AOA: FTC ISSUES WARNING LETTERS RELATED TO CONTACT LENS RULE

From your AOA: Repeated petitions for stricter enforcement of the Federal Trade Commission's (FTC's) Contact Lens Rule resulted in dozens of agency notices to potential violators, admonishing compliance or penalties.

Doctors must be in compliance with the law.

Issued to 55 contact lens sellers and prescribers last week, the FTC letters cite complaints that claim deficiencies in meeting Fairness to Contact Lens Consumers Act (FCLCA) and Contact Lens Rule requirements which grant patients the ability to comparison shop for contact lenses only in accordance with a valid prescription.

The FTC issued separate letters to sellers and prescribers, both stressing relevant portions of federal requirements and warning of legal action, including civil penalties up to $16,000 per violation. Prescribers' letters note that patients must receive their contact lens prescriptions post-fitting, free-of-charge or obligation. Similarly, sellers' letters note that contact lenses are restricted medical devices that require verification of a current, valid prescription prior to sale, and that sellers may only substitute prescribed lenses under certain conditions.

"A valid and verified prescription helps ensure that consumers have been examined for overall eye health and proper fitting by a licensed eye care (Continued on page 2)
professional," the sellers' FTC letter states. "Without guidance or supervision by a licensed eye care professional, consumers may develop serious injuries or complications from contact lenses."

**Doctors must be in compliance with the law, and the AOA offers resources to assist members in meeting such requirements and ensuring contact lens sellers do, as well.**

**Crackdown on offending sellers**

Online contact lens sellers sometimes employ business tactics that can mislead consumers or altogether sidestep the very FCLCA and Contact Lens Rule requirements designed to protect contact lens wearers. Therefore, the AOA has, and will continue, to urge the FTC to make prescription verification abuses by internet mass-retailers a top enforcement priority.

Just this past December, three dozen members of Congress signed a joint letter to the FTC, calling for the commission to do more to protect patients from seller abuses. Penned by Rep. Derek Kilmer (D-Washington), a member of the House Appropriations Committee, the letter stressed the need to curb these harmful business practices, saying: "In fact, tactics such as deceptively asserting the right to act as the patient's agent and failing to effectively communicate the need for appropriate physician oversight when using contact lenses poses a threat to public health and safety."

The Congressman's letter directly referred to action in September 2015 regarding 1-800 Contacts' use of a pre-checked authorization box (beneath users' browser windows) that was used to obtain patient agency for procuring a complete copy of their prescription. The AOA—hearing from doctors whose patients never intended to give 1-800 Contacts that authority—brought the issue to FTC officials. Subsequently, 1-800 Contacts' removed the pre-checked box and patients now have to actively select whether they would like the retailer to act as their agent to obtain prescriptions.

It's through doctors' vigilant reporting of such incidents that AOA has the ability to advocate for policies that better protect patients.

The AOA asks doctors to help hold unscrupulous contact lens sellers accountable by alerting the AOA to all FCLCA violations, and documenting and reporting them to the FTC.

Please report any issues with contact lens sellers to AOA's Associate Director for Coding and Regulatory Policy, Kara Webb, at kcwebb@aoa.org, and also report through the FTC's online complaint system.

CMS Makes Changes In How Doctors Revalidate Medicare Enrollment Data

Revalidation is the process of resubmitting and recertifying the accuracy of a provider’s enrollment information every five years.

**FROM THE AOA:** Revalidation is the process of resubmitting and recertifying the accuracy of a provider’s enrollment information. CMS has made changes to how doctors of optometry revalidate their Medicare enrollment information every five years. The changes are designed to reduce the burden on providers by making the revalidating process simpler, according to CMS. Failing to revalidate could put doctors’ Medicare payments at risk.

Among the new process improvements are:

- **Established due dates.** Revalidation due dates are now based on the last day of the month (e.g., June 30 or July 31). Sixty to 90 days before doctors are due to revalidate, notices will be sent by their Medicare administrative contractors via email or through regular mail. Due dates will generally stay the same for future revalidation cycles.

- **An online tool to look up providers’ revalidation due dates.** Doctors can find their due dates on a new CMS revalidation lookup tool. The online tool will display due dates up to six months in advance, if a provider is up for revalidation within that time frame. If a provider is not up for revalidation in the next six months, the site will display a "TBD" or to be determined.

