June 2015

NOA 3rd Party Newsletter

Nebraska Optometric Association Volume 15, Issue 6

Please forward to all of your doctors and staff

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ICD-10 Acknowledgment Testing

On October 1, 2015 ICD-10 code sets will replace ICD-9. CMS announces a national testing week for current direct submitters (providers and clearinghouses) June 1-5, 2015. This testing week will give trading partners access to the Medicare Administrative Contractors (MACs) and Common Electronic Data Interchange (CEDI) for testing with real-time help desk support. The event will be conducted virtually.

What you can expect during testing:

- Test files must be created as a Test with a T in the ISA15.
- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing National Provider Identifier (NPI) validation edits.
- Test claims will be subject to all existing EDI front-end edits including Submitter authentication and NPI validation.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be staffed to handle increased call volume during this week.

More information is available at http://tinyurl.com/lfsb4m5

Any providers that are planning to participate in this acknowledgment testing that are currently using the WPS Medicare supplied PC-Ace program please contact the EDI helpdesk to obtain a utility that can be installed to assist with your ICD-10 testing.

EDI Helpdesk: (866) 518-3285 option 1

When *must* you submit claims for Acknowledgement Testing?

You may submit acknowledgement test claims ***anytime***. CMS encourages you to test during June 1 – 5, 2015. Details at http://tinyurl.com/mznxke5

Five More Facts about ICD-10

If you cannot submit ICD-10 claims electronically, Medicare offers several options

CMS encourages you to prepare for the transition and be ready to submit ICD-10 claims electronically for all services provided on or after October 1, 2015. But, if you are not ready, Medicare has several options for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the provider be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every Medicare Administrative Contractor (MAC)
- In about half of the MAC jurisdictions, Part B claims submission functionality on the MAC's provider internet portal
- Submitting paper claims, if the Administrative Simplification Compliance Act waiver provisions are met

If you take this route, be sure to allot time for you or your staff to prepare and complete training on free billing software or portals before the compliance date.

Practices that do not prepare for ICD-10 will not be able to submit claims for services performed on or after October 1, 2015

Unless your practice is able to submit ICD-10 claims, whether using the alternate methods described above or electronically, your claims will not be accepted. Only claims coded with ICD-10 can be accepted for services provided on or after October 1, 2015.

Reimbursement for outpatient and physician office procedures will not be determined by ICD-10 codes

Outpatient and physician office claims are not paid based on ICD-10 diagnosis codes but on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, which are not changing. ICD diagnosis codes are sometimes used to determine medical necessity, regardless of care setting.

Costs could be substantially lower than projected earlier.

Recent studies by 3M and the Professional Association of Health Care Office Management have found many Electronic Health Record (EHR) vendors are including ICD-10 in their systems or upgrades—at little or no cost to their customers. As a result, software and systems costs for ICD-10 could be minimal for many providers.

It's time to transition to ICD-10

ICD-10 is foundational to modernizing health care and improving quality. ICD-10 serves as a building block that allows for greater specificity and standardized data that can:

- Improve coordination of a patient's care across providers over time
- Advance public health research, public health surveillance, and emergency response through detection of disease outbreaks and adverse drug events
- Support innovative payment models that drive quality of care
- Enhance fraud detection efforts

Keep Up to Date on ICD-10: **Visit the ICD-10 website at** http://tinyurl.com/6vxcn6w **for more news and resources.**

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ICD-10 Myths and Facts

To help dispel some of the myths surrounding ICD-10, the Centers for Medicare & Medicaid Services (CMS) recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

1. **The ICD-10 transition date is October 1, 2015.**

The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.

2. **You don't have to use 68,000 codes.**

Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.

3. **You will use a similar process to look up ICD-10 codes that you use with ICD-9.**

Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.

4. **Outpatient and office procedure codes aren't changing.**

The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

5. **All Medicare fee-for-service providers have the opportunity to conduct testing with CMS before the ICD-10 transition.**

Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure you can submit claims with ICD-10 codes. During a special "acknowledgement testing" week to be held in June 2015, you will have access to real-time help desk support. Contact your MAC for details about testing plans and opportunities. [See WPS Acknowledgement webpage at http://tinyurl.com/pxo83q8]

Stay tuned for five more facts about ICD-10: coming to you soon in another CMS ICD-10 Email Update message.

Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

On October 1, 2015, ICD-10-CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD-10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality.

The AOA 2015 ICD-10 bundle, available at http://tinyurl.com/l35m4cn, provides the tools needed for optometric professionals to confidently transition from ICD-9-CM to ICD-10-CM. Three great products approved and recommended by AOA's coding experts:

- ***2015 AOA Codes for Optometry (ICD-10)***
- ***2015 ICD-10 CM AOA Express Mapping Card*** *NOW AVAILABLE SEPARATELY @ https://www.aoa.org/marketplace-homepage/browse-products?sso=y*
- ***2015 AMA CPT Professional Edition***

AOA Directory of ACOs in Nebraska

Brand New!! AOA released a **Directory of Accountable Care Organizations**. Members now have the tools to identify ACO's nationwide. The ACO search is by state and includes the following information: ACO Name, Provider type, Metropolitan Area, Description, Data Resource Links, Key Contact information, and much more. View the Directory of Accountable Care Organizations at http://www.aoa.org/aco-search. *Quack Note: See possible addition below the chart.*

Entity Name *[Click URL for Specific Information]*	Contract Type	Metro Area	Provider Type
Accountable Care Alliance (Nebraska Health Alliance) http://tinyurl.com/nephean	Commercial	Omaha-Council Bluffs NE-IA	Hospital System **[UNMC & Methodist]**
Alegent Health Partners (Omaha) http://tinyurl.com/puumx7c	Government and Commercial	Omaha-Council Bluffs NE-IA Norfolk NE	Both **[CHI—Catholic Health Initiatives]**
Midwest Independent Physicians LLC http://tinyurl.com/nbezd5a	Government	Omaha-Council Bluffs NE Hutchinson MN Willmar MN Austin MN Minneapolis-St. Paul-Bloomington MN-WI	Physician Group **[Midwest Independent Physicians MIPPA]**
SERPA ACO, LLC http://tinyurl.com/nmgwlby	Government and Commercial	Columbus NE Omaha-Council Bluffs NE-IA	Physician Group **[Southeast Rural Physician Alliance—9 Independent Medical Practices]**

Quack Note: In addition, a late May World-Herald article covered a newly formed ACO by Aetna-CHI. Dr. Quack's understanding of the contents of the article are found below. Source: http://tinyurl.com/nda4xft

Aetna Whole Health℠ – CHI Health Accountable Care Network	**Commercial**	**Omaha area**	**Both?**

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

AOA: How to Successfully Navigate Medicare Advantage Plans

See complete AOA article at http://tinyurl.com/n9bb43y

Opportunities exist to capitalize on the rapidly expanding market of Medicare Advantage (MA) Plans—provided that you know how to navigate these plans, and know where to seek help.

"Every plan is different—however, more and more are creating very narrow networks."

AOA says its members are seeing growth in MA plans in their respective states, and as a result, are caring for more patients covered by these plans. According to the latest statistics from the Kaiser Family Foundation, enrollment in MA plans has risen by 41 percent or 4.6 million lives since the enactment of the Affordable Care Act. More than 15 million beneficiaries are enrolled in MA plans in the United States, making up about 30 percent of the total Medicare population.

Gradually over time, more MA plans have been offering embedded vision benefits to help market their plans to Medicare beneficiaries. Today, roughly 80 to 90 percent of MA plans cover routine eye exams, and according to one study, about 60 percent cover vision hardware. Other research suggests that, among seniors aware of this coverage, nearly 80 percent are satisfied with their MA vision benefits.

This emphasis on vision coverage is attractive to optometrists, who join such networks to expand their Medicare patient base—a cohort often in need of medical eye care. MA plans, however, often use restrictive or narrow networks to artificially limit access to care and utilization of services. ODs often find out that they have given up many of their rights as Medicare providers for their MA patients.

