The Centers for Medicare & Medicaid Services’ Office of E-Health Standards and Services (OESS) is announcing that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions. If any entity is experiencing difficulty reaching a MAC, please contact Karen Jackson at Karen.Jackson1@cms.hhs.gov.

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.
More on Medicaid Managed Care In Greater Nebraska

The Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC) is planning an expansion of the physical health managed care program statewide effective July 1, 2012. The Intent to Award has been issued and is available at the following website: [http://www.das.state.ne.us/material/purchasing/3792.htm](http://www.das.state.ne.us/material/purchasing/3792.htm)

MLTC will be implementing two (2) health plans to manage physical health services for clients in the 83 counties not currently served by Physical Health Managed Care. MLTC intends to contract with:

- **Coventry Cares**, by Coventry Healthcare of Nebraska, Inc.
- **Arbor Health**, by Amerihealth Nebraska via BCBS.

Providers must enroll as a network provider with these new plans to be able to serve their respective managed care clients.

For those interested, contact information for enrolling is as follows...

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**Arbor Health**, by Amerihealth Nebraska via BCBS, to use Avesis for Medical and Routine Care.

**Avesis Medical and Routine Vision Benefits**

*From Avesis: The following is a letter mailed to Nebraska ODs affected by the new Medicaid Managed Care Organizations (MCOs) providing coverage to Medicaid patients in the western 83 counties of Nebraska beginning July 1st.*

Dear Eye Care Provider:

We are pleased to announce that Avesis Third Party Administrators, Inc. has entered into an Agreement with AmeriHealth Nebraska, Inc. operating as Arbor Health Plan to provide routine eye and eye medical surgical benefits to eligible Medicaid recipients in all counties not already served by the State’s current Medicaid Managed Care Program. Arbor Health Plan is a Medicaid managed care organization whose goal is to keep families and communities healthy by keeping them connected to their physicians. Avesis Third Party Administrators, Inc. is a national vision, dental, and hearing program administrator, with over five million members nationwide of which three million are Medicaid or Medicare members. Avesis Third Party Administrators, Inc. is a wholly owned subsidiary of Avesis Incorporated, an ancillary benefit provider for over 34 years.

The program will be effective July 1, 2012. As there is a very short time frame within which to credential and contract the Provider Network, Avesis will work closely with you and your staff to complete the contracting and credentialing process. If your application is not on CAQH, we ask that you complete and return the enclosed Avesis Provider Application. Please be sure to include copies of your current license, DEA certificate, if applicable and your professional liability insurance certificate. If you are on CAQH, please complete and return the attached form providing us with your CAQH number and the exact spelling of your name, as it is registered with CAQH. Please be certain that your attestation, credentialing documents and office location information are current with CAQH and that you have designated “Global” or “Avesis” as being authorized to receive your documents. Please also complete, sign, and return the Provider Agreement with Plan Sheet and Nebraska Medicaid Addendum to the following email address, fax number, or standard mail address:

- NebraskaMedicaid@avesis.com
- Fax number: 866-331-9514
- Avesis Third Party Administrators, Inc.
  10324 South Dolfield Road
  Owings Mills, MD 21117
- ATTN: NEBRASKA MEDICAID NETWORK DEVELOPMENT

(Continued on page 3)
**NOA 3rd Party Newsletter**

(Avesis Letter, Continued from page 2)

Please note that all providers participating in the Nebraska Medicaid program are required to have an active State Medicaid ID number and a NPI number prior to rendering services. If you do not have a Nebraska Medicaid ID number, information necessary to apply can be found on the Avesis website at: [www.avesis.com](http://www.avesis.com).

Thank you for your time and consideration. We look forward to building a strong business relationship with you and your staff. Please do not hesitate to contact either Eilene Fennelly or Cheryl Beyenka, should you have any questions.

Sincerely,

Eilene Fennelly
Contracting Specialist
(800) 643-1132, ext. 116
Email: efennelly@avesis.com

Cheryl Beyenka
Contracting Specialist
(800) 643-1132, ext. 141
Email: cbeyenka@avesis.com

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**Current Managed Care in Eastern Nebraska Unaffected by the Upcoming MCO Arrangements in Western Nebraska**

The existing Medicaid Managed Care setup is not affected by the upcoming managed care arrangement in western Nebraska: **Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, Washington will continue to be covered by United HealthCare’s Share Advantage and by Coventry Nebraska**. Both of these eastern MCOs use Block Vision for routine care. The separate MCO systems for eastern and western Nebraska is likely to continue for some time due to disparate MCO contract end-dates.

