2010 3rd Party Update

Optometry and 3rd parties:
What has Changed over the Last 12 Months
2010 3rd Party Update

- CMS
- PQRI
- E-Rx
- EHR
- HIPAA
- WPS (Medicare B)
- Noridian (DME)
- Medicaid
- Coding
- Potpourri
This Presentation Online

http://nebraska.aoa.org/prebuilt/NOA/index.htm

Nebraska Optometric Association

3rd Party Resources
- 3rd Party Index of Articles and Links
- Archived 3rd Party Newsletters
- HIPAA—Privacy, Security, EDI, NPI, 5010
- 3rd Party New Licensee Information
- Help on using 3rd Party pages
- Email Ed Schneider OD, 3rd Party Consultant

Links to Previous 3rd Party Education
- 2010 PQRI In-Office Traffic Sheet & [92-10] correction
- 2009 Kearney New Licensee Information
- 2009 Kearney Yearly 3rd Party Update
- 2009 PQRI & E-prescribing Webinar
- Third Party Webinar - Evaluating 3rd Parties
- 3rd Party Webinar - Medicare DME
- HIPAA (the 2nd half)
2010 3rd Party Update

- CMS
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CMS: Signatures

- Legible signature must be applied
  - Promptly
  - By practitioner who is responsible for providing, evaluating, or ordering the service(s)
- Use of initials are likely to be found unacceptable, not recommended
- Use of a log of signatures should be kept up-to-date (signatures change over time)
- Must sign all extra testing
CMS: Signatures

Penalty for no signature?

- CMS can recoup all records affected, going back years and years in the process if the provider
  - Has not signed records legibly
  - Does not have signed, written orders for extra testing
  - MARCH
CMS Record Reviews - WPS

2010 WPS Probe Results for CPT 99214 by Optometry

- 48% of 99214 Optometric Claims were denied.
  - 5% were denied for insufficient documentation
  - 11% were downcoded due to documentation
  - 6% were denied as routine due to documentation
  - 26% were denied as no response
Respond To WPS Medicare B Probes

- If you do not respond to requests for medical records on a timely basis
  - Your claim will be denied and
  - Other untoward things may happen (Request for multiple records; recoupment.)
HealthDataInsights is our CMS Recovery Audit Contractor (RAC). https://racinfo.healthdatainsights.com/

Two problems detected:

- Non-compliance with requested documentation
- Documentation that did not show
  - Services billed were covered services,
  - Medically necessity, or
  - Correct coding.

Not responding to a RAC request will result in recoupment of fees paid by Medicare.
Using A Substitutes Doctor
Medicare Locum Tenens Physician Rules

- A patient’s regular physician may receive Medicare Part B payment for services of a locum tenens physician as long as that physician
  - Is not an employee of the regular physician
  - Does not provide those services to Medicare patients over 60 continuous days (except military).
    - (Can subsequently use a different LT physician)
  - Claims are filed with modifier Q6.
Using A Substitutes Doctor
Medicare Locum Tenens Physician Rules

- If a physician permanently leaves a practice, the replacement physician cannot be considered Locum Tenens.
- Physicians *leaving* a group on a permanent basis must...
  - Either Reassign Payment For His/Her Services Or
  - Bill Themselves (In Their Own Name And Billing Number).

P.2. January
Note that *Medicaid* does NOT allow any type of substitute physician.
Paper Claims

- Time to switch to electronic claims
- New HIPAA 5010 and ICD-10 coming up
  - Change in CMS-1500
- Waiver To Use Paper Claims Must Be renewed every two years
- Must have less than 10 FTE employees
  - Verified with IRS and SS system

- MAY
Paper Claims

To Inquire about Filing Electronically:

- **WPS Medicare B claims:**
  - (866) 503-9670
  - http://www.wpsmedicare.com/j5macpartb/departments/edi/

- **Noridian DME Claims:**
  - National Government Services
  - 866-311-9184
  - http://www.ngscedi.com/
PECOS is how CMS keeps track of providers.

As A Medicare Provider, You Must Be…

- Enrolled And
- Up-to-date

…In The Medicare PECOS System, Or Your Reimbursements From Medicare Will Cease (Date TBA).
You can update PECOS data using 855 Medicare enrollment forms (855i, 855b, 855r) or by using the Internet.
PECOS – Enrollment Training

WPS Medicare Provider Enrollment Training is now available via three new ‘on-demand’ Computer-Based Training Courses to help providers choose the correct provider enrollment form.

- **All provider enrollment courses at**
  
  http://www.wpsmedicare.com/j5macpartb/training/on_demand/audio_visual/

- **855i at**
  
  http://www.wpsmedicare.com/j5macpartb/training/on_demand/audio_visual/_files/855i/855i.html

- **855b at**
  
  http://www.wpsmedicare.com/j5macpartb/training/on_demand/audio_visual/_files/855b/855b.html

- **855r at**

  http://www.wpsmedicare.com/j5macpartb/training/on_demand/audio_visual/_files/855r/855r.html

P.4. September
PECOS

- Once you are set up with Internet PECOS, it is the quickest way to alter PECOS. However, getting set up in the Internet PECOS system can be time consuming.
  https://pecos.cms.hhs.gov/pecos/login.do

- The Internet-based access to PECOS can
  - Submit an initial Medicare enrollment application
  - View or change your enrollment information
  - And…
PECOS

- also be used to:
  - Track your enrollment application through the web submission process
  - Add or change a reassignment of benefits
  - Submit changes to existing Medicare enrollment information
  - Reactivate an existing enrollment record
  - Withdraw from the Medicare Program

https://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage
PECOS

Make sure *all of your data matches, including*...

- Names (business, provider)
- Addresses (no PO Boxes)
- NPIs (make sure all are listed)
- PTANs (make sure all are listed)

*It should match on all of the following...*

- All 855 forms,
- NPI registration,
- CEDI enrollment, and
- NSC enrollment (for DME - Noridian)
PECOS

Also, Up-to-Date PECOS Enrollment is required

- For all Physicians Who Order Or Refer Items Or Services…
- In Order For The Ordered Or Referred Item Or Service To Be Covered.