Where roadblocks with MA plans exist

April Jasper, O.D., who practices in West Palm Beach, Florida, says she's able to participate with many of the state's MA plans, though a lot of them pay doctors at much lower rates than Medicare fee-for-service. "Every plan is different—however, more and more are creating very narrow networks—eliminating all different medical specialists" including ODs, she observes.

While MA plans are prohibited from discriminating against providers based on their licensure, AOA continues to fight for better oversight of MA plans and encourages members to report instances of discrimination, such as in reimbursement or network selection. In the meantime, there are things ODs can do to better navigate these plans:

Emphasize your worth

ODs need to make this clear not only to patients but to their fellow providers. Providing excellent care to your patients will increase your visibility, Dr. Jasper advises. ODs should also work to build relationships with other primary care doctors and pediatricians. “One way to do this is to send reports to these primary care providers regarding their patients' exam findings”, she says.

Ask your patients for help

If you find yourself cut out of a plan, find out which patients are affected by that decision, says Dr. Kraupa. "Ask them to send a letter to the plan asking for you to be added to the provider panel. Third party payers do listen to their enrollees."

Seek assistance from your third party center

Contact AOA's Third Party Center (http://tinyurl.com/o8f8f4k) for assistance, or reach out directly to your state optometric association's third party committee. Look to develop a relationship with them before problems arise, Dr. Kraupa says. It also helps to find ways to help the third party payers with their challenges. "If you scratch their back today, they will be more inclined to scratch yours in the future," he says.

Know your chair cost

Every OD should be encouraged to calculate and understand what it costs to see a patient. Don't sign up for participation in a plan that doesn't meet or exceed your chair cost. "If everyone follows this simple rule, life will be better for the entire profession," Dr. Kraupa recommends.

"Items and Services That Are Not Covered Under the Medicare Program" Booklet — Revised

The "**Items and Services That Are Not Covered Under the Medicare Program**" Booklet (ICN 906765, found at http://tinyurl.com/mqzlt3y) was revised and is now available in downloadable format. This booklet is designed to provide education on the four categories of items and services that are not covered under the Medicare Program and applicable exceptions (items and services that may be covered), as well as Beneficiary Notices of Noncoverage. It includes information on services and supplies that are not medically reasonable and necessary; non-covered items and services; services and supplies denied as bundled or included in the basic allowance of another service; and items and services reimbursable by other organizations or furnished without charge.

Quack note: this booklet is a good resource should you be questioned about Medicare coverage of routine eye exams, etc.

IACS DISCONTINUED IN JULY!

CMS Announces July 2015 Transition from IACS to EIDM

The Centers for Medicare & Medicaid Services (CMS) would like to inform Physician Quality Reporting System (PQRS) participants and their staff to an important system update scheduled to be in place on **July 13, 2015**.

The Individuals Authorized Access to CMS Computer Services (IACS) system will be retired, but current IACS user accounts will transition to an existing CMS system called Enterprise Identity Management (EIDM). The EIDM system provides a way for business partners to apply for, obtain approval, and receive a single user ID for accessing multiple CMS applications.

Existing PQRS IACS users, their data, and roles will be moved to EIDM and will be accessible from the 'PQRS Portal' portion of the CMS Enterprise Portal at http://portal.cms.gov. Users will then access the PQRS Portal to submit data, retrieve submission reports, view feedback reports, or conduct various administrative and maintenance activities. New PQRS users will need to register for an EIDM account.

Stay tuned for more information and resources in the coming weeks and months! In the meantime, please ensure that your IACS account is active, current, and you're able to log in. This will help ensure a smoother transition to EIDM.

For additional assistance regarding IACS or EIDM, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) from 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday, or via email at qnetsupport@hcqis.org. To avoid security violations, do not include personal identifying information, such as Social Security Number or TIN, in email inquiries to the QualityNet Help Desk.

2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline

GRPO: Group Reporting Option for PQRS

Groups have 4 weeks to register to participate in the 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) via the Physician Value - Physician Quality Reporting System (PV-PQRS) Registration System. PQRS GPRO is an option available to groups with 2 or more eligible professionals (EPs). Groups must meet the satisfactory reporting criteria through the PQRS GPRO in order to avoid the -2.0% CY 2017 PQRS payment adjustment. More information is available on the **PQRS Payment Adjustment Information** web page at http://tinyurl.com/pukwggj.