For further information, see Provider Bulletin 12-15 located at [http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx](http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx)
Nebraska Medicaid 5010 Claims Problems

Although many 5010 claims are going through the Nebraska Medicaid system smoothly, a significant number of "trading partners" (clearinghouses, direct filers, other fiscal intermediaries) have not yet attempted to file using the 5010 format, and others have tried and failed. Given the Trading Partner status and submission/file issues, Nebraska Medicaid believes that providers and Trading Partners who previously submitted electronic claims are now dropping claims to paper. This temporary workaround by clearinghouses may be occurring without the knowledge of their Medicaid provider customers. While initially considered a short-term fix, it appears to becoming a customary practice. Approximately ten weeks ago Medicaid was surprised to see the data entry (paper claims) grow to 80 thousand claims and 20 days in age. At the first of March, while holding at 22 days out, the amount increased to nearly 107 thousand. This is for paper claims that require manual entry. Manual entry of paper claims is labor intensive, and will not result in speedier reimbursement.

Medicaid has stated that a number of efforts are underway (and have been) to reduce the 5010 claim backlog. They include:

- Hiring of temporary staff
- Overtime
- Reducing CMS adjustments through electronic means
- Working with providers & clearinghouses on 5010 and NPI issues to eliminate dropping claims to paper

If your Medicaid reimbursement is slow, check with your clearinghouse or other fiscal intermediary, and ascertain they are filing in 5010 format successfully and not dropping to paper. If they are unable to file in 5010 format successfully, and/or they are dropping to paper, they should be reminded that the old 4010 format is still being accepted by Medicaid through June 30th.

WPS's New E/M Coding Guide Is Now Available

In response to interest expressed by the provider community for assistance in the correct coding of Evaluation and Management (E/M) Services, WPS Medicare Part B has provided an E/M Coding Guide, which is now available on the WPS Medicare website. THIS GUIDE WILL BE EFFECTIVE ON APRIL 19, 2012, FOR E/M SERVICES WITH DATES OF SERVICE APRIL 19, 2012 AND AFTER.

Containing both an Introduction/Instructions section and a Computation Guide, the E/M Coding Guide includes detailed instructions for its use. There are also helpful hints to assist in the determination of how each documented piece of the E/M encounter fits into the most appropriate section of the 3 KEY COMPONENTS of an E/M service (according to the 1995 and the 1997 E/M Guidelines). In addition, the Coding Guide will help users determine the level of E/M code which should be billed, according to the applicable CPT description of the service. Please access this Evaluation and Management (E/M) Coding Guide on the WPS Medicare Part B website at http://www.wpsmedicare.com/j5macpartb/resources/provider_types/_files/em-coding-guide.pdf.

(Note: The guide is housed on our E/M web page at http://www.wpsmedicare.com/j5macpartb/resources/provider_types/evalandmngmnt.shtml.)

Quack Note: the WPS E/M Coding Guide is helpful, but does not specifically address the examination component for single organ systems. ODs should refer to page 25 of the 1997 E&M Documentation Guidelines at http://nebraska.aoa.org/prebuilt/NOA/1997%20E_M%20Guidelines.PDF for E&M requirements regarding the examination component of the eyes and visual system.
All Providers Are Expected To Subscribe To WPS Medicare E-news - Sign Up Today!

WPS Medicare is pleased to offer the convenient services of our WPS Medicare eNews to all providers in our jurisdiction. WPS Medicare eNews is an electronic newsletter (Listserv) sent to you via e-mail. When you subscribe, WPS Medicare eNews will bring the latest Medicare news directly to your e-mail box, free of charge! You may unsubscribe at any time and, as with all aspects of the WPS Medicare publications, we value your privacy and will never disclose, give, sell, or transfer any personally identifiable information to third parties.

WPS Medicare eNews announces the posting of the following:

- Time-sensitive national and local Medicare news
- Medicare program changes
- Policy updates, including new, retired, and revised policies
- Training events (including seminars, teleconferences, webinars, and on demand trainings!)
- Communiqué newsletters
- Specialty- and service-specific educational articles
- Much, much more!

It is important to note that the Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors (including WPS Medicare) to increase provider subscribership to their Listservs every year. In addition, CMS has instructed that every Medicare provider (including physicians, nurses, and billing staff) should be subscribed to eNews. It is a common belief that only one provider in an office can be subscribed to WPS Medicare eNews; however, CMS and WPS encourage and expect ALL Medicare providers to subscribe to eNews.

