

YOU cannot afford to ignore what is occurring in your health care arena.

**AOA Third Party Center Recorded Webinar is Available to Answer Critical Questions about ACA Changes**

The AOA Third Party Center conducted one of AOA’s most highly attended webinars on December 3, 2013. Numerous AOA members registered for “ACA Implementation and Coverage Expansion Opportunities for ODs” where AOA Third Party Center Executive Committee member Stephen Montaquila, O.D., and AOA Third Party Center Director Lendy Pridgen, informed members of the biggest changes that lie ahead under the Affordable Care Act, where members can identify coverage expansion opportunities and what ODs should do to capitalize on these opportunities. For those unable to attend the live webinar, a recorded version is available on [www.aoa.org](http://www.aoa.org) (member log-in required) on page [http://www.aoa.org/advocacy/about-the-third-party-center/third-party-center-newsletters-and-webinars/coverage-expansion-under-aca](http://www.aoa.org/advocacy/about-the-third-party-center/third-party-center-newsletters-and-webinars/coverage-expansion-under-aca).

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**CMS Listing of Medicare Accountable Care Organizations in Nebraska**

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<tr>
<th>Midwest Independent Physicians LLC</th>
<th>Alegent Health Partners, LLC</th>
<th>SERPA-ACO</th>
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<td>Dr. Gamini Soori</td>
<td>Ann Oasan</td>
<td>Joleen TenHulzen Huneke</td>
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<td><em>ACO Executive</em></td>
<td><em>ACO Executive</em></td>
<td><em>ACO Executive</em></td>
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<tr>
<td>Ann Jones</td>
<td>Heidi Grunkemeyer</td>
<td>Bob Rauner, M.D.</td>
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<td><a href="mailto:brauner@healthylincoln.org">brauner@healthylincoln.org</a></td>
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**Nebraska Hospital Organizations**

UniNet is a not-for-profit Physician Hospital Organization (PHO) providing managed care services to six medium-sized metropolitan hospitals located in the Omaha-Council Bluffs metropolitan area; four rural hospitals located in Iowa and Nebraska; a comprehensive array of ancillary programs serving the region; and over 950 metropolitan and rural health care physicians and over 200 midlevel providers. It has existed for 15 years.

The Omaha World Herald reports a new hospital organization is forming, made up of “...nine independent hospitals stretch from Omaha to Scottsbluff and represent nearly half of the hospital care provided in the state... Officials from all nine hospitals have signed letters of intent to form a board that would govern the network, and the paperwork could be completed in the next 90 days.” [http://www.omaha.com/article/20131201/LIVEWELL01/131209944](http://www.omaha.com/article/20131201/LIVEWELL01/131209944)

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To access the NOA 3rd Party web page: [http://nebraska.aoa.org/prebuilt/NOA/index.htm](http://nebraska.aoa.org/prebuilt/NOA/index.htm)
President Obama Signs the *Pathway for SGR Reform Act of 2013*
Temporary Medicare Fee Fix through March 2014—

On December 26, 2013, President Obama signed into law the *Pathway for SGR Reform Act of 2013*. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014. President Obama remains committed to a permanent solution to eliminating the Sustainable Growth Rate (SGR) reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.

WPS: Recognizing the Meaning of "Standing Orders"

Providers need be cognizant of the various meanings represented by use of the term "standing orders." Some understand this to mean recurring orders specific to the care of an individual patient, while others understand this as routine orders for services delivered to a population of patients. You can view an article to help you understand the various uses of "standing orders" on our website:


which includes the following statement:

... *any order(s) that does not specifically address an individual patient's unique illness, injury or medical status, as not reasonable and necessary.* As is required by law, Medicare does not accept such "standing orders" as supporting medical necessity for the individual patient. Services related to population-based or condition-based orders are not reimbursable.

Quack Note: for example, it appears to Dr. Quack that a standing order from an OMD for an A-scan on all to-be-referred cataract surgery patients would fall under this restriction. Read more via the link above.

WPS Provider Enrollment Update

CMS has identified over 90,000 additional revalidation letters to be sent to Jurisdiction 5 (J5) and Jurisdiction 8 (J8) providers. These will be mailed in 60-day increments over the next 15 months. Large clinics will receive letters to revalidate their members in portions that should equate to 1/9th of their members in each of the mailings. Please watch for these revalidation letters. All revalidation letters are mailed to the correspondence address on file for each respective physician's National Provider Identifier (NPI).

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm
With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, [this exception applies to ODs] providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application either an application fee in an amount prescribed by CMS, and/or a request for a hardship exception to the application fee.

Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee. [Quack note: This fee applies to ODs, for initial DME enrollment and for DME revalidation every 3 years].

