January 2011

NOA 3rd Party Newsletter

ERRATA
The 2nd page of the *2011* PQRI Score sheet in last months issue was labeled *2010* in error.

Special points of interest:

- EHR Registration, Attestation, and Software Information. Pp. 1-3.
- 2011 eRx Program Update P.5.
- 92004 Exam Coding P.5.
- Most ODs Exempt from Red Flag Rule P.6.
- Medicare Cuts Delayed to 2012 P.7.
- CMS *Physician Compare* Website P.9.

Inside this issue:

Nebraska Optometric Association **Volume 11, Issue 1**

EHR Incentives Registration Starts Jan. 3, 2011

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR incentive programs. Beginning January 3, 2011, that registration will be available.

On January 3, registration in the Medicaid EHR Incentive Program will also be available in some states. [Quack note: Nebraska Medicaid is limiting EHR incentive eligibility to GPs, internists, Ob-Gyn, pediatricians, and nurse practitioners.]

"It's time to get connected," said David Blumenthal, MD, MPP, National Coordinator for Health Information Technology. "ONC (Office of the National Coordinator for Health Information Technology) and CMS have worked together over many months to prepare for the startup on January 3rd. ONC's *Certified HIT Product List* at http://onc-chpl.force.com/ehrcert includes more than 130 certified EHR systems or modules and is updated frequently.

To prepare for registration, interested providers should first familiarize themselves with the incentive programs' requirements by visiting CMS' *Official Web Site for the Medicare and Medicaid EHR Incentive Programs* at http://www.cms.gov/ehrincentiveprograms/ The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

Medicare and Medicaid incentive payments will be available to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) when they adopt certified EHR technology and successfully demonstrate "meaningful use" of the technology in ways that improve quality, safety, and effectiveness of patient-centered care.

Under the EHR incentive programs, eligible professionals can receive as much as $44,000 over a five-year period through Medicare. A basic resource on EHR, including the amount of EHR incentives, time frame, 10% bonus for Health Profession Shortage Areas, Medicare Advantage incentive programs, etc., can be found in the CMS Pamphlet at https://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf

"The benefits of EHRs are widely recognized, and support for the incentive programs is strong in the health care field and among policymakers," Dr. Berwick said. "... We've provided flexibility in meeting the meaningful use requirements, both agencies have conducted extensive outreach, and we have the resources in place to help providers acquire certified EHR technology and meet the programs' requirements. Immedi-

(Continued on page 2)

New and Revised OCT Codes for 2011

The American Medical Association's 2011 Current Procedural Terminology (CPT) contains significant OCT coding changes affecting optometry. 92135, the previous code for OCT, has been deleted. In it's stead are three new level one OCT codes.

- 92132—Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral. 92132 replaces Category III code 0187T. [see page 4 regarding WPS limitations on this code.]
- 92133—Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- 92134—Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

2011 CPT also states the following:

- Do not report 92133 and 92134 at the same patient encounter
- 92135 has been deleted

(Continued on page 4)

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CMS ANNOUNCED THE FOLLOWING KEY DATES FOR THE MEDICARE AND MEDICAID INCENTIVE PROGRAMS' FIRST YEAR:

JAN. 3, 2011 – REGISTRATION FOR THE MEDICARE EHR INCENTIVE PROGRAM BEGINS.

JAN. 3, 2011 –STATES THAT ARE READY MAY LAUNCH THEIR INCENTIVE PROGRAMS FOR MEDICAID PROVIDERS.

JANUARY 2011 – SOME STATE AGENCIES BEGIN ISSUING MEDICAID EHR INCENTIVE PAYMENTS.

APRIL 2011 – ATTESTATION FOR THE MEDICARE EHR INCENTIVE PROGRAM BEGINS.

MAY 2011 – ISSUING OF MEDICARE EHR INCENTIVE PAYMENTS EXPECTED TO BEGIN.

JULY 3, 2011 – LAST DAY FOR ELIGIBLE HOSPITALS TO BEGIN THEIR 90-DAY REPORTING PERIOD TO DEMONSTRATE MEANINGFUL USE FOR THE MEDICARE EHR INCENTIVE PROGRAM FOR FEDERAL FY 2011.

OCT. 3, 2011 – LAST DAY FOR ELIGIBLE PROFESSIONALS TO BEGIN THEIR 90-DAY REPORTING PERIOD FOR CALENDAR YEAR 2011 TO DEMONSTRATE MEANINGFUL USE FOR THE MEDICARE EHR INCENTIVE PROGRAM.

NOV. 30, 2011 – LAST DAY FOR ELIGIBLE HOSPITALS AND CAHS TO REGISTER AND ATTEST TO RECEIVE AN INCENTIVE PAYMENT FOR FEDERAL FISCAL YEAR 2011.