Sign up today! Visit our website at http://www.wpsmedicare.com/listserv to subscribe (it only takes a minute). And if you know a co-worker or another Medicare provider who isn't receiving WPS Medicare eNews, let them know that they're missing out on a very informative educational resource and direct them to http://www.wpsmedicare.com/listserv to sign up as well!
**NOA 3rd Party Newsletter**

**Face-To-Face Requirement For E/M Services**

WPS Medicare has noticed recent Comprehensive Error Rate Testing (CERT) findings for E/M services because the provider failed to document a face-to-face encounter with the patient. These are findings often noted for discharge day management services.

A face-to-face encounter with the patient must occur and be documented in the medical record in order to bill an E/M service. Upon medical review, Medicare will reduce or deny these services if there is no documentation for a face-to-face service.

We recommend physician practices perform periodic self audits to ascertain if any problem areas exist which may warrant further education or corrective actions. For more guidance on proper billing and documentation of E/M services, visit our Evaluation and Management web page at [http://www.wpsmedicare.com/Smacpartb/resources/provider_types/evalandmgmnt.shtml](http://www.wpsmedicare.com/Smacpartb/resources/provider_types/evalandmgmnt.shtml).

**Medicare Cuts Killed Through the End of the Year**

On Wednesday, February 22, 2012, President Obama signed into law the *Middle Class Tax Relief and Job Creation Act of 2012* (Job Creation Act). This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on March 1, 2012. The new law extends the current zero percent update for such services through December 31, 2012. President Obama remains committed to a permanent solution to eliminating the Sustainable Growth Rate reductions, which result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal, as well as implement the policies in the Affordable Care Act to move toward a patient-centered, quality oriented system.

**Electronic Signature Available for PECOS**

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers and suppliers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using internet-based PECOS. (This feature does not change who is required to sign the application.)

In internet-based PECOS, all Individual Provider applications that do not include new reassignments may e-sign the application as part of the submission process. This applies to Physicians and Non-Physician Practitioners, including those enrolling just to order and refer.

Any Organizational Provider applications that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized official/delegated official (AO/DO) of the application as part of the submission process. The AO/DO can then follow the instructions in the email and electronically sign the application. This applies to Institutional Providers; Clinics, Group Practices, and Certain Other Suppliers; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the AO/DO for the Organization that is accepting the reassignment and enter that official’s email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to their appropriate contractor).

Learn more about PECOS at [https://PECOS.CMS.hhs.gov](https://PECOS.CMS.hhs.gov), and be on the look-out for more enhancements in the coming months! Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk.
**Medicare Secondary Payer MSP Seminar In Omaha June 8**

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 2012, 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, event details and for easy access registration, please refer to our website for the schedule:

[http://www.wpsmedicare.com/Smacpartb/training/training_programs/seminars/medicaresecondarypayer.shtml](http://www.wpsmedicare.com/Smacpartb/training/training_programs/seminars/medicaresecondarypayer.shtml)

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**Mastering The Medicare Maze Seminar In Omaha June 7**

WPS Medicare is pleased to offer an all-day seminar to help you navigate the Medicare maze. Mastering the Medicare Maze offers hands-on learning and participant engagement to work through the world of Medicare.

Note: This course is not designed to be a general overview, nor is it specialty specific. The course has something for everyone.

To view the full details or register for this program visit our website:


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**Changes in Medicare LCDs Affecting Optometry**

WPS has announced changes in the following Local Coverage Determinations

**New Low Vision Services LCD**  
L32007  OPHTH-026  02/15/2012

Low Vision Services Local Coverage Determination (LCD)


Low Vision Services Billing and Coding instructions


**Revised Optometry Services LCD**  
L32001  OPHTH-503  04/01/2011

Correction of inadvertent omission of CPT code 95930 from table II. Effective 04/01/2011.


Quack Note: The effective date of this change is May of last year. If you filed a claim for 95930 (Visual Evoked Potentials) and were denied since that effective date, you might try refilling that claim line.
January 2012 Updates to the Physician Compare Website

On Thu Jan 26, CMS released its quarterly enhancement to the Physician Compare website. Improvements were based on recommendations made during July 2011 testing as well as suggestions from users and stakeholders. This is part of the Agency’s ongoing effort to improve the Physician Compare website’s data accuracy and ease of use.

What’s New?

✦ **Page updates:** Home, results, and profile pages were updated and content reorganized to make it easier for providers and beneficiaries to find information. For example, a new menu option, “Provider Resources,” is a direct link providers can use to find information about updating their PECOS information.