Thus, both the Orderer/Referrer and the Supplier must be in the PECOS system.
PECOS and DME

- For most ODs, the most likely claim to suffer complications regarding an ordering/referring provider not being in PECOS will be a cataract post-op claim. (Co-management and Post-op Rxs)

- NOVEMBER
PECOS

PECOS Phase 2 Deadline Postponed until January, 2011

- Phase 2 will cause claims to reject if the referring or ordering provider [box 17-17b] is not in the PECOS system, regardless of the PECOS status of the provider providing the service or material.

MARCH
CMS PECOS
Ordering-Referring Provider List

- CMS Has Updated The “Ordering and Referring report”
  https://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp

- File Containing The NPI And The Name Of Practitioners Eligible
  - To Order And Refer In The Medicare Program And
  - Who Have Current Enrollment Records In PECOS That Contain An NPI.
Another PECOS Source

- Medicare's online *Physician and Other Healthcare Professional Directory* offers another way to confirm that a provider is in the PECOS system.

- DME Suppliers (for post-op Rxs) are now able to obtain PECOS information through the Noridian Interactive Voice Response (IVR) System. 877-320-0390  **MAY**
Are YOU in the PECOS System?

Check For Your Name On The PECOS List Of Doctors

- If You Have Submitted An Enrollment Application Recently But Have Not Received Approval
  - Then Check On The List Of New Applicants.
    https://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp

- P.1. AUGUST
EHR and PECOS

PECOS Enrollment Required For EHR Incentive Program

- For EHR incentive payments your enrollment information must be in PECOS, so act now if you do not have an enrollment record in this system. P.9. **JULY**
Medicare Advantage

- A CMS directory of Medicare Advantage Plans and of Medicare Part D plans is available online at
  http://www.wpsmedicare.com/j5macpartb/training/resources/cms_resources/

- A Nebraska Dept of Insurance listing of MA plans is available at

Pg.3. [link to newsletter] December
Medicare Advantage

If you are unfamiliar with a patient’s PFFS MA plan…

- Check that patient’s MA insurer before providing services or materials (contact info on ID card).
- Once you furnish the services or materials to a MA PFFS patient, you may be “deemed” by the plan to be a contract provider and thus accept their reimbursement rates.
- If you DO NOT wish to accept a PFFS MA plans terms and conditions of payment, then you should not furnish services or materials to their member.
- Emergency services are exempted from this limitation.  

MARCH
CMS Rules for Medicare Advantage Insurers

CMS Medicare Advantage Payment Guide for MA Insurers

- Important Multiple Resources to help you understand your relationship with MA insurers.
- It can be found at http://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

MARCH
C-SNAP
CMS - Secure Net Access Portal

C-SNAP is a comprehensive, secure website that offers registered users a FREE Web Portal That Provides:

- Access Claim Status (real time)
- Patient Eligibility Information (real time)
- Duplicate R/As
- 24 Hours A Day Service.
- Contact with the C-SNAP Technical Support staff

More Info at

September AUGUST
The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals offers information on the Medicare Program. . . .

- General Medicare information
- Becoming a provider or supplier
- Reimbursement
- Payment policies
- Evaluation & Management Svcs

- Protecting the Medicare trust fund
- Inquiries
- Overpayments
- Fee-for-service appeals.

CMS Education

CMS Quick Reference Charts

- *The Quick Reference: Chart for All Medicare Providers* includes a list of CMS web pages that ALL Medicare providers use most frequently, and can be found at
  

- *The Quick Reference: New Medicare Provider Chart* includes a list of CMS web pages that NEW Medicare providers use most frequently, and is available at
  

P.4.  [link to newsletter]  February
CMS Education

How To Use Medicare Coverage Database

- The searchable Medicare Coverage Database contains a wealth of information.
  https://www.cms.gov/MLNProducts/downloads/MedicareCvrgeDatabase.pdf

Booklet on NPI-What You Need to Know

- Information on the basics of the NPI

MARCH
CMS Education

New Web-based Training On Medicare Fundamentals

http://www.cms.gov/MLNgeninfo/ (Look under Web Based Training Modules)

- CMS Form 1500
- Diagnosis Coding: Using the ICD-9-CM
- HIPAA EDI Standards
- Medicare Fraud and Abuse
- PQRI and E-Prescribing
- Skilled Nursing Facility Consolidated Billing
- Understanding the Remittance Advice for Professional Providers
- World of Medicare
- Your Office in the World Of Medicare

P.4. [link to newsletter] February
Medicare Education

NEW: *How to Use the National Correct Coding Initiative (NCCI) Tools* at


---explains---

National Correct Coding Initiative

- **NCCI Program** to reduce incorrect coding based on
  - Mutually exclusive codes (92083 & 92081)
  - Anatomic considerations (cataract extraction & enucleation).
- **Medically Unlikely Edits (MUEs)**
  - Program to reduce errors due to clerical entries and incorrect coding based on frequency of procedures on same day.
    - P.5. September
HPSA

2010 HPSA 10% BONUS ZIP CODES

- Medicare pays a 10% bonus on the professional component of services offered in a Health Professions

- Find more at: http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses

P.2 APRIL
HPSA Bonus ZipCodes 2010

68003, 68015, 68017, 68018, 68033, 68040, 68041, 68042, 68050, 68065, 68066, 68070, 68073,

68623, 68628, 68638, 68640, 68648, 68663,

68710, 68717, 68727, 68728, 68732, 68736, 68739, 68745, 68749, 68751, 68753, 68757, 68759, 68768, 68770, 68771, 68774, 68778, 68779, 68784, 68785, 68792,

68816, 68821, 68826, 68827, 68833, 68864,

68920, 68922, 68924, 68926, 68936, 68945, 68946, 68948, 68959, 68966, 68967, 68969, 68971, 68977, 68982, ......MORE ON NEXT PAGE

HPSA Bonus ZipCodes 2010

690
22, 69023, 69024, 69025, 69027, 69028, 69032, 69033, 69038, 69039, 69040, 69042, 69043, 69044, 69045, 69046,

691
21, 69125, 69128, 69129, 69133, 69142, 69145, 69147, 69148, 69152, 69154, 69157, 69161, 69163, 69166, 69167, 69190,

692
10, 69214, 69217,

693
31, 69333, 69334, 69335, 69336, 69339, 69340, 69343, 69345, 69346, 69347, 69350, 69351, 69360, 69365, 69366, 69367.