Doctors have two options for revalidating. They can resubmit their information via:

- **Internet.** Submit your revalidation information to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). You also can upload any supporting documentation there.

- **Regular mail.** Mail paper certification statements (Paper CMS-855) to your Medicare administrative contractor.

CMS warns that if doctors are within two months of their due dates, and haven't received notice from their Medicare administrative contractor, they should go ahead and submit their revalidation application.

Failing to revalidate or not providing all information to the Medicare administrative contractor by the deadline could result in a hold on doctors' Medicare payments and possible deactivation of their Medicare billing privileges. Doctors won’t be paid for services performed during deactivation.

"So we encourage all providers to submit complete and full applications to their contractor when it’s time for them to revalidate and respond to all contractors’ requests for information to avoid your enrollment being deactivated," Alisha Banks, director of CMS’ Division of Enrollment Operations, Center for Program Integrity, said during a conference call March 1 with providers.

For full AOA Article, click **HERE**.
Open Payments Data
What You Have Been Given by Manufacturers and Others

The Centers for Medicare & Medicaid Services continues to publish data from applicable manufacturers and group purchasing organizations (GPOs) about payments they make to physicians and teaching hospitals on its website, https://openpaymentsdata.cms.gov/. The public has searched Open Payments data more than 6.3 million times. Doctors, teaching hospitals and others receiving payments or other transfers of value that are reported to CMS should take steps to ensure that this information about related research, ownership, and other financial concerns is accurate.

Through May 15, 2016, doctors and teaching hospitals may review and dispute information before CMS posts the new and updated Open Payments data on June 30, 2016. This window is the only chance for health care providers to dispute inaccurate or incomplete data, which will be posted by CMS through the end of the year.

Any doctor or teaching hospital that wants to look at the financial information reported on them by manufacturers and GPOs can register on the Open Payments website to create an account or log if they already have an account. Visit CMS’s website for instructions and quick tips.

PC-ACE Billing Software Upgrade Version 3.0 Now Available Online

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

Now available online is:
• The upgrade to the latest version of PC-ACE, version 3.0
• Instructions related to the upgrade
• Users Guides/Manuals
• Change Summary for the version 3.0 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 at the following email address: EDIMedicareB@wpsic.com
(1) Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

(2) Use clinical decision support to improve performance on high-priority health conditions.

(3) Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

(4) Generate and transmit permissible prescriptions electronically (eRx).

(5) Health Information Exchange The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

(6) Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

(7) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

(8) Patient electronic access Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

(9) Use secure electronic messaging to communicate with patients on relevant health information.

(10) Public Health Reporting The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

View or download all of the EP modified objectives and measures for meaningful use in 2016

CMS will continue to update the EHR Incentive Programs website to include additional information and resources for eligible professionals and eligible hospitals/CAHs. Stay tuned!
New CMS EHR Resources...

EHR Incentive Programs 2016 Program Requirements

To help eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) successfully participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs in 2016, CMS posted new resources on the EHR Incentive Programs website, including:

- What You Need to Know for 2016 Tip Sheets for Eligible Professionals
- Specification Sheets for Eligible Professionals
- Attestation Worksheets for Eligible Professionals
- Alternate Exclusions and Specifications for 2016 Fact Sheet
- Public Health Reporting in 2016 Tip Sheets for Eligible Professionals
- Security Risk Analysis Tip Sheet
- Patient Electronic Access Tip Sheet
- Guide for Eligible Professionals Practicing in Multiple Locations

This is a reminder that Nebraska Revised Statute 28-711 requires that suspected or observed child abuse or neglect must be reported to the Child Abuse and Neglect Hotline at 1-800-652-1999 or to law enforcement.

When any physician, any medical institution, any nurse, any school employee, any social worker, the Inspector General, or any other person has reasonable cause to believe that a child has been subjected to child abuse or neglect or observes such child being subjected to conditions or circumstances which reasonably would result in child abuse or neglect, he or she shall report such incident or cause a report of child abuse or neglect to be made to the proper law enforcement agency or to the department on the toll-free number.

Adult & Child Abuse & Neglect Hotline 1-800-652-1999
AOA MORE Registry Receives CMS’ Qualified Clinical Data Registry Designation

MORE is a quality measures reporting tool that saves users immeasurable time and money.