✦ **Improved feedback tool:** The tool now allows providers and beneficiaries to contact Physician Compare administrators directly with questions or concerns.

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WPS: Transitioning From 4010 To 5010 835

When filing with WPS, submitting 837 5010 does not automatically set you up for 5010 835. If you are receiving your 835 in the 4010 format, we strongly encourage you to transition to the 5010 format. The entire submitter number can be transitioned from 4010 to 5010 835 as well as on a provider by provider basis. We currently have 80% of our trading partners transitioned to 5010 835.

MREP (Medicare Remit Easy Print) Version 3.2.2 is 5010 ready. Therefore, MREP users are strongly encouraged to transition now. MREP users who are not on the current version must upgrade at the following website: [http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp](http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp). If you are using another software vendor besides MREP or WPS PC-Ace, you must contact your vendor about their 5010 835 readiness.

Requests to transition from 4010 to 5010 835 must be done in writing. You may e-mail your request to EDIMedicare@wpsic.com or fax your request to (608) 223-3824. Please be sure to include your WPS Submitter ID and Lines of Business in your request.

If you do not request to be transitioned, you will automatically be transitioned to 5010 835 effective March 31, 2012.

If you have questions about this or any other Medicare electronic billing issue, please contact EDI at (866) 503-9670.
Compliance: What You Need to Do to Avoid Billing Errors


This webpage provides the latest Medicare Learning Network products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

For Healthcare Providers; Social Security’s new electronic signature

We are forwarding this message on behalf of the Social Security Administration.

On Thu Mar 22, Commissioner Astrue signed an Open Letter to Healthcare Providers, Health Information Managers, and Medical Records Administrators about Social Security’s new electronic signature process for Form SSA-827, “Authorization to Disclose Information to the Social Security Administration.” To see this important message, visit http://go.usa.gov/EUu. To learn about Social Security’s new electronic signature process, visit http://go.usa.gov/P7V.

Register Early for EHR Incentive Programs

CMS recommends that all eligible professionals (EPs) register as early as possible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

Registering does not mean you are required to participate. By registering early, however, you can make sure your information is completely up to date in all of the CMS systems and resolve any issues which might otherwise prevent you from participating in the EHR Incentive Programs. If you do not resolve registration problems, you will not be able to attest and could potentially miss out on a payment year.

Give yourself plenty of time and register today. For more information on registration in the EHR Incentive Programs, visit the Registration page of the EHR website.

Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

CMS EHR Videos Available

CMS has posted a series of new videos about the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to the CMS YouTube channel http://www.youtube.com/user/CMSHHSgov.

At the 2011 American Osteopathic Association (AOA) Conference, CMS filmed seven conference attendees who provided their stories about EHRs and the EHR Incentive Programs. In the series, the testimonial videos discuss topics such as benefits of EHRs and navigating the Incentive Programs.

Also take a look at CMS’s additional EHR videos on the CMS YouTube channel, including additional provider testimonials and EHR incentive payment highlights.

Want more information about the EHR Incentive Programs? Make sure to visit the EHR Incentive Programs website http://www.cms.gov/EHRIncentivePrograms/ for the latest news and updates on the EHR Incentive Programs.
From the AOA:
Hold Off on ICD-10 Expenditures At This Time

The following is a letter from the AOA’s Chuck Brownlow, OD., to Association Execs regarding preparations for ICD-10-CM.

As you may know, AOA has established a task force to create materials, webinars, seminars, AOA News articles, and other materials to assist members and their staff get ready for the eventual implementation of ICD-10. The date for the changeover from ICD-9 to ICD-10 for reporting diagnosis codes is currently set at October 1, 2013. The Centers for Medicare and Medicaid Services (CMS), recently announced that they are considering yielding to the considerable pressure from providers and that they might extend the deadline. If they do, implementation will be delayed at least until January 1, 2014 and possibly even until April 1, 2014.

There are several things that you, as association execs, should consider regarding ICD-10:

1) Consultants are planning to make a lot of money putting on full day seminars for doctors and staff. They would prefer to do the seminars now, well in advance of whatever the deadline will be, because a dollar in the hand is worth more than two that might (or might not) be in the hand eighteen months or two years from now.