DEC. 31, 2011 – CALENDAR 2011 PAYMENT YEAR ENDS FOR ELIGIBLE PROFESSIONALS

EHR Incentives Registration, continued...

(Continued from page 1)

ate registration is not required, but we encourage eligible providers to sign up as soon as they have certified EHR technology and are prepared to participate. *[?? - See information below…]* We are ready to help."

CMS has an updated, reorganized, and more user-friendly website for the EHR incentive programs, still located at www.CMS.gov/EHRIncentivePrograms.

We encourage providers to register for the Medicare and/or Medicaid EHR Incentive Programs as soon as possible. You can register before you have a certified EHR, and should do so even if you do not have an enrollment record in PECOS.

Registration: Learn how you can prepare, located at - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage

Path to Payment, located at - https://www.cms.gov/EHRIncentivePrograms/10_PathtoPayment.asp#TopOfPage
Explains what steps must you take to receive an EHR incentive payment.

Meaningful Use, located at - http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage
Defines "Meaningful Use", explains the criteria for meaningful use, and how to meet meaningful use requirements. Includes *Meaningful Use Objectives Specification Sheets* for the Medicare and Medicaid EHR Incentive Programs. These bring together critical information on each objective to help eligible professionals understand what they need to do to demonstrate meaningful use successfully.

Educational Materials, located at - https://www.cms.gov/EHRIncentivePrograms/55_EducationalMaterials.asp#TopOfPage
See these educational products to learn more about eligibility, payment, and meaningful use.

Frequently Asked Questions, located at - https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage
See responses to frequently asked questions on topics including eligibility, program timeline, and meaningful use.

What You Need for EHR Registration and Attestation

Make sure you have enrollment records in the appropriate systems. You'll need:

- A National Provider Identifier (NPI) All eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must have a National Provider Identifier (NPI) to participate in the Medicare and Medicaid EHR Incentive Programs.
- An account in the National Plan and Provider Enumeration System (NPPES) Most providers will need an active user account in the National Plan and Provider Enumeration System (NPPES). Please visit the link under "Related Links Inside CMS" for more information on NPPES.
- An enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs.
- If you do not have an enrollment record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs.

Registering for the Medicare EHR Incentive Programs is easy when you have the following information immediately available during the process:

- National Provider Identifier (NPI)
- National Plan and Provider Enumeration System (NPPES) ID and Password
- Payee Tax Identification Number (if you are reassigning your benefits)
- Payee National Provider Identifier (NPI) (if you are reassigning your benefits)

NOTE: You do not have to provide information on the certified EHR technology you are using when you register. However, this information is required when you attest.

The Electronic Health Record (EHR) Information Center will be open to assist the EHR Provider Community with inquiries.

Hours of operation are:

8:30 a.m. – 4:30 p.m. (Central Time) Monday through Friday (except federal holidays)
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

There is a 10% EHR Bonus for practicing in a Health Professions Shortage Area (HPSA).

See https://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf

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AOA: Fourth Optometric EHR Product Certified by CCHIT

Condensed from *AOA News,* December 2010, at http://viewer.zmags.com/publication/e0b9be2b

Madison, Wisconsin-based Health Innovation Technologies, Inc., announced Nov. 23 its RevolutionEHR version 5.1.0 had been certified by the Certification Commission for Health Information Technology (CCHIT®), a federally authorized testing and certification body (ATCB), as an EHR module, providing functionality necessary to support participation in the incentive program. The RevolutionEHR system was certified last month as a module providing functionality that will allow practitioners to maintain up-to-date health care problem, active medication, and active medication allergy lists; record patient demographics and smoking status; record and chart patient vital signs; and perform medication reconciliation. However, Revolution- EHR will seek certification for the additional functionalities required in a complete EHR by the end of the year. The firm becomes the fourth provider of optometric EHR products to achieve certification for the federal incentive program that begins Jan. 1, 2011.

The others include:

Westlake Village, Calif.- based Compulink Business Systems, Inc., became the first to be certified when its Advantage EHR Version 10 package was certified on Oct. 14 as a complete EHR by the CCHIT.

Irvine, Calif.-based Eyefinity/OfficeMate announced that its Office- Mate/ExamWriter Version 10 was certified Oct. 29 as a complete EHR.

Hillsboro, Ore.-based First Insight Corporation announced that its Maxim- Eyes SQL Electronic Health Records, Version 1.1.0.0, was certified Nov. 2 by the CCHIT as an EHR module.

Certified EHR products must have readouts that will allow practitioners to check on their performance in meeting meaningful use objectives. Many practitioners will probably use that feature to ensure they have met the necessary criteria over the course of a 90-day reporting period, before formally applying for incentives, he said.