Physicians in groups of all sizes and physician solo practitioners are subject to the Value Modifier in 2017, based on performance in 2015. Under the Value Modifier, these physicians and groups must meet the criteria to avoid the downward payment adjustment under PQRS in order to avoid an additional automatic downward adjustment under the Value Modifier and qualify for adjustments based on their quality performance. Satisfactorily reporting via a PQRS GPRO is one of the ways groups can avoid automatic downward adjustments and qualify for performance-based payment incentives under the Value Modifier. For more information see "**What Physicians Need to do in 2015 for the 2017 VM"** on the **Value Modifier web page** at http://tinyurl.com/qbd5vpf.

Groups can participate in the PQRS program for the 2015 performance period by selecting one of the GPRO reporting mechanisms between April 1, 2015, and June 30, 2015, at 11:59pm ET:

- Qualified PQRS Registry.
- Electronic Health Record (EHR) via Direct EHR using Certified EHR Technology (CEHRT) or CEHRT via Data Submission Vendor.
- Web Interface (for groups with 25 or more EPs only).
- Consumer Assessment of Health Providers and Systems (CAHPS) for PQRS Survey via a CMS-certified Survey Vendor (as a supplement to another GPRO reporting mechanism). See "**CAHPS for PQRS Made Simple"** for complete details at http://tinyurl.com/pbbey9n.

Physician groups with 2 or more EPs that choose not to register, must ensure that at least 50% of the EPs in the group meet the criteria to avoid the 2017 PQRS payment adjustment as individuals in order for the group to avoid the automatic 2017 Value Modifier downward payment adjustment (-2.0% or -4.0% depending on the group's size).

The **Registration System** can be accessed at http://tinyurl.com/nfsqkht using a valid Individuals Authorized Access to the CMS Computer Services (IACS) account. CMS strongly encourage groups to obtain an IACS account and register by June 26, since registration will close on June 30, 2015. CMS will be transitioning to a new Enterprise Identity Management (EIDM) system in the upcoming months; therefore, all registrations must be received before the deadline. Stay tuned for more information and resources in the coming weeks and months about the EIDM. In the meantime, please ensure that your IACS account is active, current, and you're able to log in. This will help ensure a smoother transition to EIDM. Instructions for obtaining an IACS account with the correct role are provided on the **PQRS GPRO Registration** web page at http://tinyurl.com/p7cnzre. Instructions for registering to participate in the 2015 PQRS GPRO are provided in the **2015 PQRS GPRO Registration Guide** at http://tinyurl.com/nuqq6j6.

2014 Mid-Year QRURs Available— Your Cost and Quality Outcome Measures

CMS has released the 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) to physician solo practitioners and groups of physicians nationwide, including those who participated in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014.

The 2014 MYQRURs were made available for *informational purposes only* and contain information on a subset of the measures used to calculate the 2016 Value Modifier. The MYQRUR provides interim information about performance on the six cost and three quality outcomes measures that CMS calculates from Medicare claims. These are some of the measures used in the calculation of the Value Modifier. The information in the MYQRUR is based on care provided from July 1, 2013, through June 30, 2014, a period that precedes the actual 2014 performance period for the 2016 Value Modifier. More information is available on the **2014 MYQRUR** web page at http://tinyurl.com/noxcyqo.

The 2014 MYQRUR can be accessed on the **CMS Enterprise Portal** https://portal.cms.gov/, using a valid Individuals Authorized Access to the CMS Computer Services (IACS) account. For more information, visit **How to Obtain a QRUR** at http://tinyurl.com/oluuj8z.

New Video on PQRS and the Value-Based Payment Modifier

CMS has released the following MLN Connects® video at http://tinyurl.com/otucm45: **The Physician Quality Reporting System & the Value-based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2015**. This MLN Connects video presentation provides an overview of the Physician Quality Reporting System (PQRS) and how your participation in 2015 will determine how the Value-Based Payment Modifier will be applied to your reimbursement in 2017. Run time: 45 minutes: 10 seconds.