Earning a crucial CMS distinction, AOA’s newest member benefit delivers a quality measures reporting tool that saves users immeasurable time and money.

"Doctors of optometry give great care, now AOA MORE helps them to report that great care seamlessly through their EHR.”

AOA MORE (Measures and Outcomes Registry for Eyecare), by Prometheus Research, received CMS approval as a Qualified Clinical Data Registry (QCDR) for the 2016 Physician Quality Reporting System (PQRS) reporting year. This important recognition places AOA MORE in the same category as other medical professions’ clinical data registries.

Jeffrey Michaels, O.D., AOA Quality Improvement & Registries Committee chair, says this CMS acknowledgement is a great accomplishment for AOA—one that ensures members will be able to participate in quality initiatives for PQRS and future quality reporting initiatives.

"Doctors of optometry—who have EHR systems integrated into AOA MORE—can simplify their lives by registering for our QCDR and allowing it to process their PQRS measures,” Dr. Michaels says. He adds, "QCDR covers quality measures across multiple payers and is not limited to Medicare.”

CMS defines a QCDR as an approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A QCDR will complete the collection and submission of PQRS data on behalf of doctors, helping them satisfactorily report and avoid penalties. Those who satisfactorily report for the 2016 program year will avoid the 2018 PQRS negative payment adjustment of -2.0 percent.

The QCDR designation means AOA MORE will seamlessly integrate data from users’ EHR and submit that 2016 PQRS data to CMS on doctors’ behalf. By doing so, doctors will no longer have to report additional "claims-based" codes or be forced to report measures that may not be applicable to their practice based on EHR limitations. As long as doctors properly document in their EHR, AOA MORE is programmed to appropriately report PQRS measures. Users will be required to formally "agree to submit" this data to PQRS when it’s time to do so—for 2016, this occurs during the first 60 days of 2017—and AOA MORE will notify doctors of this deadline. It should be noted that if the EHR system a doctor uses is not yet integrated with AOA MORE, other methods of reporting should be used to avoid any future payment penalties. Doctors can use EHR-based reporting, claims-based reporting, qualified registry reporting or one of the Group Practice Reporting Options to meet the CMS PQRS reporting requirements. AOA MORE will eventually have most EHR systems integrated so doctors of optometry will be able to easily use the registry for reporting in future years.

Click here to read frequently asked questions regarding AOA MORE and PQRS.

AOA Source

AOA MORE: Have you enrolled?

Enroll today to take advantage of this AOA member benefit.

Optometry’s portal to the data revolution puts an unparalleled level of clinical information at doctors’ fingertips—simply enroll now to take advantage of this AOA member benefit.

Two years in the making, AOA MORE (Measures and Outcomes Registry for Eyecare) by Prometheus Research, is a private, secure database that systematically integrates anonymized patient data from multiple electronic health record (EHR) systems and facilitates secondary uses of that data by doctors themselves, and the profession.

For complete info, Click Here.

Do not take life too seriously. You will never get out of it alive.

Elbert Hubbard
PQRS EVOLVES INTO MIPS

YOUR PRACTICE IS BEING EVALUATED BASED ON QUALITY AND VALUE

PQRS, the Physician Quality Reporting System, is gradually evolving into MIPS, the Merit-Based Incentive Payment System over the next three years. Starting in 2019, PQRS, EHR, and VM will be consolidated into the single MIPS program.

- **PQRS** has been evaluating quality of care for various PQRS measures, such as treatment of glaucoma. PQRS reporting has affected provider reimbursement.

- **EHR**, the Electronic Health Records Meaningful Use, has also promoted quality of care, and previously offered considerable financial incentives for participation.

- **VM** (aka VBM) is the value modifier, which takes into account quality (via PQRS) and efficiency (via FFS claim data). [Note of clarification: VM is not a coding modifier, but a percent that reimbursement is adjusted upward or downward based on QRUR evaluations; see following bullet.]

- **QRUR**, the Quality and Resource Use Report, provides to providers their performance information based on both quality and efficiency. The QRUR analysis is used to compute the VM, or value modifier, which directly affects provider reimbursement.