AOA: Exceptions to EHR Meaningful Use

Condensed from *AOA News,* December 2010, at http://viewer.zmags.com/publication/e0b9be2b

During a recent series of presentations before health care practitioner organizations, David Blumenthal, M.D., the HHS national coordinator of health information technology, attempted to encourage participation in the incentive program, noting that practitioners can effectively defer a meaningful use objective by claiming an exception, thus leaving them with fewer measures to satisfy initially.

Exceptions may be appropriate when a practitioner is not called upon to use specified EHR functions at the levels indicated in the measures during a reporting period, either because the function falls outside the practitioner's normal scope of practice or simply because insufficient numbers of patients required or requested the function, he said. However, Philip Gross OD, Chair of the AOA HIT sub-committee, cautions that the HHS has not officially indicated the measures for which optometrists might appropriately claim exemptions.

Based on information provided during a recent presentation by Dr. Blumenthal to the American Academy of Ophthalmology, Dr. Gross believes there may be only a few circumstances under which optometrists might defer compliance by claiming exemptions from core meaningful use objectives:

- Computerized physician order entry (CPOE) and eprescribing: Eligible providers (EPs) could opt out of CPOE and e-prescribing if they write fewer than 100 prescriptions in a 90-day reporting period, but still get credit for the measure.
- Electronic copy of health records: If no patients ask for an electronic copy of their health records during the 90- day reporting period, EPs can meet this core set objective as an exception and still get credit for the measure.

Allowing health care practitioners to initially defer five of the 10 menu meaningful use objectives under the program rule is one way the HHS has attempted to make the earning of incentives a realistic and achievable goal next year, the AOA Advocacy Group notes.

The AOA HIT Subcommittee is seeking clarification on additional core or menu meaningful use objectives for which optometrists may be able to defer compliance by claiming exceptions. The AOA HIT Subcommittee suggests optometrists frequently check for updates on the AOA Web site EHR page (www.aoa.org/EHR).

Exceptions may be appropriate when a practitioner is not called upon to use specified EHR functions at the levels indicated in the measures during a reporting period, either because the function falls outside the practitioner's normal scope of practice or simply because insufficient numbers of patients required or requested the function.

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Changes in OCT Coding, Continued…

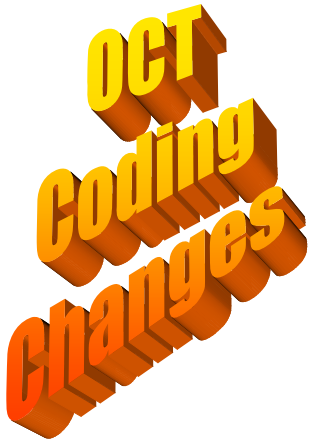
(Continued from page 1)

The following codes are new to the ophthalmoscopy section:

- 92227— Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
- 92228—Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral

2011 CPT also states for both 92227 and 92228 state:

- Do not report 92227 in conjunction with 92002-92014, 92133, 92134, 92250, 92228 or with the evaluation and management of the single organ system, the eye, 99201-99350)



The 2011 OCT coding changes will have a significant effect on the level of reimbursement for OCT services.

Dr. Quack's Estimates of 2011 OCT Fees

The previous CPT code for OCT, 92135, was paid "per eye", has been replaced by three different codes in 2011. The new codes (92132, 92133,92134) are paid "unilaterally or bilaterally" (which means it is paid once, whether for one or for both eyes). See http://codingstrategy.com/category/92132/

At press time the WPS 2011 fee schedule included the 25% Medicare fee cut Congress recently delayed until 2012. The outdated fees can be found at: http://www.wpsmedicare.com/j5macpartb/fees/physician_fee_schedule/

Dr. Quack adjusted those fees upward, eliminating the 25% cut, giving the following estimates:

- 92227 reimbursement around $11
- 92228 reimbursement around $26
- 92132 reimbursement around $32
- 92133 reimbursement around $40
- 92134 reimbursement around $40

WPS on 92132: For Tumors Only

The following is initial information on the 2011 CPT changes in OCT coding from WPS, our Medicare carrier.

WPS Medicare is aware of the recent CPT coding updates, in which CPT code. Code 92135 has been deleted and replaced with CPT codes 92133 and 32134. LCDs OPHTH-003 and OPHTH-015 have been updated to reflect this change and will be viewable on the WPS internet site and the CMS database site 01/01/2011. [Quack Note: as of 1/3/11, these LCD changes had not been made.]