For a list of videos on PQRS and the Value-based Payment Modifier, as well as videos on a variety of other Medicare topics, visit **MLN Connects Videos** at http://tinyurl.com/p2dj77y. For more information, visit the **PQRS** [http://tinyurl.com/pwnr489]and **Medicare FFS Physician Feedback Program/Value-Based Payment Modifier** [http://tinyurl.com/ct7vyy6] web pages.

Upcoming Changes in Medicaid Enrollment

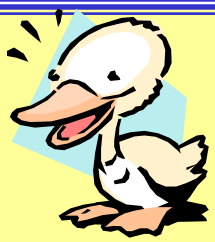
Medicaid has contracted with Maximus Health Services, Inc. (Maximus) to aid in new provider screening and enrollment requirements and processes. Maximus will develop a web portal through which providers will complete and submit their application electronically by late summer. Benefits of the web portal include:

- Elimination of paper applications
- Improved turnaround time for enrollment submission and processing
- Fewer agreements returned to providers due to missing and/or incomplete information
- 24/7 access to provider enrollment information

Providers are strongly encouraged to visit and subscribe to the Provider Screening and Enrollment webpage found at http://dhhs.ne.gov/medicaid/Pages/Provider-Screening-and-Enrollment.aspx. Please direct questions to DHHS.MedicaidPSEProject@nebraska.gov. Questions received may be used to update the Frequently Asked Questions document.

Dr. Quentin Quack's Queries and Questionable Quotes

Third Party Questions from NOA Doctors and Staff



Documentation of Current Medications in the Medical Record

Dear Dr. Quack: What do we do in situations when we are unable to fulfill the requirements of meeting PQRS. The patient does not know the medication name or exact dosage, and it is not available thru e-Prescribe which is our electronic medication link. Do we use the next best option of guessing the dosage? Or using the smallest dosage listed? What if we were to just use "free text" and only list the medication name? In some circumstances only listing "high blood pressure med" as the patient does not know the exact name of the medication?

Dr. Quack's Quote: That is a frequent problem faced by all practitioners of all persuasions. And the PQRS measure is rather specific, in that you need to know the med and dosage (see pages 8 and 16 for specifics at http://nebraska.aoa.org/prebuilt/NOA/2015-PQRS-Newsletter2.pdf). If the information is not available, you have at least a couple of choices:

- Code G8428 which says you did not document the meds; however, it will adversely affect you PQRS "quality of care" score if you do it with any regularity; or
- Have the patient call you with the Rx particulars as soon as they get home; however, this will screw up your ability to complete the visit information on your patient record until you get the call.
- When confirming appointments prior to a visit, we HIGHLY recommend you tell ALL patients to bring in a list of meds and dosage, or a bag or wheelbarrow of their current medications so you can read the labels.

You do not want to "plug" in a med, nor "plug" in a dosage.

Coding a Diabetic Patient During Post-Op Care

Dear Dr. Quack: We have a question having to do with PQRS measures. Our diabetic patient today was in our office for a one day follow-up to cataract surgery. When a diabetic patient is in our office for post operative care, is it necessary to use a diabetic procedure code 2022F along with the modifier 8P? Is this the correct situation for that combination of codes?

Dr. Quack's Quote:

- See http://nebraska.aoa.org/prebuilt/NOA/2015-PQRS-Newsletter2.pdf, pages 7 and 14.
- Your coding would indicate whether the patient has had a DFE within the last 12 months.
- If the patient has had a DFE, then you would document in your records that the DFE has taken place, then file 2022F without a modifier.
- If it has not taken place, you can do a DFE before filing the claim. However, I would be surprised if a DFE had not been performed prior to the cataract surgery.

Filing the 2022F with the 8P modifier is problematic like we described with the previous G8428 diabetic coding: it will adversely affect you PQRS "quality of care" score if you do it with any regularity.

Dr. Quentin Quack's Queries and Questionable Quotes

...Continued...

Medicaid MCO Reimbursement Disparities

Dear Dr. Quack: I have been wondering about the reimbursement that we get from Avesis for Medicaid. They pay significantly less than Block. My biller tells me that the net payment is that much less than Block because Avesis only lets her bill a intermediate exam - no matter what level of service was provided. For medical diagnosis we use the 99 codes, I believe. Can they do that?

