AOA MORE provides support for the meaningful use public health objective for specialized registry reporting. For program year 2016, participants are required to meet two public health objectives, unless an exclusion applies. To actively engage with MORE for the 2016 program year, you must enroll by February 29th. For More Information Click Here.

For information on 2015 reporting, click here

Please visit the CMS site for more information on registration and attestation: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html. Attestations for the 2015 program year will be accepted from January 4, 2016 through February 29, 2016.
CMS Announces the PQRS Web-Based Measure Search Tool

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of the new Physician Quality Reporting System (PQRS) Web-Based Measure Search Tool located directly at https://pqrs.cms.gov/#/home and via the PQRS Measures Codes webpage.

This tool will assist eligible professionals (EPs) and PQRS group practices with easily identifying claims and registry measures that may be applicable, and help find measures that meet satisfactory reporting requirements for the 2016 PQRS program year. Users may search measure-related keywords as well as search and filter important measure-related information such as:

- Measure Number
- Reporting Methods
- National Quality Strategy (NQS) Domain
- Cross-Cutting Measures
- Measure Steward

The PQRS Web-Based Measure Search Tool allows users to click on a measure to view the individual claims and registry measure specifications available for 2016.

For further assistance or questions regarding measures, contact the QualityNet Help Desk at 1-866-288-8912 or via the e-mail address: qnetsupport@hcqis.org
Dr. Quack’s Annual PQRS Traffic Sheets

As he has done annually since the inception of PQRS, Dr. Quack has created in-office traffic sheets to be used for 2016 claims-based PQRS. If you missed it when it was emailed, you can find it at [http://nebraska.aoa.org/prebuilt/NOA/2016-Jan-PQRS-Newsletter.pdf](http://nebraska.aoa.org/prebuilt/NOA/2016-Jan-PQRS-Newsletter.pdf).

A total of ten 2016 PQRS measures are applicable to optometry. Nine of these must be reported on appropriate patients at least 50 percent of the time for the full year (1/1/2016 – 12/31/2016). The appropriate measures include six eye-specific measures and three of four available “crosscutting” [general health] measures.

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AOA PQRS Educational Resource Links:

- **2016 PQRS Reporting**
  - [PQRS in 2016 What ODs Need to Know (Webinar Recording)]
  - [PQRS 2016 What OD’s Need to Know Webinar Slides (PDF)]
  - [2016 PQRS Summary Chart (ICD-10)] (see below)
  - [CMS Provider Call on "Medicare Quality Reporting Programs: 2016 Physician Fee Schedule"]

American Optometric Association Summary Chart

**TABLE OF 2016 PQRS EYE CARE MEASURES FOR OPTOMETRISTS**

Modifiers are used in PQRS reporting only if the reported measure was not performed during the visit. The modifiers indicate why measure was not done.
Reminder:
AVOID USE OF EXTERNAL CAUSE CODES IN ICD-10-CM

External Cause Coding

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity. If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation.

Sign/Symptom Coding

In ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

CEDI Logic you may see used in rejecting V, W, X, or Y codes

CSCC A7: “Acknowledgement /Rejected for Invalid Information…”
CSC 254: “Primary Diagnosis Code”
CSC 509: “E-Code”

Logic: ICD-10 codes that begins with letter “V”, “W”, “X”, or “Y” are not allowed.
http://www.ngsedi.com/ngsportal/ngsedi/icd10testing

Laterality and Use of Modifiers with ICD-10

One of the features available in ICD-10 is the ability to choose a code that identifies laterality (i.e. left, right, bilateral). The use of lateral ICD-10 diagnosis codes does not negate the use of the LT/RT modifiers. For Medicare claim processing purposes, it is imperative to report an appropriate LT or RT modifier when submitting such services to WPS GHA. For additional information about new features in ICD-10-CM, please refer to the CMS Medicare Learning Network ICD-10-Classification Enhancements.

NOA TABLE of ICD-10 OPTOMETRY CODES

RETURN TO PAGE ONE
MODIFIERS 24 & 25

Abridged Article from the AOA’s Coding Experts

See the full AOA article by clicking Ask the Coding Experts: Modifier 24 and 25 usage

Ask the Coding Experts, by Doug Morrow, O.D., Harvey Richman, O.D., and Rebecca Wartman, O.D. From the November/December 2015 edition of AOA Focus, pages 46-47

**Modifier 24**

- For doctors of optometry, modifier 24 is most often used when the doctor is providing co-management services.
- Modifier 24 is defined as an "unrelated evaluation and management service by same physician during post-operative period." This means if a patient has surgery and has a condition that requires an evaluation that is completely separate from anything related to the surgery, an evaluation and management (E/M) service would be reported and modifier 24 would be appended.
- Modifier 24 is often reported by doctors of optometry in cases in which the patient experiences an eye problem in the eye that was not operated on, or when the patient has an eye problem in the operated eye that is located in the region of the eye that was not impacted by the surgery.
- This modifier should only be used with E/M services.