- **MIPS**, the Merit-Based Incentive Payment System, will meld the data from PQRS, EHR, and VM, and compute reimbursement based on the results.

What follows is a CMS example of a QRUR report which would be used to compute the VM for the example practitioners. It should help ODs understand the mechanism that will be used in the future to compute Medicare reimbursement. [VM will not affect OD reimbursement for 2016. However, it can have an effect beginning in 2017, based on 2015 data.]

**CMS EXAMPLE QRUR REPORT**

Below and on the following page are excerpts from the CMS example QRUR report. The full example, 12 pages long, can be see by clicking here.

This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period for this report (July 1, 2014 to June 30, 2015) on up to three quality outcome measures and six cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare fee-for-service claims data. These measures are a subset of the quality and cost measures CMS uses to calculate the 2017 Value Modifier. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in this report.

(Continued on page 9)
**MID-YEAR QUALITY AND RESOURCE USE REPORT**

Sample Medical Practice  
Last Four Digits of Your Medicare Taxpayer Identification Number (TIN): 0000

**PERFORMANCE PERIOD: 07/01/2014 - 06/30/2015**

**ABOUT THIS REPORT**

- This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period for this report (July 1, 2014 to June 30, 2015) on up to three quality outcome measures and six cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare fee-for-service claims data. These measures are a subset of the quality and cost measures CMS uses to calculate the 2017 Value Modifier. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in this report.

- This report is provided for informational purposes only. It will not affect your TIN’s Medicare Physician Fee Schedule payments. The data in this report reflect a performance period that is different than the one used to calculate the 2017 Value Modifier (January 1, 2015 to December 31, 2015) and may not represent actual performance during the later period. The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS’ discretion, including but not limited to, circumstances in which an error is discovered.

### Per Capita and Per Episode Costs of Care for Specific Services

Exhibits 9 and 10 show the dollar difference, by category of service, between your TIN’s costs and the mean costs among TINs with at least 20 eligible cases for each of the per capta cost measures indicated in the column headings (Exhibit 9) or at least 125 eligible episodes of care for the Medicare Spending per Beneficiary measure (Exhibit 10).

**Exhibit 9. Differences between Your TIN’s Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Service Category:**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Amount by Which Your TIN’s Costs Were Higher(Lower) than Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
</tr>
<tr>
<td></td>
<td>Per Capita Costs for Beneficiaries with Diabetes</td>
</tr>
<tr>
<td></td>
<td>Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td></td>
<td>Per Capita Costs for Beneficiaries with Coronary Artery Disease</td>
</tr>
<tr>
<td></td>
<td>Per Capita Costs for Beneficiaries with Heart Failure</td>
</tr>
<tr>
<td>TOTAL PER CAPITA COSTS</td>
<td>$0</td>
</tr>
<tr>
<td>Evaluation &amp; Management Services Billed by Eligible Professionals in Your TIN*</td>
<td>$0</td>
</tr>
<tr>
<td>Evaluation &amp; Management Services Billed by Eligible Professionals in Other TINs*</td>
<td>$0</td>
</tr>
<tr>
<td>Major Procedures Billed by Eligible Professionals in Your TIN*</td>
<td>$0</td>
</tr>
<tr>
<td>Major Procedures Billed by Eligible Professionals in Other TINs*</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulatory/Minor Procedures Billed by Eligible Professionals in Your TIN*</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulatory/Minor Procedures Billed by Eligible Professionals in Other TINs*</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Physical, Occupational, or Speech and Language Pathology Therapy</td>
<td>$0</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital Inpatient Services</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Services Not Included in a Hospital Admission</td>
<td>$0</td>
</tr>
<tr>
<td>Post-Acute Services</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice</td>
<td>$0</td>
</tr>
<tr>
<td>All Other Services</td>
<td>$0</td>
</tr>
</tbody>
</table>

Note: Service-specific per capita costs are based on the total number of Medicare beneficiaries attributed to a TIN for that measure, rather than only those who used the service. If dashes (-) appear in this table, this indicates that there were no beneficiaries attributed to your TIN for a specific condition.