As for the new CPT code 92132, WPS Medicare asked our ophthalmology CAC members for advice on inclusion of this code in the two policies referenced above. Below is the summary of their comprehensive response

"Anterior segment OCT may be used to measure the diameter to the angles for anterior chamber lenses used at the time of cataract surgery, however the IOL Master and Lenstar measure this as well and they are instruments used on almost all biometry prior to cataract surgery. I still think there is no medical indication for anterior segment OCT other than tumors at this time."

Based on this information, WPS Medicare may develop an ICD-9 coding list that will be specific for use of CPT code 92132. Until than, CPT code 92132 will be reimbursed when furnished for individuals for medically necessary indications.

A MUST READ concerning PQRI & eRX

A "Must Read"

"Physician Quality Reporting Initiative and Electronic Prescribing Incentive Program Quick Reference Support Guide for Eligible Professionals"

Dr. Quack highly recommends you take advantage of a new Medicare Learning Network® publication titled "Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) Incentive Program Quick Reference Support Guide for Eligible Professionals", which is downloadable from

http://www.cms.gov/MLNProducts/downloads/PQRIQuickRefChart-ICN904324.pdf.

This resource is designed to provide education on how to participate in the PQRI and the eRx Incentive Programs, and includes resources for the PQRI Feedback Report Availability and Access, Individuals Authorized Access to the CMS Computer Services, PQRI Incentive Payment Calculation & Feedback Report Access, Medicare Provider Enrollment Updates, as well as general information.

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2011 eRx Incentive Program Update; 2012-14 Penalties

In November, CMS announced that, beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment [decrease] on their Medicare Part B Physician Fee Schedule (PFS) covered professional services.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part B PFS covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part B PFS covered professional services.

The payment adjustment does not apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

Please note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2011.

How to Avoid the 2012 eRx Payment Adjustment

Eligible professionals – An eligible professional can avoid the 2012 eRx Payment if (s)he:

- Is not a physician (MD, DO, or podiatrist [Quack note: this should also list optometrist]), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES;
- Does not have prescribing privileges. Note: (S)he must report (G8644) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

Group Practices - For group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice MUST become a successful e-prescriber.

- Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure.

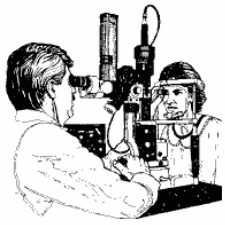
For additional information, please visit the "Getting Started" webpage at http://www.cms.gov/erxincentive on the CMS website for more information; or download the Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program under Educational Resources.

From 2012 through 2014, eRx payment penalties will increase each calendar year.

WPS Q & A on 92004 Eye Exams

Question: Is there a requirement for our office to perform mydriasis (dilation of the eye) to submit an eye procedure code (92002 - 92014)? A recently published Comprehensive Error Rate Testing (CERT) report for Ophthalmology indicated the CERT contractor reduced a service from 92004 to 92002 because there was no indication of the dilation of the eye.

Answer: Based on the description in the Current Procedure Terminology (CPT) book, the performance of mydriasis can be used "as indicated" with either an intermediate or comprehensive eye exam. While the mydriasis is not required for a comprehensive exam, if not performed, the medical record documentation must support the requirements of the CPT code and the medical necessity of providing a comprehensive as opposed to an intermediate level of service. This could include the higher level based on the nature of a new problem or initiating diagnostic/treatment programs based on an existing diagnosis. The CPT book indicates that a comprehensive eye exam must show an initiation of diagnostic or treatment programs.



92004 MUST INCLUDE INITIATION OF DIAGNOSTIC AND TREATMENT SERVICES, AND SHOULD INCLUDE DILATION, UNLESS DOCUMENTATION SHOW CONTRAINDICATION.

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AOA: Most Optometrists Exempt From Red Flags Rule

From the AOA Washington Office:

At the urging of the AOA and other health provider groups, the U.S. Senate and House of Representatives came together during Congress' post-election "lame duck" session to give final approval to an AOA-backed bill that will exempt specific businesses - including optometry practices - from having to comply with the Federal Trade Commission's (FTC) burdensome Red Flags Rule.

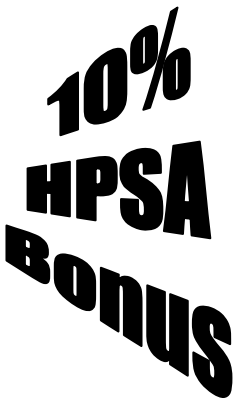
Under the legislation, which is expected to be signed by President Obama within days, the Red Flags Rule will now only apply to businesses that engage in one of three practices:

1) Using credit reports in the ordinary course of business
2) Furnishing information to credit reporting companies
3) Loaning money

The Red Flags Rule is the result of legislation approved in 2003 aimed at requiring financial institutions and creditors to develop a written plan to prevent and detect identity theft. In taking steps to implement the law in recent years, the FTC wrongly classified health professionals, including optometrists, as "creditors" and sought to apply its requirements to their practices. The AOA protested this action, helped secure four administrative enforcement delays stretching for more than two years and built support on Capitol Hill for a permanent legislative fix that included optometrists.