The fee for January 1, 2014, through December 31, 2014 is $542.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

Post-Op Claims from Outside Sources: Ordering and Referring Denial Edits Begin on January 6, 2014

After multiple previous start-dates and subsequent cancelations, CMS states that, effective for claims submitted on/after January 6, 2014, CMS will deny DME claims that fail the ordering/referring provider edits. If you fill outside Post-op prescriptions for patients with whom you have no professional relationship, you should take the following steps to ascertain the ordering/referring provider is enrolled in Medicare:

1. Verify that the ordering physician NPI is enrolled in PECOS. This can be done by:
   a. Checking the CMS ordering/referring provider downloadable report containing the NPI, first name, and last name of providers enrolled in PECOS located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html
   b. Calling the NAS IVR, 1-877-320-0390 and selecting Option 6 to enter the NPI and name of the referring provider. The IVR will then respond if the individual is or is not enrolled in PECOS.

2. Ensure you are correctly entering the Ordering/Referring Provider's name on the claim.
   a. Do not use "nicknames" on the claim, as this could cause the claim to fail the edits.
   b. Do not enter a credential (e.g., "Dr.") in a name field.
   c. On paper claims (CMS-1500), enter the ordering provider's first name first, and last name second (e.g., John Smith), in Item 17.
   d. Ensure that the name and the NPI for the ordering provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order.
   e. On electronic claims, make sure that the qualifier in the 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.
   f. On electronic claims, ensure that you are not submitting the last name in the first name field and vice versa. NAS has seen several suppliers who are submitting the ordering physician name backwards.
   g. Make sure you are spelling the ordering physician’s name correctly as listed in the PECOS listing in step 2b above.

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm
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Use of New CMS-1500 Claim Form REQUIRED April 1st; Current CMS-1500 Claim Form Will Be Rejected

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.

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 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.

DME on Demand - A Tool to Gain Knowledge on DME Topics

Noridian has announced new self-paced education tools called DME on Demand. A DME on Demand is a self-paced presentation, varying in length, which allows viewers an opportunity to listen to presentations at their convenience. Numerous DME on Demand presentations are now posted which cover topics varying from general to policy-specific topics. The purpose of DME on Demands is to provide a brief overview on specified topics. Topics may also be broken into numerous presentations to pinpoint areas of interest to suppliers so please watch for multiple presentations for one topic with detailed titles about content. These presentations can be found on our website at https://www.noridianmedicare.com/dme/train/education_tools.html. Refer to the Local Coverage Determinations (LCDs), related Policy Articles and Supplier Manual for additional information about coverage and documentation requirements.

**General**
- Advance Beneficiary Notice of Noncoverage.
- Before You Bill.
- Certificate of Medical Necessity and DME Information Form.
- CMS 1500 Claim Form.
- Modifiers:
  - RT/LT.
  - Email List.
- New Detailed Written Order and Face-to-Face Requirements.

**Policy-Specific**
- DMEPOS Place of Service.
- Proof of Delivery.
- Repairs and Replacements.
- Types of Order.
- Billing.
- Coding.
- Coverage Criteria.
- Documentation.

Refer to the Local Coverage Determinations (LCDs), related Policy Articles and Supplier Manual for additional information about coverage and documentation requirements.
Learn How to Conduct a Security Risk Analysis for Your Practice

Have you reviewed your practice processes to make sure that your patients’ personal health information is protected and secure?

Even though there are no changes to the HIPAA Security Rule, if you are participating in Stage 1 or Stage 2 of the EHR Incentive Programs, you need to conduct a security risk analysis of your practice to meet Meaningful Use requirements.


- Steps for conducting a security risk analysis
- How to create an action plan
- Security areas to be considered and their corresponding security measures
- Myths and facts about conducting a security risk analysis

Be sure to review the steps and conduct your review for your practice. It is required in both stages of meaningful use to receive your incentive payment.

Additional Resources
The CMS EHR Incentive Programs website offers other meaningful use resources: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html


How the Proposed New Timeline for the EHR Incentive Programs Affects You

Last week, CMS and ONC announced the intent to change the Stage 3 timeline and extend Stage 2 of meaningful use through 2016.

Important to note about the proposed timeline
- It does not delay the start of Stage 2 of meaningful use.
- It does not affect the current reporting periods and deadlines for 2014 participation.

What this Means for You
If you begin participation with your first year of Stage 1 for the Medicare EHR Incentive Program in 2014:
- You must begin your 90 days of Stage 1 of meaningful use no later than July 1, 2014 and submit attestation by October 1, 2014 in order to avoid the 2015 payment adjustment.

If you have completed 1 year of Stage 1 of meaningful use:
- You will demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.
- You will demonstrate Stage 2 of meaningful use for two years (2015 and 2016).
- You will begin Stage 3 of meaningful use in 2017.

If you have completed two or more years of Stage 1 of meaningful use:
- You will still demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.
- You will demonstrate Stage 2 of meaningful use for three years (2014, 2015 and 2016).
You will begin Stage 3 of meaningful use in 2017.