### Medicare Spending per Beneficiary Measure

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Amount by Which Your TIN’s Costs Were Higher(Lower) than the Benchmark: Medicare Spending per Beneficiary Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL PER EPISODE COSTS</td>
<td>$0</td>
</tr>
<tr>
<td>Evaluation &amp; Management Services*</td>
<td>$0</td>
</tr>
<tr>
<td>Major Procedures and Anesthesia*</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulatory/Minor Procedures*</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Physical, Occupational, or Speech and Language Pathology Therapy</td>
<td>$0</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>$0</td>
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<tr>
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<td>$0</td>
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</tr>
<tr>
<td>Hospice</td>
<td>$0</td>
</tr>
<tr>
<td>All Other Services*</td>
<td>$0</td>
</tr>
</tbody>
</table>

Note: Service-specific per episode costs are based on the total number of episodes attributed to a TIN for this measure, rather than only those in which the specific service was used.
**Toxic Medication ICD-10 Coding**

Dear Dr. Quack, I am trying to submit for a yearly dilated fundus exam with the patient being on at-risk meds. Under ICD-9 we used to use V67.51, and when we convert that to ICD-10, it tells us Z09, but the description of that code just seems so vague and the patient is still taking the risk med, not following completion of risk meds. Do you have a suggestion for this code?

Dr. Quack’s Quote: I’m not sure what meds your patient is currently taking. If it is Plaquenil or something similar, the correct code is Z79.899, which is a conversion from V58.69. Take a look at [http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99-Z79.899](http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99-Z79.899) for other drugs that this code covers.

The code you have been using, V67.51, is to follow after the discontinuance of toxic medication, and Z09 is a catch-all to cover that situation. See [http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z00-Z33/Z09](http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z00-Z33/Z09). Also, note on this page the section Use Additional < additional use> to code the underlying cause.

**Post-Op OCT for Possible CME**

Dear Doctor Quack, Seems that there are a small percentage of patients that have mildly reduced VA after cataract surgery. When I encounter this type of patient, the first thing I think of is CME. The problem is that I have a hard time seeing it without OCT and if I perform an OCT and there is no CME, I don’t get paid. I understand that I could have them fill out an ABN. Any comments???

Dr. Quack’s Quote: This situation is a “rule out” diagnosis, and CMS is loath to pay for “screening”, although they will sometimes pay for a rule out diagnosis when there is a justifiable history and/or symptom. (See page 7 of CMS [https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/manual201301.pdf](https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/manual201301.pdf)).

The symptom here would be decreased visual acuity H53.8 (see [http://www.icd10data.com/ICD10CM/Codes/H00-H59/H53-H54/H53-/-H53.8](http://www.icd10data.com/ICD10CM/Codes/H00-H59/H53-H54/H53-/-H53.8)). But, alas, that diagnosis is not found as justification for OCT in the WPS Local Coverage Determination for SCODI, so WPS could still deny payment.

As a last ditch effort, on those claims that do not reveal CME and you cannot use CME as the diagnosis on the claim, you might try using the blurred vision diagnosis on the claim. But that may be a futile effort.

Having the patient sign an ABN (Advance Beneficiary Notice) would be prudent and advisable.
WINTER

It's late fall and the Indians on a remote reservation in South Dakota asked their new chief if the coming winter was going to be cold or mild.

Since he was a chief in a modern society, he had never been taught the old secrets. When he looked at the sky, he couldn't tell what the winter was going to be like.

Nevertheless, to be on the safe side, he told his tribe that the winter was indeed going to be cold and that the members of the village should collect firewood to be prepared.

But, being a practical leader, after several days, he got an idea. He called the National Weather Service and asked, 'Is the coming winter going to be cold?'

'It looks like this winter is going to be quite cold,' the meteorologist at the weather service responded.

So the chief went back to his people and told them to collect even more firewood in order to be prepared.

A week later, he called the National Weather Service again. 'Does it still look like it is going to be a very cold winter?' 'Yes,' the man at National Weather Service again replied, 'it's going to be a very cold winter.'

The chief again went back to his people and ordered them to collect every scrap of firewood they could find.

Two weeks later, the chief called the National Weather Service again. 'Are you absolutely sure that the winter is going to be very cold?'

'Absolutely,' the man replied. 'It's looking more and more like it is going to be one of the coldest winters we've ever seen.'

'How can you be so sure?' the chief asked.

The weatherman replied, 'The Indians are collecting one hell of a lot of firewood.'