Quack Note: If your practice does not qualify as being exempt as described above, take a look at the following 'fill-in-the-blank' form from the FTC. Dr. Roger Filips reports it took him 5 minutes to fill out the form and print the results. http://www.ftc.gov/bcp/edu/microsites/redflagsrule/RedFlags_forLowRiskBusinesses.pdf

2011 Annual Update For HPSA Bonus Payments



The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors by early December of each year.

Since 2005 a modifier no longer has to be included on claims to receive the HPSA bonus payment, which will be paid automatically, if services are provided in ZIP code areas that either:

- Fall entirely in a county designated as a full-county HPSA; or
- Fall entirely within the county, through a USPS determination of dominance; or
- Fall entirely within a partial county HPSA.

However, if services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

The following are the specific instances in which a modifier must be entered:

- When services are provided in ZIP code areas that do not fall entirely within a designated full county HPSA bonus area;
- When services are provided in a ZIP code area that falls partially within a full county HPSA but is not considered to be in that county based on the USPS dominance decision;
- When services are provided in a ZIP code area that falls partially within a non-full county HPSA;
- When services are provided in a ZIP code area that was not included in the automated file of HPSA areas based on the date of the data run used to create the file.

The following Nebraska ZIP codes are considered HPSA ZIP codes for 2011:

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, 69022, 69023, 69024, 69025, 69027, 69028, 69032, 69033, 69038, 69039, 69040, 69042, 69043, 69044, 69045, 69046, 69121, 69125, 69128, 69129, 69133, 69135, 69142, 69145, 69147, 69148, 69152, 69154, 69157, 69161, 69163, 69166, 69167, 69190, 69210, 69214, 69217, 69331, 69333, 69334, 69335, 69336, 69339, 69340, 69343, 69345, 69346, 69347, 69350, 69351, 69360, 69365, 69366, 69367

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WPS CERT Common Coding Errors for Ophthalmology

WPS reported the following Comprehensive Error Rate Testing (CERT) Provider Specialty 18 Ophthalmology Error Summary Primary Documentation Errors:

1. Insufficient Documentation Billed CPT 99225 X 2. Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

2. Insufficient Documentation Billed CPT 92083, and 92135 X2. Required legible identifier for services provided/ordered and which shall be hand written or an electronic signature. There is no signature of the provider/author of the interpretation of the Visual Field report and Scanning Computerized Ophthalmic Diagnostic Imaging.

3. Service Incorrectly Coded Billed CPT 92004. Submitted record is for a visit to r/o a possible retinal tear because of floaters. She hasn't had new floaters since '83 and is c/o not being able to read fine print. Per CPT definition of a comprehensive visit - "it always includes initiation of diagnostic and treatment programs." Per the record she should be seen in a yr. No treatment plan or further diagnostic treatments are ordered." Documentation supports code change from 92004 to 92002. Only a basic eye exam was performed. No notation found that the eye was dilated.

4. Service Incorrectly Coded Billed CPT 99214. Billed code 99214 requires at least two of these three key components: detailed history, detailed exam and moderate complexity medical decision making. Submitted documentation supports code change of 99214 to 99213 with expanded problem focused history, detailed exam and straightforward complexity medical decision making.

The CERT report is on the WPS website:
http://www.wpsmedicare.com/part_b/business/1109_cert_errors.pdf

Obama Signs the Medicare Extenders Act of 2010

President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. The Centers for Medicare & Medicaid Services (CMS) is pleased that this law has addressed key issues for beneficiaries and providers and we are actively engaged in implementing these changes.

These provisions will improve care for Medicare beneficiaries and we encourage you to share this information with your patients. More information on these Affordable Care Act provisions can be found at Medicare.gov and at healthcare.gov. Healthcare.gov also contains a timeline and other key information about the new law and a highly praised insurance finder for coverage options in public and private insurance programs, which family members and friends of Medicare beneficiaries may find useful.

This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect.

Incentive Payment Qualifications under Medicare Advantage

See much more at: http://www.cms.gov/MLNProducts/downloads/wPQRIMAPlansTS.pdf

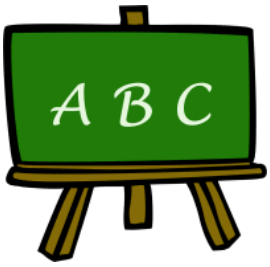
PQRI or eRx Incentive Program payments to eligible professionals who have contracted with MA organizations are governed by the terms of the contract between the health care professional and the MA organization. It is up to the MA organization and the health care professional whether eligibility for a PQRI or eRx Incentive Program payment under the Original Medicare Program affects the amount that the MA organization owes a health care professional under a contract covering MA plan enrollees.