Non-Participating Medicare Providers Cannot Bill or Charge Usual and Customary Fees.

The rules are....

- You do not have to see Medicare patients.
- But, if you see ANY Medicare patients, federal law requires you to follow Medicare guidelines.
- Non-Par providers must file claims for their Medicare Patients.

- Pp.4-5. JULY and P.8. [link to newsletter] February
Non-Participating Medicare Providers *Cannot* Bill or Charge Usual and Customary Fees.

- Non-Par providers must not *bill* more than the Medicare limiting charge (last column on Medicare Fee Schedule), under penalty of federal law.
- Non-par Providers *Cannot* *Collect* From Medicare Patients & Medigap &/or Patient a Total $ Amount More Than The *Medicare Limiting Charge*
- *Excessive billing or failure to file claims will incur severe fines.*

Pp.4-5. **JULY** and P.8. [link to newsletter] February
Medicare Fees

You Cannot Charge Medicare Patients Extra Fees such as

- A Finance Charge
- Interest
- Other Similar Types Of Charges.
Medicare Fees

Medicare Now Gives Option To Purchase Medigap With Higher Co-Pays

- “Modernization” Of The Medigap Insurance Gives Medicare Enrollees The Option To Purchase Supplemental Coverage At Reduced Premiums.
- In Exchange For Increased Beneficiary Cost Sharing –
  - Including A $20 Copayment Requirement For Health Care Practitioner Office Visits.
Medicare Fees Corrected Through End Of Year

- Law establishes a 2.2 percent update to the Medicare Physician Fee Schedule retroactive from June 1 through November 30, 2010. P.1. **JULY**

- Medicare 2.2% Fee Increase Does Not Require Collection Of Increased Co-Pays
  - Retroactively Raise Medicare Part B Fee-For service Reimbursements Will Not Require Health Care Practitioners To Collect Corresponding Increases In Medicare Co-Payments From Patients. P.2. **AUGUST**
2010 3rd Party Update

- CMS
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PQRI

Pqri Denial Code Must Be N-365

- The PQRI claim lines on your Medicare B remittance advice (EOB) should have the denial reason code as N-365. That indicates that you filed the PQRI claim line correctly.

P.4. [link to newsletter] February
Individual PQRI Feedback via NPI

- CMS reports that individual eligible providers (EPs) can call their A/B MAC to request 2007 Re-Run and 2008 PQRI feedback reports on their individual NPI. (866) 503-3807.

- Thus EPs who are part of a group practice can get their individual feedback reports via their e-mail address.

- EPs can expect e-mailed feedback within 30 days. If no report is available, the provider will receive an e-mail notification.
Group PQRI Feedback via TIN

- Eligible Professionals who request feedback reports based on TIN or group practice information will still be required to access their PQRI feedback reports via the PQRI Portal after first registering in IACS.
- An IACS user identification and password is required to access the PQRI Portal.
- The PQRI Portal may be found at http://www.qualitynet.org/pqri.
PQRI Ratings For ODs

- The public can now go online and compare
  - Hospitals,
  - Surgical centers, and
  - Nursing homes.

- Recently New Information on Quality Of Care
  - Outpatient And Emergency Departments

- How Soon Will CMS Release Your PQRI Information (or the lack thereof) To The General Public…?
PQRI • Incentive payments

– 2008 adjusted payments
  • Those related to the technical problems have been issued
  • Those related to analysis of measures not originally included will be made 8/25/10 - 9/17/10.
  • The indicator on the Remittance Advice will be PQ08

– 2009 Incentive payments to be issued 10/25/10 - 11/12/10
  • The indicator on the Remittance Advice will be PQ09
  • Feedback reports can be obtained beginning November 2010 through the PQRI portal at:

  www.qualitynet.org/portal/server.pt/community/pqri_home/212
2010 3rd Party Update

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E-Rx

Electronic Prescribing Incentive (E-Rx) Program

Changes

- CMS page on "How to Get Started" in participating with the Electronic Prescribing Incentive (eRx) program is found at...
  http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp

P.1. September
E-prescribing • Incentive payments

• 2009 payments for E-Rx will begin going out 9/21/10 - 10/22/10.
  • Still time to qualify for 2010 incentive
  • For details refer to:

• Proposed rule states that providers not meeting measure for January – July 2011 will begin to receive decreased Medicare payments in January 2012
2010 3\textsuperscript{rd} Party Update

- CMS
- PQRI
- E-Rx
- EHR
- HIPAA

- WPS (Medicare B)
- Noridian (DME)
- Medicaid
- Coding
- Potpourri
CMS And ONC* Jointly Announce Their Final Rules For Both

- Electronic Health Record Standards For Certification And
- The Medicare And Medicaid EHR Incentive Programs,

Including The Definition Of *Meaningful Use.*

Pp.7-9. AUGUST

*ONC: Office of the National Coordinator for Health Information Technology*
EHR

The Recovery Act specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner (e.g., e-Prescribing);
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care; and
- The use of certified EHR technology to submit clinical quality and other measures.
Meaningful Use Lingo

- Health Outcomes Policy Priorities (e.g., “improve care coordination”)
  - Objectives (e.g., “capability to exchange key clinical information”)
    - Core objectives (required)
    - Menu set of objectives (optional)
  - Quality Measures to meet those objectives (e.g., “perform at least one successful test exchanging key clinical information”)
What are the Requirements of Stage 1 (2011) Meaningful Use?

- Stage 1 Objectives and Measures Reporting
- Eligible Professionals must complete:
  - 15 core objectives, plus
  - 5 objectives out of 10 from menu set
  - For a total of 20 out of 25 objectives.