It is critical that documentation should include the specific reason why the visit that occurred during the postoperative period was not related to the surgery.

**Modifier 25**

- Modifier 25 is officially defined as "a significant evaluation and management service by same physician on date of global procedure." This means if E/M services are provided that exceed what is normally involved in preparing a patient for a procedure and the standard follow-up services directly following a procedure, then an E/M service should be reported along with modifier 25.
- Reporting modifier 25 may be necessary in certain cases when removing a foreign body or closing a punctum with a punctal plug.
- It’s important to recognize that many E/M services are provided as a standard part of performing surgical services. For example, during a foreign body removal, obtaining the patient’s ocular and general medical history; performing an external exam; evaluating distance vision; and a slit lamp examination would all be standard procedures performed prior to the foreign body removal.
- However, it is possible for additional E/M services to be necessary when performing surgical services. For example, if a patient presented for treatment of glaucoma and in the course of treating the patient the doctor identified a foreign body, the evaluation for glaucoma and the foreign body removal would be reported. The E/M would be reported with modifier 25.
- Modifier 25 should only be used when reporting E/M services.
- Documentation must reflect the necessity of the E/M service.

Doctors of optometry should be aware that an E/M service that is provided on the day of procedure with a global fee period will only be reimbursed if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and postoperative work of the procedure.
WHAT IS HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS®) is a performance measurement tool that is coordinated and administered by the National Committee for Quality Assurance (NCQA) and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of health plans. HEDIS® consists of a set of performance measures utilized by more than 90 percent of American health plans which compares how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS® IS IMPORTANT

HEDIS® results are used to measure performance, identify quality initiatives and provide educational programs for providers and members. HEDIS® ensures health plans are offering quality preventive care and services to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS® TO YOU, OUR PROVIDERS

HEDIS® can help save you time while also potentially reducing health care costs. By proactively managing patients’ care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

MONITORING HEDIS® MEASURES CAN HELP YOU:

- Identify noncompliant members to ensure they receive preventive screenings
- Understand how you compare with other Plan providers as well as with the national average

MONITORING HEDIS® MEASURES CAN HELP YOU:

- Play a central role in promoting the health of our members
- Facilitate the HEDIS® process improvement by: Providing the appropriate care within the designated time frames
- Documenting all care in the patient’s medical record
- Accurately coding all claims
- Responding to our requests for medical records within 5-7 days

BCBSNE has contracted with Verisk Health to perform HEDIS medical record abstraction. Verisk Health may be contacting your office to coordinate the retrieval of medical records for a subset of BCBSNE members within your patient panel. The records you provide us during this process help us to validate the quality of care provided to our members. We appreciate your cooperation and timeliness in submitting the requested medical record information.

Watch for additional HEDIS® information in upcoming BCBSNE Update editions!

For more information on HEDIS®, visit [https://www.ncqa.org/ HEDISQualityMeasurement/HEDISMeasures.aspx](https://www.ncqa.org/ HEDISQualityMeasurement/HEDISMeasures.aspx)
The HIPAA Privacy Rule has always provided individuals with the right to access and receive a copy of their health information from their doctors, hospitals and health insurance plans. This right is critical to enabling individuals to take ownership of their health and well-being. Individuals with access to their health information are better able to monitor chronic conditions, adhere to treatment plans, find and request fixes to errors in their records, track progress in wellness or disease management programs, and directly contribute their information to research. As the health care system evolves and transforms into one supported by rapid, secure exchange of electronic health information and more targeted treatments discovered through the new precision medicine model of patient-powered research, it is more important than ever for individuals to have ready access to their health information. Unfortunately, based on recent studies and our own enforcement experience, far too often individuals face obstacles to accessing their health information, even from entities required to comply with the HIPAA Privacy Rule. This must change.

The Office of Civil Rights recently took an important step toward ensuring that individuals can take advantage of their HIPAA right of access. We released a fact sheet and the first in a series of topical Frequently Asked Questions (FAQs) to further clarify individuals’ core right under HIPAA to access and obtain a copy of their health information. This set of FAQs addresses the scope of information covered by HIPAA’s access right, the very limited exceptions to this right, the form and format in which information is provided to individuals, the requirement to provide access to individuals in a timely manner, and the intersection of HIPAA’s right of access with the requirements for patient access under the HITECH Act’s Electronic Health Record (EHR) Incentive Program.