MA organizations offering private fee-for-service (PFFS) plans that meet access requirements through the "deeming" of qualified professionals, and all MA organizations for all MA plan types when reimbursing non-contracting health care professionals, are required to pay at least the same as Original Medicare for covered Part A and B services. In "deemed" or non-contracting cases, if the eligible professional meets incentive eligibility for either the PQRI or the eRx Incentive Program under Original Medicare, then the incentive payment is calculated just as it is calculated for Original Medicare (a percentage of Medicare Part B estimated total allowed charges).

Eligible professionals, whether contracted or not contracted with an MA organization, are not eligible for either PQRI or eRx Incentive Program payments from Original Medicare for the MA plan members they treat. Eligible professionals are only entitled to incentive payments for services provided to MA plan enrollees from MA organizations based on the parameters discussed in this fact sheet.

PQRI and eRx Incentive Program quality measures data is reported through the Original Medicare FFS Program. MA physicians/non-physicians who are eligible professionals generally do not need to submit quality measures data on claims to MA plans. (Providers contracting with MA organizations might be required to submit such data to their contracting MA organizations. However, as mentioned earlier, the terms of such a contract dictate the requirements and obligations of the parties to such a contract – not this fact sheet.)

WPS Educational Seminars Available to Nebraska ODs



There are a number of WPS educational opportunities in Nebraska this year.

New Appeals Teleconference Scheduled January 25, 2011
WPS Medicare is pleased to announce a January 25, 2011, teleconference entitled WPS Medicare Appeals Process. Attendees will increase their understanding of the five levels of appeal, specific guidelines to follow when appealing a denied Medicare claim and the difference between a reopening and a redetermination. For additional details and/or to register, please visit the following WPS Medicare web page:
http://www.wpsmedicare.com/j5macpartb/training/training_programs/teleconference/

WPS Seminar in Norfolk, NE, On April 26 2011 - Basic Principles Of Medicare
Attend this full day seminar designed to provide a high-level overview of the Medicare program. New and experienced Medicare providers and billers are welcome. The program provides information about the fundamentals of the Medicare program and includes understanding claim submissions, reading the remittance advice, Medicare reimbursement, medical documentation, exploring the WPS Medicare and CMS Website, and much more. *The seminar is not designed to answer claim specific questions, as the presenters will not have the claims processing system available.* The American Academy of Professional Coders has approved this program for 5 Continuing Education Units (CEU). To learn more about the program or to register for the program, visit:
http://www.wpsmedicare.com/j5macpartb/training/training_programs/seminars/

WPS Seminar in Norfolk, NE, On April 27, 2011 - Save Dollars, Avoid Denials
This program is designed based on data analysis to assist providers and staff members in understanding the common Medicare denials and resources used to help avoid denials. The ultimate goal is to teach you how to use the resources to avoid the denials or research the denials after receipt. *The seminar is not designed to answer claim-specific questions as the presenters will not have the claims processing system available.*
The American Academy of Professional Coders has approved this program for 4.5 Continuing Education Units (CEU). To learn more about the program or to register for the program, visit:
http://www.wpsmedicare.com/j5macpartb/training/training_programs/seminars/

WPS Seminar in Omaha February 10, 2011 - Medicare Secondary Payer (MSP) Seminar
Would you like to learn more about billing claims when Medicare is the secondary payer, rather than primary? Would you like a better understanding of the various MSP plans? New for 2011, WPS Medicare is pleased to offer a three-hour session designed specifically for those who wish to increase their skill level of billing MSP claims. Come join our face-to-face, half-day program scheduled for providers and their staff in Iowa, Kansas, Missouri, and Nebraska. To view the course description, read event details, and for easy-access registration, please refer to our website for the schedule:
http://www.wpsmedicare.com/j5macpartb/training/training_programs/seminars/

WPS Seminar in Omaha March 10, 2011 - Save Dollars Avoid Denials
This program is designed based on data analysis to assist providers and staff members to understand the common Medicare denials and resources used to help avoid denials. The ultimate goal is to teach you how to use the resources to avoid the denials or research the denials after receipt. *The seminar is not designed to answer claim specific questions as the presenters will not have the claims processing system available.* The American Academy of Professional Coders has approved this program for 4.5 Continuing Education Units (CEU). To learn more about the program or to register for the program, visit:
http://www.wpsmedicare.com/j5macpartb/training/training_programs/seminars/

Provider Signatures: Who Can Sign the Medical Record

Question: I have provided the services and dictated the note for the patient encounter. The dictation has come back. Can I have my senior nurse sign the medical record for me?