2) Promotional materials seem to frighten doctors and staff into getting education early, at whatever cost

3) ICD-10 is more complicated than ICD-9, but it is not so complicated that it will take any more than two or three months to prepare for its implementation

4) AOA has already distributed a lot of information regarding ICD-10, including a very large article, charts, etc., in the February edition of AOA News for doctors and staff to use as primer for their ICD-10 preparation

5) I'll be doing webinars March 13 and 27 on the subject, and right now I'm hoping that the new deadline is established so that I can help members and staff begin scheduling their training for ICD-10

6) If there is interest, AOA will be producing seminars regarding ICD-10 Implementation, similar to the EHR seminars, closer to the eventual implementation date

With all of this in mind, I encourage you and all AOA members to hold off on any big expenditures on ICD-10 preparation/education, at least until CMS has announced its new deadline. Once we know the date, efforts can be focused on the six to nine months immediately prior to that date. Most material presented before that will be forgotten anyway...We all know, if we don't use information regularly we forget it.

In the meantime, as if we need something else to concentrate on, it would be a very good idea to encourage members and staff to focus on their medical record keeping. It is quite clear that CMS will be auditing a significant number of physicians, including ODs, during 2012 and 2013. All ODs need to be reviewing their protocols for providing care. All care must be focused upon the needs of each patient at each visit, the medical record must include all details of each visit, orders for services must be included in each record, and all coding choices - CPT and ICD-9 - are based purely upon the content of the patient's record.

For help with those very important current issues, as well as ICD-10, members can find lots of resources at www.aoa.org/coding and askthecodingexpert@aoa.org.
Clarification on Submission of the Correct "Amount Paid" on Assigned Claims - Item 29 of the CMS-1500 Claim Form

The following instructions apply to "Assigned" Claims Only. Suppliers are reminded that Item 29 of the CMS-1500 Claim Form or the electronic equivalent is to be completed with the "total amount the patient paid on the covered services only." Any beneficiary payment amount collected for the specific covered items submitted on the claim, (i.e., coinsurance and deductible) should be reflected with the claim submission. Suppliers should not report any money collected on non-covered items, upgraded items, or items expected to be denied as not reasonable and necessary with an ABN on file. In the event Medicare is the secondary payer, suppliers should not report any primary insurance payments in the "Amount Paid" field.

Suppliers are encouraged to follow the instructions above to ensure the beneficiary's Medicare Summary Notice (MSN) reflects the proper payment due to the supplier and any Medicare payment over the total patient responsibility amount will be sent to the beneficiary.

The DME MACs remind suppliers, there is never any certainty if a deductible will or will not be applied to the claim in question. The deductible will be applied based on the first claim to complete processing and not necessarily the claim with the earliest "date of service" in the year. The information available through the eligibility systems is only as current as of the date received and not a guarantee the deductible will be applied to a specific claim. Therefore, suppliers are strongly encouraged to wait and collect the deductible after a claim has been finalized and included on the remittance advice.

Refractive Lenses Web-Based Workshop - April 25, 2012

Join NAS DME Outreach and Education on April 25, 2012, at 1 p.m. Central Time to review the Refractive Lenses Local Coverage Determination (LCD) and Policy Article. The review includes medical necessity guidelines, documentation requirements, coding and more. This workshop is scheduled for 60 minutes.

Registration
To register, go to the Web-Based Workshops page under Training and Events. https://www.noridianmedicare.com/dme/train/workshops/index.html%

Confirmation
A confirmation with the login address and call-in number is sent via e-mail from messenger@webex.com immediately after registration. Recognize this email address as safe to ensure delivery of the confirmation e-mail.

If a confirmation has not been received:

1. Ensure there is not a system block on messenger@webex.com
2. Check the SPAM email account
3. Call the Supplier Contact Center at 1-866-243-7272

The handouts are sent in a separate email from the host two – three days prior to the workshop.

The workshops are conducted using WebEx, an Internet-based meeting software. WebEx allows participants to view Web browsers and other documents on their own computers after joining the meeting. Each workshop is paired with a toll-free conference.

Please review the LCD and Policy Article located on the Coverage/MR page prior to the workshop.

https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/refractive_lenses.htm

https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/refractive_lenses.htm
Dear Dr. Quack:

We have some questions on Plaquenil patients. One of the doctors saw an article regarding the standard of care for Plaquenil pt's. Is it standard of care for Plaquenil pt's to get a 10-2 (visual fields), & a macular OCT with the yearly eye exam? If it is standard of care, will the insurance company pay for the above test with diagnosis of long term meds V58.69?