We will continue to develop additional guidance and other tools as necessary to ensure that individuals understand and can exercise their right to access their health information. In addition, the Office for Civil Rights will work with the White House Social and Behavioral Sciences Team and the Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) to produce consumer-friendly resources, including sample communications tools to encourage patients to access their digital health information.

The first set of materials may be found on OCR’s website at: http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

To learn more about non-discrimination and health information privacy laws, your civil rights, and privacy rights in health care and human service settings, and to find information on filing a complaint, visit us at http://www.hhs.gov/ocr/

Follow us on Twitter: http://twitter.com/HHSOCR
Low Vision LCD Retired by WPS

Effective January 1st, 2016, Wisconsin Physician Services, our Medicare Contractor, announced their Low Vision local coverage determination (LCD) has been retired.

LCDs are used to explain what CPT and ICD-10 codes are required, and under what circumstances, for Medicare to reimburse for the services in question. LCDs are generally retired when deemed unnecessary by the Medicare Contractor.

However, if you ever need guidance in filing a claim for Low Vision services with Medicare, Dr. Quack recommends using the retired LCD as a resource.

PC-Ace Pro32 Billing Software Upgrade Version 2.90 Now Available Online

If you are currently using the PC-Ace Pro32 billing software, you can now download the latest upgrade online.

Now available online are:

- The upgrade to the latest version of PC-Ace Pro32, version 2.90
- Instructions related to the upgrade
- Users Guides/Manuals
- Change Summary for the version 2.90 upgrade

If you are not using the version listed above, it is very important that you update your software immediately.

As software upgrades are received each quarter (January, April, July and October), please download/install the upgrades to update your program, so as to avoid the software expiring.

If you are not currently using this program but you are interested in using this HIPAA compliant software, please contact our EDI hotline at (866) 518-3285. You can also reach our help desk by email at EDIMedicareB@wpsic.com.
Updated CMS Resources Available Online

Remittance Advice Resources and FAQs Fact Sheet — New
A new Remittance Advice Resources and FAQs Fact Sheet is available. Learn about:
• Standard Paper Remittance (SPR) vs Electronic Remittance Advice (ERA)
• Enrolling in ERA
• Free Medicare ERA software
• Commercial ERA software

Medicare Vision Services Fact Sheet — Revised
A revised Medicare Vision Services Fact Sheet is available. Learn about:
• Coding requirements
• Coverage guidelines and exclusions

Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Revised
A revised Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet is available. Learn about:
• The three basic requirements for ordering and referring
• How to enroll in Medicare as an ordering/referring provider

Help Protect the Vision of Your Medicare Patients
January is National Glaucoma Awareness Month. Most often, there are no early warning signs for Glaucoma, but it can lead to permanent vision loss if left untreated. Medicare provides glaucoma screening coverage for beneficiaries in at least one high risk group. Help protect your Medicare patient’s vision by recommending an annual glaucoma screening if appropriate.

For More Information:
Medicare Preventive Services Educational Tool
Medicare Vision Services Fact Sheet
Initial Preventive Physical Examination Educational Tool
Annual Wellness Visit Educational Tool
National Eye Institute Glaucoma webpage
Visit the Preventive Services website to learn more about Medicare-covered services

New 2015 EHR Hardship Exemption Information to Prevent 2017 Payment Cut

CMS launched important changes to the Medicare EHR Incentive Program hardship exception process that will reduce burden on clinicians, hospitals, and critical access hospitals (CAHs).

CMS has posted new, streamlined hardship applications, reducing the amount of information that eligible professionals (EPs), eligible hospitals, and CAHs must submit to apply for an exception. The new applications and instructions for a hardship exception from the Medicare Electronic Health Records Incentive Program 2017 payment adjustment are available here.
New Email Boxes to Submit Inquiries to WPS GHA

New email boxes are now available to submit your inquiries regarding the following:

⇒ **Electronic Funds Transfers (EFTs) and 1099s:** Financial.Reporting.Inquiry@wpsic.com

⇒ **Medicare Secondary Payer (MSP) Overpayments:** Secondary.Payer.Inquiry@wpsic.com

⇒ **Overpayments:** Payment.Recovery.Inquiry@wpsic.com

Make sure to include the following in your email:

- State in which the inquiry is about
- Contact first & last name
- Contact phone number and the best time to reach you during our normal business hours (8:00 am to 3:00 pm CT)
- Brief explanation of your inquiry

Please do not send Protected Health Information or Personally Identifiable Information by email. If your inquiry involves claim-specific or patient-specific information, please contact us by telephone.