- 6 total Clinical Quality Measures (CQM)
  - 3 core or alternate core, and
  - 3 out of 38 from alternate set
Applicability of Meaningful Use Objectives and Measures

- Some MU objectives not applicable to every provider’s clinical practice, thus they would not have any eligible patients or actions for the measure denominator. Exclusions do not count against the 5 deferred measures
- In these cases, the eligible professional, eligible hospital or CAH would be excluded from having to meet that measure
  - Eg: Dentists who do not perform immunizations; Chiropractors do not e-prescribe

https://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
Meaningful Use
Denominators

- Two types of percentage based measures are included in demonstrating Meaningful Use:
  1. Denominator is all patients seen or admitted during the EHR reporting period
     - The denominator is all patients regardless of whether their records are kept using certified EHR technology
  2. Denominator is actions or subsets of patients seen or admitted during the EHR reporting period
     - The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified EHR technology

https://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
Meaningful Use: Core Objectives

- Eligible Professionals – 15 Core Objectives
  1. Computerized provider order entry (CPOE)
  2. E-Prescribing (eRx)
  3. Report ambulatory clinical quality measures to CMS/States
  4. Implement one clinical decision support rule
  5. Provide patients with an electronic copy of their health information, upon request
  6. Provide clinical summaries for patients for each office visit
  7. Drug-drug and drug-allergy interaction checks
  8. Record demographics
  9. Maintain an up-to-date problem list of current and active diagnoses
  10. Maintain active medication list
  11. Maintain active medication allergy list
  12. Record and chart changes in vital signs
  13. Record smoking status for patients 13 years or older
  14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
  15. Protect electronic health information

https://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
<table>
<thead>
<tr>
<th>Objective</th>
<th>Core/Menu</th>
<th>Measure</th>
<th>Reporting Requirements</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized Provider Order Entry (CPOE) for medication orders directly</td>
<td>Core</td>
<td>More than 30%</td>
<td><strong>Numerator:</strong> The number of patients in the denominator that have at least one medication order entered using CPOE. <strong>Denominator:</strong> Number of unique patients with at least one medication on their medication list seen by the EP during the EHR reporting period.</td>
<td>Any EP who writes fewer than one hundred prescriptions during the EHR reporting period</td>
</tr>
<tr>
<td>entered by any licensed healthcare professional who can enter orders into</td>
<td></td>
<td>Note: Electronic transmittal of that order to the pharmacy is not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the medical record per state, local and professional guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement drug-drug and drug-allergy checks</td>
<td>Core</td>
<td>Implement drug-drug and drug-allergy checks for the entire EHR reporting period</td>
<td><strong>Yes/No Attestation</strong></td>
<td>Any EP who writes fewer than one hundred prescriptions during the EHR reporting period</td>
</tr>
<tr>
<td>Maintain an up-to-date problem list of current and active diagnoses</td>
<td>Core</td>
<td>More than 80% of all unique patients seen by the EP have at least one entry or and indication that no problems are known for the patient recorded as structured data</td>
<td><strong>Numerator:</strong> The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data. <strong>Denominator:</strong> The number of unique patients seen by the EP during the EHR reporting period.</td>
<td>None</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
<td>Core</td>
<td>More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.</td>
<td><strong>Numerator:</strong> The number of prescriptions in the denominator generated and transmitted electronically. <strong>Denominator:</strong> The number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.</td>
<td>Any EP who writes fewer than one hundred prescriptions during the EHR reporting period</td>
</tr>
<tr>
<td>Maintain active medication list</td>
<td>Core</td>
<td>More than 80% of all unique patients seen by the EP who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data</td>
<td><strong>Numerator:</strong> The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data. <strong>Denominator:</strong> The number of unique patients seen by the EP during the EHR reporting period.</td>
<td>None</td>
</tr>
<tr>
<td>Objective</td>
<td>Core/Menu</td>
<td>Measure</td>
<td>Reporting Requirements</td>
<td>Exclusions</td>
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<tr>
<td>-----------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Maintain active medication allergy list       | Core      | More than 80% of all unique patients seen by the EP who have at least one entry (or an indication that patient has no known medication allergies) recorded as structured data in their medication allergy list. | **Numerator:** The number of unique patients in the denominator who have at least one entry (or an indication that patient has no known medication allergies) recorded as structured data in their medication allergy list.  
**Denominator:** The number of unique patients seen by the EP during the EHR reporting period. | None                                                                                     |
| Record the following demographics: preferred language, gender, race and ethnicity, and date of birth | Core      | More than 50% of all unique patients seen by the EP have demographics recorded as structured data | **Numerator:** The number of unique patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.  
**Denominator:** The number of unique patients seen by the EP during the EHR reporting period. | None                                                                                     |
| Record and chart vital signs                  | Core      | More than 50% of all unique patients age 2 and over seen by the EP have recorded height, weight and blood pressure | **Numerator:** The number of patients in the denominator who have at least one entry of their height, weight and blood pressure recorded as structured data.  
**Denominator:** The number of unique patients age 2 or over seen by the EP during the EHR reporting period. | Any EP who sees only patients 2 years old or younger  
Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to their scope of practice may attest and be excluded |
| Record smoking status for patients 13 and over | Core      | More than 50% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded as structured data | **Numerator:** The number of patients in the denominator with smoking status recorded as structured data.  
**Denominator:** The number of unique patients age 13 or older seen by the EP during the EHR reporting period. | None                                                                                     |
<table>
<thead>
<tr>
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<th>Core/Menu</th>
<th>Measure</th>
<th>Reporting Requirements</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report ambulatory clinical quality measures to CMS (or, for EPs seeking</td>
<td>Core</td>
<td>For 2011, an EP would provide the aggregate numerator and denominator through attestation. For 2012, and EP</td>
<td>An eligible provider would provide the aggregate numerator and denominator through attestation</td>
<td>None</td>
</tr>
<tr>
<td>Medicaid incentive payment, the states)</td>
<td></td>
<td>would electronically submit the measures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement one clinical decision support rule relevant to specialty or</td>
<td>Core</td>
<td>Implement one clinical decision support rule</td>
<td>Yes/No Attestation</td>
<td>None</td>
</tr>
<tr>
<td>high clinical priority along with the ability to track compliance with</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>that rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their health information</td>
<td>Core</td>
<td>More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days.</td>
<td>Numerator: The number of patients in the denominator who receive a copy of their health information within 3 business days. Denominator: The number of patients of the EP who request an electronic copy of their health information four days prior to the end of the EHR reporting period.</td>
<td>Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.</td>
</tr>
<tr>
<td>Clinical summaries provided to patients for all office visits</td>
<td>Core</td>
<td>Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. The</td>
<td>Numerator: The number of patients in the denominator who are provided a clinical summary of their visit within three business days Denominator: The number of unique patients seen by an EP for an office visit during the EHR reporting period.</td>
<td>Any EPs who have no office visits during the EHR reporting period.</td>
</tr>
<tr>
<td>Capability to exchange key clinical information among providers of care</td>
<td>Core</td>
<td>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information</td>
<td>Yes/No Attestation</td>
<td>None</td>
</tr>
<tr>
<td>and patient authorized entities electronically</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Meaningful Use: Menu Set Objectives