Dr. Quack's Quote:

You can see information on Plaquenil (hydroxychloroquine) on the National Institutes of Health web site [http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000171/](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000171/). As you can see, regular eye exams (which would include fields) are recommended with long term use of the drug. The V-codes available for this type of encounter are secondary codes. That is, the primary diagnosis code would be the REASON the Plaquenil was prescribed; the secondary code would be the v-code. You would use the secondary code as the reason for the visit on the claim line.

Example diagnosis codes if the patient were being treated for Rheumatoid Arthritis:

- 714.0x Rheumatoid Arthritis (the x indicates the location of the RA; you can get the appropriate diagnosis code from the patient's physician)
- V-58.69 Long term (current) use of toxic medication
- Then, on your claim line(s), you would point to diagnosis 2.

Will the insurer pay for a problem oriented exam, OCT and fields, and at what frequency? It depends on the insurer's policies, of course. I have heard of no difficulties regarding this type of claim, however.

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Dr. Quentin Quack's Queries and Questionable Quotes

Third Party Questions from NOA Doctors and Staff

Bilateral Code Done on One Eye Only

Dear Dr. Quack:

The doctors attended a meeting in KC and came back with some question about how we bill photos. We were taught that photos are bilateral and if we take 1 photo we still bill the standard fee. Now the doctors said that we need to use the 52 modifier & cut our fees submitted in 1/2...please let me know the answer to this question.

Also if a patient has routine vision insurance coverage and Medicare.....if they have a medical diagnosis.....where does the claim go to...Medicare or the routine vision. And if we submit the exam to Medicare....what about the refraction.

Dr. Quack's Quote:

You are correct regarding the 52 modifier being needed when you do a test unilaterally that is paid bilaterally. If you do the test only on one eye, but are being paid for two eyes, you are overcharging Medicare, which makes them very unhappy. So you need to cut your fee by 1/2 and use the 52 modifier.

Regarding routine vs. medical coverage of a patient with a medical diagnosis: I think most providers use the routine coverage for the exam (this usually gives the patient a lower co-pay, which they appreciate, plus the refraction is included.). Then, if the medical diagnosis requires additional testing (e.g. OCT or fields for GLC) or more frequent exams (e.g., 6 month), I think most ODs then bill those interim visits to the medical insurer.

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Plaquenil and Testing

Dear Dr. Quack:

We have some questions on Plaquenil patients. One of the doctors saw an article regarding the standard of care for Plaquenil pt's. Is it standard of care for Plaquenil pt's to get a 10-2 (visual fields), & a macular OCT with the yearly eye exam? If it is standard of care, will the insurance company pay for the above test with diagnosis of long term meds V58.69?

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The V-codes available for this type of encounter are secondary codes. That is, the primary diagnosis code would be the REASON the Plaquenil was prescribed; the secondary code would be the v-code. You would use the secondary code as the reason for the visit on the claim line.

Example diagnosis codes if the patient were being treated for Rheumatoid Arthritis:

- 714.0x Rheumatoid Arthritis (the x indicates the location of the RA; you can get the appropriate diagnosis code from the patient’s physician)
- V-58.69 Long term (current) use of toxic medication
- Then, on your claim line(s), you would point to diagnosis 2.

Will the insurer pay for a problem oriented exam, OCT and fields, and at what frequency? It depends on the insurer’s policies, of course. I have heard of no difficulties regarding this type of claim, however.
Biologist studies frogs

A noted biologist, who had been studying little green frogs in a swamp, was stumped. The frog population, despite efforts at predator control, was declining at an alarming rate.

A chemist at a nearby college came up with a solution: The frogs, due to a chemical change in the swamp water, simply couldn't stay coupled long enough to reproduce successfully. The chemist then brewed up a new adhesive to assist the frogs' togetherness, which included one part sodium. It seems the little green frogs needed some monosodium glue to mate.

Man goes to a dentist

A man went to his dentist because he felt something wrong in his mouth. The dentist examined him and said, "that new upper plate I put in for you six months ago is eroding. What have you been eating?"

The man replied, "all I can think of is that about four months ago my wife made some asparagus and put some stuff on it that was delicious...Hollandaise sauce. I loved it so much I now put it on everything --- meat, toast, fish, vegetables, everything."

"Well," said the dentist, "that's probably the problem. Hollandaise sauce is made with lots of lemon juice, which is highly corrosive. It's eaten away your upper plate. I'll make you a new plate, and this time I'll use chrome."

"Why chrome?" asked the patient.

To which the dentist replied, "It's simple. Everyone knows that there's no plate like chrome for the Hollandaise!"