To access the NOA 3rd Party web page: http://nebraska.aoa.org/prebuilt/NOA/index.htm
The “Medical Privacy of Protected Health Information” Fact Sheet (ICN 006942) [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SE0726FactSheet.pdf] was released and is now available in downloadable format. This fact sheet is designed to provide education on resources and information regarding the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and how this rule applies to customary health care practices. It includes guidance on common patient encounters with the Privacy Rule and lists HHS HIPAA web page resources.

**Dermatology practice settles HIPAA violations for $150,000**

Adult & Pediatric Dermatology, P.C., of Concord, Mass., (APDerm) has agreed to settle potential violations of the HIPAA Privacy, Security, and Breach Notification Rules with the Department of Health and Human Services, agreeing to a $150,000 payment. The HHS Office for Civil Rights (OCR) opened an investigation of APDerm upon receiving a report that an unencrypted thumb drive containing the electronic protected health information (ePHI) of approximately 2,200 individuals was stolen from a vehicle of one of its staff members. The investigation revealed that APDerm had not conducted an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality of ePHI as part of its security management process. Further, APDerm did not fully comply with requirements of the Breach Notification Rule to have in place written policies and procedures and train workforce members.

APDerm will also be required to implement a corrective action plan to correct deficiencies in its HIPAA compliance program. APDerm is a private practice that delivers dermatology services in four locations in Massachusetts and two in New Hampshire. This case marks the first settlement with a covered entity for not having policies and procedures in place to address the breach notification provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA).

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

Coding Progressive Lenses for Medicare DME

Dear Dr. Quack,

We have a question for you about submitting to DMEPOS. We would like to know what the correct way and codes to use to submit this claim. Patient got plastic no-line lenses only, no frame. Rx is OD -0.75 +1.75 x169 +2.50 , OS -1.25 +1.75 x9 +2.50. Can you tell me what V-code you would have used and how it would have looked on a red CMS-1500??

Thank You so much for your help. We thought that we were doing it correct but then we are receiving letters from Noridian saying that we are doing something wrong.

Dr. Quack’s Quote,

You would need two lines of code for the lenses:

- Your first line on the claim form would be the V-code for regular trifocal lenses in the Rx for that patient, listing your total usual and customary fee for both lenses and units of 2 (since it is paid per lens).

- Your second line would be the V-code for progressive lenses, V2781, with a GY modifier to indicate the patient is responsible for payment. The $$ amount is the difference between your usual and customary fee for progressive lenses and the $$ amount you put in the first line, with units of 2 (always per lens).

So, as an $$ example, say you charge $20 per lens for as standard trifocal for the Rx in question, but you would charge $50 per lens for the same Rx in a progressive.

- Line one would be V2303 with a charge of $40 and units of 2
- Line two would be V2781GY with a charge of $60 and units of 2 [the difference between $50 and $20, times two]

DME should pay their allowable for the first line; the second line is the patient’s responsibility

As a reference, take a look at the Refractive lens information on the Noridian web site which is found at https://www.noridianmedicare.com/dme/coverage/resources/refractive_lenses.html and contains the following

- The Refractive lens LCD https://www.noridianmedicare.com/dme/coverage/docs/lcds/current/refractive_lenses.htm

Also, take a look at our NOA 3rd Party Newsletter article that describes the various modifiers you should use with DME http://nebraska.aoa.org/prebuilt/NOA/2009-08%203RD%20PARTY%20NEWLLETTER.pdf

Hope that helps!
A precocious little boy got on the bus, sat next to a man reading a book, and noticed he had his collar on backwards. The little boy asked why he wore his collar that way.

The man, who was a priest, said, "I am a Father."

The little boy replied, "My Daddy doesn't wear his collar like that."

The priest looked up from his book and said, "I am the Father of many."

The boy said, "My Dad has four boys and four girls and he doesn't wear his collar that way."

The priest, getting impatient, said "I am the Father of hundreds," and went back to reading his book.

The little boy sat quietly... but on leaving the bus, he leaned over and said, "Well, maybe you should wear your pants backwards instead of your collar."

Many years ago, in a backward, rural area of eastern Europe, an old married couple resided. Whenever there was a confrontation, yelling could be heard deep into the night.

The old man would shout, "When I die, I will dig my way up and out of the grave and come back and haunt you for the rest of your life!"

Neighbors feared him, and the old man liked the fact that he was feared. To everyone's relief, he finally died of a heart attack and his wife had a closed casket at the funeral.

After the burial, her neighbors, concerned for her safety, asked "Aren't you afraid that he may indeed be able to dig his way out of the grave and haunt you for the rest of your life?"

The wife said, "Let him dig. I had him buried upside down and I know he won't ask for directions."