- Menu objectives – may defer 5 of 10
- Eligible Professionals – 10 Menu Objectives
  1. Drug-formulary checks
  2. Incorporate clinical lab test results as structured data
  3. Generate lists of patients by specific conditions
  4. Send reminders to patients per patient preference for preventive/follow up care
  5. Provide patients with timely electronic access to their health information
  6. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
  7. Medication reconciliation
  8. Summary of care record for each transition of care/referrals
  9. Capability to submit electronic data to immunization registries/systems*
  10. Capability to provide electronic syndromic surveillance data to public health agencies*

* At least 1 public health objective must be selected.

https://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
<table>
<thead>
<tr>
<th>Objective</th>
<th>Core/Menu</th>
<th>Measure</th>
<th>Reporting Requirements</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Health Information</td>
<td>Core</td>
<td>Conduct or review a security risk analysis per CFR 164.308 (a) (1) of the certified EHR technology and implement updates and correct identified security deficiencies as part of its risk management process.</td>
<td>Yes/No Attestation</td>
<td>None</td>
</tr>
<tr>
<td>Implement drug-formulary checks</td>
<td>Menu</td>
<td>The EP has enabled drug-formulary functionality and has access to at least one internal or external formulary for the entire EHR reporting period.</td>
<td>Yes/No Attestation</td>
<td>Any EP who writes fewer than one hundred prescriptions during the EHR reporting period</td>
</tr>
<tr>
<td>Lab results</td>
<td>Menu</td>
<td>More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider to whose results are in a positive/negative or numerical format are incorporated in certified EHR technology.</td>
<td>Numerator: The number of lab test results whose results are expressed in a positive or negative affirmation or as a number and are incorporated as structured data. Denominator: The number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.</td>
<td>Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period</td>
</tr>
<tr>
<td>Generate lists of patient based on specific conditions to use for quality improvement, reduction of disparities, research or outreach.</td>
<td>Menu</td>
<td>Generate at least one report listing patients of the EP with a specific condition.</td>
<td>Yes/No Attestation</td>
<td>None</td>
</tr>
<tr>
<td>Send reminders to patients based on patient preferences and selected by specific criteria</td>
<td>Menu</td>
<td>Reminder sent to at least 20% of all unique patients seen by the EP that are greater than or equal to 65 years of age or less than or equal to 5 years of age.</td>
<td>Numerator: The number of patients in the denominator who were sent the appropriate reminders Denominator: The number of unique patients 65 years old or older or 5 years old or younger.</td>
<td>Any EP who has no patients 65 years old or older or 5 years old or younger.</td>
</tr>
<tr>
<td>Objective</td>
<td>Core/Menu</td>
<td>Measure</td>
<td>Reporting Requirements</td>
<td>Exclusions</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP | Menu      | More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being uploaded in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information. | **Numerator**: The number of patients in the denominator who have timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information online.  
**Denominator**: The number of unique patients seen by the EP during the EHR reporting period. | Any EP that neither orders nor creates any of the information listed in the ONC final rule 45 CFR 170.304 (g). (lab test results, problem list, medication list and medication allergy list) |
| Provide access to patient-specific education resources upon request        | Menu      | More than 10% of all unique patients seen by the EP are provided patient-specific education resources. | **Numerator**: The number of patients in the denominator who are provided patient education specific resources  
**Denominator**: The number of unique patients seen by an EP during the EHR reporting period. | None                                                                                             |
| The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation | Menu      | The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP. 
Medication reconciliation is described as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider. 
Transition of care is clarified as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. We also clarify that the receiving eligible hospital or EP would conduct the medication reconciliation. | **Numerator**: The number of transitions of care in the denominator where medication reconciliation was performed.  
**Denominator**: The number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. | Any EP that was not on the receiving end of any transition of care during the EHR reporting period. |


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## Final Rule - Meaningful Use

<table>
<thead>
<tr>
<th>Objective</th>
<th>Core/Menu</th>
<th>Measure</th>
<th>Reporting Requirements</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide summary care record for each transition of care</td>
<td>Menu</td>
<td>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.</td>
<td>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided.</td>
<td>Any EP that does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period.</td>
</tr>
<tr>
<td>Capability to submit electronic data to immunization registries</td>
<td>Menu</td>
<td>Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).</td>
<td>Yes/No Attestation</td>
<td>Any EP that has not given any immunizations during the EHR reporting period.</td>
</tr>
<tr>
<td>Capability to submit electronic syndromic surveillance data to public health agencies</td>
<td>Menu</td>
<td>Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)</td>
<td>Yes/No Attestation</td>
<td>Any EP that does not collect any reportable syndromic information on their patients during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Meaningful Use: Clinical Quality Measures

- Details of Clinical Quality Measures
  - 2011 – Eligible Professionals, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by ATTESTATION.
  - 2012 – Eligible Professionals, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.
### Meaningful Use: Clinical Quality Measures