Dr. Quack's Quote: There are two separate policies involved in your query.

1) If any Medicaid patient's diagnosis is refractive only (no medical diagnosis), Nebraska Medicaid reimburses at the 92xxx intermediate level, regardless of whether it is billed at the 92xxx comprehensive level. This has been NE Medicaid's policy since the 1990s (first for traditional Medicaid, and with the advent of MCOs, for all Managed Care Organizations). The policy can be found in NE Medicaid regulations as follows:

> 24-003.01A3 Payment for Eye Exams: Eye examinations provided primarily for the purpose of prescribing, fitting, or changing eyeglasses for refractive errors are reimbursed at the NMAP fee schedule allowable for intermediate level general ophthalmological services, as defined in the American Medical Association's Physicians' Current Procedural Terminology (CPT). Determination of the refractive state is reimbursed separately from examination services. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-24.pdf

2) Regarding the disparity between Avesis and Block reimbursements: When the Nebraska Unicameral passed an increase in reimbursement for Medicaid providers last year, Block increased their reimbursement accordingly, to the extent they retroactively paid some additional claim amounts. However, as I understand it, Avesis has declined to increase reimbursement per the Unicameral's legislation, saying that the MCO contract they signed [with Arbor Health?] specified the amount of reimbursement for vision care, and they were going to abide by that agreement. We have been in contact with Avesis about the Unicameral's action on more than one occasion (most recently at the NOA 2015 Spring Conference), apparently without result.

A recent email response from Avesis stated as follows: *"Avesis has a contractual agreement regarding professional fees for all eye care services with its health plan partner in Nebraska."*

Last week we brought this inequity before the Medicaid Assistance Advisory Committee (MAAC), and the Medicaid Director and staff promised to look into the matter. In addition to requesting that future Avesis reimbursement be corrected, we requested that retroactive reimbursement be provided, rectifying Avesis' underpayment since the Unicameral's 2014 fee increase. As an aside, Arbor Health's MAAC representative told me personally that he was embarrassed by the situation. The outcome remains to be seen.

Dr. Quentin Quack's Quacked Humor - Irreligious issue

A man in Los Angeles decided to write a book about churches around the country. He started by flying to San Francisco and started working east from there.

Going to a very large church, he began taking photographs and making notes. He spotted a golden telephone on the vestibule wall and was intrigued with a sign, which read "Calls: $10,000 a minute."

Seeking out the pastor, he asked about the phone and the sign. The pastor answered that this golden phone is, in fact, a direct line to heaven, and if he pays the price he can talk directly to God.

The man thanked the pastor and continued on his way. As he circled his way around the United States, he visited churches in Phoenix, Salt Lake City, Denver, Oklahoma City, Miami, New York, Detroit, Chicago, Des Moines, finding more phones with the same sign, and the same answer from each pastor.

Finally, he arrived in Nebraska, and upon entering a church in Falls City, behold-- he saw the usual golden telephone. But THIS time, the sign read "Calls: 35 cents."

Fascinated, he asked to talk to the pastor. "Pastor, I've been in cities and towns all around the country, and in each church I've found this golden telephone and have been told it's a direct line to heaven and that I could talk to God, but in the other churches the cost was $10,000 a minute. Your sign reads only 35 cents a call.

Why?"

The pastor, smiling benignly, replied, "Son, you're in Nebraska now. You're in God's Country-- it's a local call."

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Man goes to see the Rabbi. "Rabbi, something terrible is happening and I have to talk to you about it."
The Rabbi asked, "What's wrong?"
The man replied, "My wife is poisoning me."

The Rabbi, very surprised by this, asks, "How can that be?"
The man then pleads, "I'm telling you, I'm certain she's poisoning me, what should I do?"
The Rabbi then offers, "Tell you what. Let me talk to her, I'll see what I can find out and I'll let you know."

A week later the Rabbi calls the man and says, "Well, I spoke to your wife. I spoke to her on the phone for three hours. You want my advice?"
The man anxiously says, "Yes."
"Take the poison," says the Rabbi.