WPS GHA strives to address all inquiries as quickly as possible. Please allow up to three business days for a response. If your inquiry requires immediate attention, please contact us by telephone.

Read More about What’s Next for the EHR Incentive Programs in New CMS Blog Post

In a blog post released recently, CMS Administrator Andy Slavitt and HHS Acting Assistant Secretary Karen DeSalvo are providing expanded insight into the future of Meaningful Use. Visit The CMS Blog to read the full post.

To stay up to date on information on the EHR Incentive Programs, visit the CMS website.
OCT for Evaluation of Plaquenil Therapy Experimental?

**Dear Dr. Quack**, We have had Aetna insurance for service code 92134 which is Macular OCT, turning down as being experimental for the diagnosis codes of: M35.01 and Z79.899. I submitted the claim the first time with the M35.01 as the first diagnosis and then submitted it with the Z79.899 diagnosis code as being first. I just got off the phone with them and they said that either code is experimental.

Do you know how we can get that paid? They say we can charge the patient if we have a signed ABN.

**Dr. Quack's Quote:** It looks to me like you are doing everything correctly. I wish I had a magic bullet here, but I am afraid I do not.

Unfortunately, there does seem to be some question in the literature regarding the efficacy of OCT in determining retinal/macular toxicity secondary to Plaquenil therapy. See [http://www.reviewofophthalmology.com/content/t/imaging_and_diagnostic_instruments/c/49802/](http://www.reviewofophthalmology.com/content/t/imaging_and_diagnostic_instruments/c/49802/) where it states in part

> “More investigations involving larger numbers of patients need to be performed to better determine what SD-OCT-based indices may be reliably assessed in early HCQ toxicity. However, given its rapid image acquisition time, noninvasive nature and wide availability in many clinics, the majority of practitioners continue to favor SD-OCT as the primary adjunct to visual field testing in HCQ screening.” - See more at: [http://www.reviewofophthalmology.com/content/t/imaging_and_diagnostic_instruments/c/49802/#sthash.ZeMvI771.dpuf](http://www.reviewofophthalmology.com/content/t/imaging_and_diagnostic_instruments/c/49802/#sthash.ZeMvI771.dpuf)

And, as you can guess, the insurers will be hesitant to reimburse for procedures that are not absolutely proven to be effective, despite the fact that the majority of providers find the test necessary.

This indeed is a case for the ABN. Explain to the patient as per above, and let them decide if they want the procedure and are willing to pay for it.

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Glaucoma Testing: Need for BCBS Prior Authorization Seems Limited to Codes 92132 and 92499

**Dear Dr. Quack**, I just thought I would let you know I had a call from BCBS this morning. She was returning my call from January 8th about the pre-authorization. I gave her the procedure codes for optic nerve OCT (92133), Extended VF (92083), serial tonometry (92100), photos (92250), and pachymetry (76514) and she said we do NOT need pre-authorizations on any of these codes. I then called into BCBS member services to ask them about a certain patient that would be coming for an appointment in the next 2 weeks & asked if the 92133 needed pre-authorization & I was told NO also. I also asked this person if VF or photos would need pre-authorization & she said NO.

So as of now it sounds like we can just keep billing as we have been doing. Hopefully when we do submit a claim, we will not have any issues. Thanks for your help. Just thought I would let you know what I was told today.

**Dr. Quack’s Quote:** Thanks. I think that makes it official. The only codes that Dr. Quack has been able to confirm needing prior authorization are 92132 (anterior segment OCT) and 92499 (a catchall code). So, the BCBS bulletin requiring prior authorization for glaucoma testing was a tempest in a teapot, apparently. Thanks again...I appreciate your help and letting me know!!
A man wakes up hearing a horrible thumping on his roof. He runs outside, and there is a huge gorilla stomping around up there. What to do?

He runs inside, and he looks up the yellow pages and sure enough, there’s an ad for "Gorilla Removers". He calls the number, and the gorilla remover says he’ll be there in 30 minutes.

The gorilla remover arrives and gets out of his van. He's got a ladder, a baseball bat, a shotgun and a huge, ferocious looking dog.

"What are you going to do?", the homeowner asks.

"I'm going to put up this ladder against the roof, then I'm going to go up there and knock the gorilla off the roof with the bat. When the gorilla falls off, the dog is trained to grab the gorilla's testicles and squeeze. The gorilla will be subdued enough for me to lock him in the cage in the back of the van", says the gorilla remover and hands him the shotgun.

"What's the shotgun for?", asks the homeowner.

"If the gorilla knocks ME off the roof, shoot the dog."