- **Eligible Professionals— Core Set CQMs**

<table>
<thead>
<tr>
<th>NQF Measure Number &amp; PQRI Implementation Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0013</td>
<td>Hypertension: Blood Pressure Measurement</td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention</td>
</tr>
<tr>
<td>NQF 0421 PQRI 128</td>
<td>Adult Weight Screening and Follow-up</td>
</tr>
</tbody>
</table>

### Meaningful Use: Clinical Quality Measures

- **Eligible Professionals – Alternate Core Set CQMs**

<table>
<thead>
<tr>
<th>NQF Measure Number &amp; PQRI Implementation Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
</tr>
<tr>
<td>NQF 0041 PQRI 110</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older</td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
</tr>
</tbody>
</table>

Additional Set CQM – EPs must complete 3 of 38

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

http://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
MU: Clinical Quality Measures

- Additional Set CQM– EPs must complete 3 of 38 (cont.)
  19. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
  20. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
  21. Diabetes: Eye Exam
  22. Diabetes: Urine Screening
  23. Diabetes: Foot Exam
  24. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
  25. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
  27. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
  28. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
  29. Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
  30. Prenatal Care: Anti-D Immune Globulin
  31. Controlling High Blood Pressure
  32. Cervical Cancer Screening
  33. Chlamydia Screening for Women
  34. Use of Appropriate Medications for Asthma
  35. Low Back Pain: Use of Imaging Studies
  36. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
  37. Diabetes: Hemoglobin A1c Control (<8.0%)
CMS Medicare and Medicaid EHR Incentive Programs

Milestone Timeline

- **Fall 2010**: Certified EHR technology available and listed on CIN website
- **Winter 2011**: Registration for the EHR Incentive Programs begins
- **Spring 2011**: Medicare payment adjustments begin for EPs and eligible hospitals that are not meaningful users of EHR technology
- **Fall 2011**: Attestation for the Medicare EHR Incentive Program begins
- **Winter 2012**: Last day for EPs to register and attest to receive an Incentive Payment for CY 2011
- **February 29, 2012**: Last day for eligible hospitals and CAHs to register and attest to receive an Incentive Payment for FFY 2011
- **November 30, 2011**: Last day for Medicaid providers, States may launch their programs if they so choose
- **May 2011**: EHR Incentive Payments begin
- **2014**: Last year to initiate participation in the Medicare EHR Incentive Program
- **2015**: Last year to receive a Medicare EHR Incentive Payment
- **2016**: Last year to initiate participation in Medicaid EHR Incentive Program
- **2021**: Last year to receive Medicaid EHR Incentive Payment

Resources to Get Help and Learn More

- Get information, tip sheets and more at CMS’ official website for the EHR incentive programs:
  [http://www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)
  Follow the latest information about the EHR Incentive Programs on Twitter at [http://www.Twitter.com/CMSGov](http://www.Twitter.com/CMSGov)

- Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition:
  [http://healthit.hhs.gov](http://healthit.hhs.gov)
What are the Requirements of Stage 1 (2011) Meaningful Use?

- Reporting period is 90 days for first year and 1 year subsequently
- Reporting through *attestation* only in 2011
- Objectives and Clinical Quality Measures
  Reporting may be yes/no or numerator / denominator attestation
- To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology.

https://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf
An Eligible Professional who works at multiple locations, but does not have certified EHR technology available at all of them would: Have to have 50% of their total patient encounters at locations where certified EHR technology is available

Would base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available
EHR Reporting

Details of Clinical Quality Measures

- 2011 – Eligible Professionals, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate CQM [clinical quality measures] numerator, denominator, and exclusion data to CMS or the States by ATTESTATION.

- 2012 – Eligible Professionals, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.
EHR

EHR Incentives –

Get The EHR Facts From CMS

- The CMS website is the official federal source for facts about the Medicare & Medicaid EHR Incentive Programs. The site contains up-to-date resources that will give you the insight you need to make educated decisions.

http://www.cms.gov/EHRIncentivePrograms/

P.1. September
EHR

AOA's Electronic Health Records Information

http://www.aoa.org/x14207.xml
2010 3rd Party Update

- CMS
- PQRI
- E-Rx
- EHR
- HIPAA

- WPS (Medicare B)
- Noridian (DME)
- Medicaid
- Coding
- Potpourri
HIPAA Privacy

HIPAA Enforcement Becomes More Stringent

- Recent legislation Addresses The Privacy And Security Concerns Associated With The Electronic Transmission Of Health Information
- Several Provisions Strengthen The Civil And Criminal Enforcement Of The HIPAA Rules. P.1.

- Rite Aid Fined $1 Million For HIPAA Violation Rite Aid Corporation And Its 40 Affiliated Entities Have Agreed To Pay $1 Million To Settle Violations Of HIPAA Privacy Rule. P.3. AUGUST

- Review your Notice of Privacy Practices
HIPAA Privacy

You are Required to Report Breaches Of Protected Health Information

- OCR has posted on its website a list of the covered entities that have reported breaches of unsecured protected health information affecting more than 500 individuals.

- Exempt only if you software includes
  - Encryption
  - Self destructing data
HIPAA 5010  ICD-10

ICD-10-CM For Physicians (ODS) And Clearinghouses

- If you have a telephone in your office, you are covered by HIPAA. [https://www.cms.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf](https://www.cms.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf)

- If you are covered by HIPAA, you need to prepare for two firm deadlines to comply with mandated changes to ICD-10-CM.
  - **January 1, 2012** — for full compliance with Version 5010 standards for electronic claims
  - **October 1, 2013** — for full implementation of ICD-10 code sets for electronic and paper claims

P.3  September
HIPAA 5010  ICD-10

Version 5010 And ICD-10-CM: Will You Be Ready In January, 2011 to test your electronic claims using the HIPAA 5010 system?

- The First Recommended Deadline For A Successful Transition To Version 5010 Is Only 2 1/2 Months Away.

P.5. AUGUST
ICD-10-CM

- ICD-10-CM Transition General Introduction
- A CMS fact sheet provides
  - Background on the ICD-10-CM transition,
  - General guidance on how to prepare for it, and
  - Resources for more information.