Answer: No - only the physician or practitioner who performed the service may sign the documentation for Medicare purposes. CMS Internet Only Manual (IOM) Publication 100-08, Chapter 3, Section 3.4.1.1.d states "For medical review purposes, Medicare requires that services provided/ordered by authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable."

For more information, please review the articles available on signatures at:
http://www.wpsmedicare.com/j5macpartb/departments/cert/2009_1005_cert.shtml
http://www.wpsmedicare.com/j5macpartb/departments/cert/2009_1026_sigrequire.shtml

NOA 3rd Party Newsletter

New CMS Physician Compare Website

PQRI Information Will Soon Be Online for Patients to See

CMS recently enhanced the Physician Directory tool at www.medicare.gov with new information about physicians and other healthcare workers in their communities and the services those professionals provide.

The new feature, called Physician Compare, expands and updates CMS' Healthcare Provider Directory, which has helped millions of beneficiaries find Medicare-participating doctors online for over a decade. The new tool expands the doctor-specific information into the suite of informational tools for Medicare beneficiaries and other consumers.

"The new Physician Compare tool begins to fill an important gap in our online tools by providing more information about physicians and other healthcare workers," said Donald Berwick, M.D., CMS administrator. "This helps to pave the way for consumers to have similar information about their physicians as they have for nursing homes, home health agencies and health and drug plans."

The new site, at www.medicare.gov/find-a-doctor, which was required by the Affordable Care Act of 2010, contains information about physicians enrolled in the Medicare program, which include Doctors of Medicine, Osteopathy, Optometry, Podiatric Medicine, and Chiropractic. The site also contains information about other types of health professionals who routinely care for Medicare beneficiaries, including nurse practitioners, clinical psychologists, registered dietitians, physical therapists, physician assistants, and occupational therapists.

The Physician Compare Web Site is designed to be consumer friendly and help all patients—whether on Medicare or not—locate health professionals in their communities. The information on the site includes

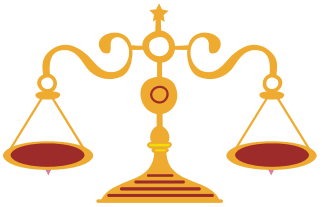
- Contact and address information for offices, the professional's medical specialty,
- Where the professional completed his or her degree as well as residency or other clinical training,
- Whether the professional speaks a foreign language, and
- The professional's gender.
- which physicians participate in the Medicare program.
- Whether the practice reported certain data to CMS through the Physician Quality Reporting System, formerly known as the Physician Quality Reporting Initiative (PQRI).

Currently, the PQRI reporting system is a voluntary reporting program that rewards physicians and other eligible healthcare professionals for reporting data on quality measures related to services furnished to Medicare beneficiaries. These quality measures are based on the best available medical evidence and designed to help professionals improve care for patients. In 2009, over 200,000 professionals reported data to CMS through the Physician Quality Reporting System.

Later in 2011, CMS plans a second phase of the Web site which will indicate whether professionals chose to participate in a voluntary effort with the Agency to encourage doctors to prescribe medicines electronically, rather than through traditional paper-based prescription methods.

In future years, the Physician Compare Web site will be expanded with information about the quality of care Medicare beneficiaries receive from physicians and the other healthcare professionals profiled on the site. The expansion will include information on quality of care and patient experience that can help consumers learn more about the care provided by Medicare-participating physicians. CMS is required by the Affordable Care Act to develop a plan to implement this expansion by 2013.

To learn more about the quality information CMS already collects through Medicare's Physician Quality Reporting System, visit http://www.cms.gov/pqri. To visit the Physician Compare Web site, visit www.medicare.gov/find-a-doctor or click on the Compare tab at www.healthcare.gov.



Comparing Providers

- **The website will include whether the practice reported certain data to CMS through the Physician Quality Reporting System, formerly known as the Physician Quality Reporting Initiative (PQRI).**
- **In future years, the Physician Compare Web site will be expanded with information about the quality of care Medicare beneficiaries receive from physicians and the other healthcare professionals profiled on the site.**

Problems with 3rd Party Plans in Nebraska?

Convincing managed care organizations to contract with optometrists for medical eye care has been a challenge faced by optometry for many years. An AOA guide to assist optometrists and state optometric associations with the persuasion process of local Managed Care Plans.

The Third Party Center (TPC) of the American Optometric Association (AOA) created and refined these tools and processes through years of experience, industry knowledge and results with large, national managed care organizations and employers. The TPC/AOA would like to assist any affiliate with their negotiations.