P.2. September
2010 3rd Party Update

- CMS
- PQRI
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- EHR
- HIPAA
- WPS (Medicare B)
- Noridian (DME)
- Medicaid
- Coding
- Potpourri
Discontinued LCDs

WPS Retires Some Ophthalmology-Optometry Local Coverage Determinations

- The Wisconsin Physician Services retired some Local Coverage Determinations effective 09/1/2009, including:
  - Extended Ophthalmoscopy
  - Fundus Photography
  - YAG Capsulotomy

P.4.
99000 Coding

Help in Coding the 99000 E&M Codes Correctly

- Due to his concern about recent Medicare probes into OD coding, Dr. Quack inserted his revised E&M coding evaluation form into today’s handout.

- Note some changes at the top of the second page under “Diagnosis and Management Options.” The previous edition was based directly on our previous Medicare carrier’s recommendations.

- However, due recent information from the AOA, we recommend you use this revised form.
Post-op Coding

Medicare B Co-Management Coding After Cataract Surgery

- Co-management post-op coding techniques are explained on page 3 of

Notify WPS of Therapeutic Licensure

Some Medicare Claim Denials Continue with Reason #172

- When the new WPS optometry LCD became effective on January 16th, 2010, a number of claims were incorrectly denied due to reason code #172.
- Despite subsequent corrections made to the WPS claim system, some Nebraska ODs continue to have therapeutic claims denied using reason code #172.
- This problem can be avoided by notifying WPS enrollment (866-503-7664) that your ODs are therapeutically certified.
2010 3rd Party Update

- CMS
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DME Surety Bonds

- The AOA suggests that members revise their practice arrangements to ensure that they perform some sort of examination or test for Medicare beneficiaries whose first interaction with the practice is to obtain prescription eyeglasses following cataract surgery.

- Some optometrists and ophthalmologists had their DMEPOS billing number revoked by NSC for not having a surety bond.
Surety Bonds

- DMEPOS supplier must submit an addendum to the existing bond (or submit a new bond) to the NSC in the following instances:
  1. change in bond terms,
  2. change in bond amount, or
  3. a location on a bond covering multiple non-chain locations is being added or deleted.

MAY
Noridian’s *Endeavor* provides suppliers access to patient eligibility, claim status, and remittance advices online, 24/7, once they have completed the registration process. See…

[https://www.noridianmedicare.com/dme/claims/endeavor.html](https://www.noridianmedicare.com/dme/claims/endeavor.html)
Frequent Replacement Contact Lenses For Medicare True Aphakics

- Make sure the patient is aware that Medicare may not cover frequent replacement contact lenses.
- Have them sign an ABN, giving the reason for possible none coverage as "frequency of replacement of contact lenses may exceed Medicare limitations".

P.11. NOVEMBER
CEDI

Noridian: CEDI Ordering/Referring Provider Edits

- CMS Has Updated The “OrderingReferringreport” File Containing both
  - The NPI
  - The Name (Last Name, First Name)
- Check This Before Filling Medicare Post-Op Rxs.
  https://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp

Pg.6 .  JUNE  APRIL
CEDI

CEDI Inactivates Trading Partners After 90 Days

- Since March 31, 2010, Noridian’s electronic claim service, CEDI, disables Submitter/Trading Partner IDs that have been inactive for 90 days, and will remove them from the system if inactive for 13 months.
Ordering vs. Referring Provider Warning Edits At CEDI

- The ordering provider is required on a DME claim,
- But the referring provider does not need to be sent on DME claims.
- The referring provider may be removed from the submitted claim. However, if the information is sent, it must be correct.

P.3. [link to newsletter] February
Free CEDI Billing Software

- CEDI has made the decision to offer and support a single free billing software solution to DME suppliers.
- Express Plus submitters should migrate to PCACE Pro32, the software of choice.
- Call 866-311-9184 for more information
2010 3rd Party Update

- CMS
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Medicaid Audits

Medicaid Records Review From Three Directions

- **PERM** is the Payment Error Rate Measurement program, designed to measure improper payments in the Medicaid and CHIP programs. See… [http://www.cms.gov/PERM/](http://www.cms.gov/PERM/)

- **CERT** is the Comprehensive Error Rate Testing program, designed to measure improper payments in the Medicare FFS program. See… [http://www.cms.gov/CERT/01_overview.asp#TopOfPage](http://www.cms.gov/CERT/01_overview.asp#TopOfPage)

- **MIG** The Medicaid Integrity Group is required to review Medicaid provider actions, audit claims, and identify over payments. MIG’s web page is [http://www.cms.gov/MedicaidIntegrityProgram/](http://www.cms.gov/MedicaidIntegrityProgram/)
Medicaid Eligibility

Determining Medicaid Exam Eligibility
- Check eligibility information at the Medicaid web site: http://www.hhs.state.ne.us/med/IDCards.htm.

P.7. September

Confirming A Medicaid Patient’s Eyeglass Eligibility
- Currently, the only way to determine whether a Medicaid recipient is eligible for frames or lenses is to call the Medicaid phone number on the recipient’s Medicaid ID card.

P.3. January
Medicaid Managed Care

Medicaid Managed Care Changed August 1st

- Managed care affects Medicaid recipients that are not also on Medicare (not 65 years old and not on Medicare disability)

- August 1 Medicaid managed care changes affected the following counties:

<table>
<thead>
<tr>
<th>Cass</th>
<th>Otoe</th>
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<tbody>
<tr>
<td>Dodge</td>
<td>Sarpy</td>
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<tr>
<td>Douglas</td>
<td>Saunders</td>
</tr>
<tr>
<td>Gage</td>
<td>Seward</td>
</tr>
<tr>
<td>Lancaster</td>
<td>Washington</td>
</tr>
</tbody>
</table>
Medicaid Managed Care

Medicaid Managed Care Changes August 1st

- If providers in these counties wish to see managed care patients, they need be contracted with
  - ShareAdvantage & Coventry for medical care, and
  - Block Vision for routine care.
- Providers in adjacent counties may wish to consider enrolling as well.

Pp. 1-3, JULY
A Preferred Drug List is a list of medications considered first line choices.

- A Preferred Drug List is a list of medications which are “preferred” and are considered first line choices.
- Drugs designated as non-preferred will still be available, but may require authorization of coverage prior to dispensing.
## NEBRASKA MEDICAID PREFERRED DRUG LIST

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Preferred</th>
<th>Not Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPHTHALMICS, ANTIBIOTICS</strong> (Implementation 10/14/09)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ciprofloxacin</td>
<td></td>
<td>QUIX (levofloxacin)</td>
</tr>
<tr>
<td>- CILOXAN intr. (ciprofloxacin)</td>
<td></td>
<td>QUIXIN (levofloxacin)</td>
</tr>
<tr>
<td>- ofloxacin</td>
<td></td>
<td>ZYMAR (gatifloxacin)</td>
</tr>
<tr>
<td>- MIGAMOX (moxifloxacin)</td>
<td></td>
<td>BESIVANCE (besifloxacin)NR</td>
</tr>
<tr>
<td><strong>FLUOROQUINOLONES</strong></td>
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</tr>
<tr>
<td><strong>MACROLIDES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- erythromycin</td>
<td></td>
<td>AZASITE (azithromycin)</td>
</tr>
<tr>
<td><strong>AMINOGLYCOSIDES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- gentamicin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- tobramycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- TOBREX ointment (tobramycin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER ANTIBIOTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- bacitracin</td>
<td></td>
<td>NATACYN (natamycin)</td>
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<tr>
<td>- bacitracin/polymyxin B</td>
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<tr>
<td>- neomycin/polymyxin B/gramicidin</td>
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<td>- polymyxin B/thrimethoprim</td>
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<tr>
<td>- sulfaacetamide</td>
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<tr>
<td>- triple antibiotic (neomycin/bacitracin/polymyxin B)</td>
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<td><strong>OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS</strong> (Implementation 11/12/09)</td>
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<tr>
<td>- ALREX (lotreprednol)</td>
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<td>ACULAR (ketorolac 0.5%)</td>
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<td>- cromolyn</td>
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<td>ALAMAST (pemrolast)</td>
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<td>- ketotifen OTC</td>
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<td>ALOCRIL (nedocromil)</td>
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<tr>
<td>- PATADAY (olopatadine 0.2%)</td>
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<td>ALOMIDE (lodoxamide)</td>
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<tr>
<td>- PATANOL (olopatadine 0.1%)</td>
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<td>ELESTAT (epinastine)</td>
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<td>- EMADINE (emadastine)</td>
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<td>OPTIVAR (azelastine)</td>
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<tr>
<td>- BEPREVE (bepotastine besilate)NR</td>
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<td><strong>OPHTHALMICS, CORTICOSTEROIDS</strong></td>
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2010 3rd Party Update

- CMS
- PQRI
- E-Rx
- EHR
- HIPAA
- WPS (Medicare B)
- Noridian (DME)
- Medicaid
- Coding
- Potpourri
 Coding Post-op

- **Post-op Co-managemnt Diagnosis Coding** The primary diagnosis listed is the surgeon’s diagnosis (ex: 366.16), and the secondary diagnosis as V43.1 - and the pointer (box 24e) is a 2, pointing to the V43.1 diagnosis. P.9. February

- **Billing The SNF For Post-op Glasses** If a patient is temporarily under Medicare A when Rxing post-op glasses, then an OD needs to bill the DME post-op Rx to the SNF, not to Noridian. Make arrangements with the SNF prior! For information directly from CMS, go to: [http://www.cms.hhs.gov/snfconsolidatedbilling/](http://www.cms.hhs.gov/snfconsolidatedbilling/) P.9. February
Punctal Plugs

- Can You Bill Medicare For Temporary Punctal Plugs? You can bill for temporary plugs. Remember, you should have documentation that you have tried other methods to treat dry eye before inserting and billing punctal plugs. Use the HCPCS code for temporary plugs on the claim. Pg.11. December

- Plug Reimbursement Included With Insertion? It appears other insurers are following Medicare's lead of bundling plug reimbursement with the insertion procedure code. P.9. February
Coding

WPS: Correct Placement Of Claim Modifiers

- To speed up processing, the Multi-Carrier System (MCS) requires placement of certain pricing modifiers in the first modifier position.
  - TC Technical component
  - 26 Professional component

Pg.6. December
Optomaps And Coding

Remember….

- That Medicare Does Not Pay For Screening Tests
- That You Must Charge All Insurers And Patients The Same Fee For The Same Optomap Service
- That A Non-Screening Optomap Must Follow A Prior Written Order And Must Conclude With A Written Interpretation And Report.

P.11. AUGUST
Coding

CMS Allows Reimbursement For Only One Bilateral Visual Field Per Day

- On The One Hand The WPS LCD On Eyelid Surgery Requires Two Sets Of Fields Be Run Prior To Surgery,
- Yet The CMS MUE (medically unlikely edits) Says Medicare Will Pay For Only One Set Of Fields Per Day.

- P.6. AUGUST
Coding

Medicare Now Requires Claims To Be Filed Within One Year In Order To Receive Reimbursement, According CMS Pg.7. JUNE

Billing All Patients the Same E&M Code? Review Likely!!

- If you repeatedly charge the same E&M codes for multiple patients, CMS is going to suspect improper coding an review your records. MARCH
2010 3rd Party Update

- CMS
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Use of Scribes

Guidelines For The Use Of Scribes By ODS

- It is important to be certain that the scribe's services are used and documented appropriately, and

- That the documentation is present in the medical record to support that the physician actually performed the E/M service at the level billed.

P.4. January
Report Changes in Your Practice

Report All Changes In Your Practice Situation Immediately

- Doctors
- Business entity name or type
- Address
- Tax ID number
- Branch offices
- Etc.

Make sure you change this information in all appropriate enrollments: Insurers, Medicare B, Medicaid, DME, NPI, etc., so all MATCH EXACTLY.