NOA's Dr. Quack should be contacted whenever there is a problem in the following areas with a Managed Care Plan:

- Managed Care Plan will not contract o for medical eye care
- Managed Care Plan will not reimburse optometrists for medical eye care
- Managed Care Plan does not provide coverage for medical services provided by optometrists in their medical plan

Contact Dr. Quack (schneidered@msn.com) if you are experiencing any of the above problems. If the situation warrants, a meeting can be set up with the 3rd party plan to resolve such issues.

http://www.aoa.org/documents/AOA_TPC_Mtg_Planner.pdf

Dr. Quentin Quack's Quacked Humor

A very successful lawyer parked his brand-new Mercedes in front of his office, ready to show it off to his colleagues. As he got out, a truck passed too close and completely tore off the door on the driver's side. The lawyer immediately grabbed his cell phone, dialed 911, and within minutes a policeman pulled up.

Before the officer had a chance to ask any questions, the lawyer started screaming hysterically. His Mercedes, which he had just picked up the day before, was now completely ruined and would never be the same, no matter what the body shop did to it.

When the lawyer finally wound down from his ranting and raving, the officer shook his head in disgust and disbelief. "I can't believe how materialistic you lawyers are," he said. "You are so focused on your possessions that you don't notice anything else."

"How can you say such a thing?" asked the lawyer.

The cop replied, "Don't you know that your left arm is missing from the elbow down? It must have been torn off when the truck hit you."

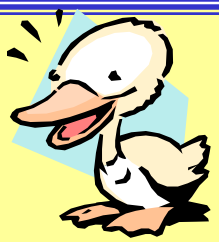
"My God!" screamed the lawyer. "My Rolex! My Rolex!".

To access the new NOA 3rd Party web page directly:

1. Go to http://nebraska.aoa.org/
2. Click on DOCTORS (gray horizontal bar)
3. Click on THIRD PARTY INDEX (gray bar, left side of screen)
4. Enter your User Name (AOA member #) and Password (DOB MMDDYY) when requested.

Dr. Quentin Quack's Queries and Questionable Quotes

Third Party Questions from NOA Doctors and Staff



Baseline Fundus Photos

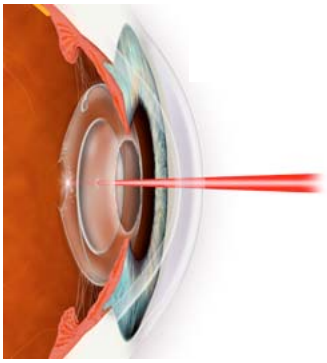
Dear Dr. Quack,
I am needing a CPT code for baseline photos. Could you help me with this please.

Dr. Quack's quote:
Dr. Quack isn't sure what you mean by "baseline" photos. Fundus photos are 92250, but make sure that there is a reasonable and necessary medical need for the photos, and there must be a written order, plus a written interpretation and report. Taking a retinal photo just to document a retinal lesion when it is not necessary to follow the lesion is not reimbursable. To quote an LCD (not our carrier's, but a good one to follow):

> *Sequential series of photographs will only be covered only if they document a clinically relevant condition that is subject to change in extent, appearance or size, and where such change would directly affect the management. Routine images to embellish the record, but a succession of which would not influence treatment, would not be reimbursed.*
>
> https://www.highmarkmedicareservices.com/policy/mac-ab/l27498-r4.html

Billing Post-op YAG

Dear Dr. Quack,
How do we handle post-op on a YAG capsulotomy…do we use the 55 modifier like we do with cataracts? Or should we bill an office visit?



Dr. Quack's Quote:
You can bill the YAG with the 55 modifier (exactly like you do with cataract post-op care, only using the correct diagnosis and procedure codes for YAG), but you can do so only if the surgeon billed with the 54 modifier (which they generally do not, unfortunately). The days in box 19 (narrative section in electronic claims), the information in 17 and 17b (referring doctor), are both the same as cataract post-op care.

If the surgeon does not bill with the 54 modifier, then Medicare is paying the surgeon for the post-op care. And, if you then bill for post-op care as well, you will be double billing Medicare. Double billing Medicare is not something you should consider. BTW, some surgeon's offices tell ODs to bill the post-op care using an E&M code...that is not correct, and is indeed double-billing Medicare for the same post-op service.

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The NOA Third Party Newsletter is published monthly by the Nebraska Optometric Association with the assistance of Ed Schneider, O.D., Third Party Consultant.

To reach Ed (aka Dr. Quack):

> BEST to contact via Email at: SchneiderEd@msn.com

> Ed's mobile phone is 402-310-2367. Voicemail available.

> Fax number is 402-464-1214. Call Ed before faxing.

NOA Third Party Newsletter—ABSTRACTS OF THIS MONTH'S ISSUE